

**Exploring connectedness: The meaning of transition  
experiences for patients within a forensic psychiatric  
service**

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2011**

A thesis submitted in partial fulfilment of the  
requirements for the degree of Master of  
Occupational Therapy at the  
Otago Polytechnic

## **Acknowledgements**

This thesis has been made possible by the support and contribution of many people and organisations who I would like to thank.

Firstly to the interviewees who shared with me their stories about their experience of their transitions. I would like to sincerely thank you for allowing me into your world, for taking the time to speak with me and for your honesty and courage to participate in this project.

I would like to thank my two supervisors, Dr Linda Wilson and Dr Sue Galvin for the wisdom, knowledge and support you have provided through this journey.

Thank you to the District Health Board for allowing me to proceed with this study and especially to Diane who worked tirelessly to ensure I had enough participants included in the project.

I would like to thank my friend Sue, for the time you spent editing this work.

Lastly, and sincerely, to my partner Pat, thank you for your support, encouragement and patience throughout this journey.

## **Abstract**

Literature highlights transitions as being significant in a person's life. Occupational therapy literature relating to transition and transition plans suggests that occupation, and the personal meaning of it, is central during life transitions.

This Heideggerian phenomenological hermeneutic study explores the lived experience of those patients transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service. An interpretation of the narratives of five males, aged between 23 and 37 years of age, in six interviews, is presented. Interviews could occur at three stages; prior to transition commencing; during their transition plan; and between two and four week after their plan had completed.

The purpose of this study is to understand and describe the meanings attached to the transition process these men underwent. Four themes emerged from the interviews: 'Being-in-the-world of being free', 'Stepping Stones', 'Doing what you have to, to prove yourself' and, 'Assistance comes in many forms'. These are discussed along with their subthemes. The discussion suggests connectedness to the process is central to undergoing transition. It explores the importance of connections to occupation, place, and people, when developing connectedness to the transition process.

Implications for practice for health professionals and particularly occupational therapists are outlined, along with limitations of the study and suggested future research directions.

## Table of Contents:

ACKNOWLEDGEMENTS .....	I
ABSTRACT .....	II
<b>CHAPTER ONE: INTRODUCTION AND CONTEXT TO THE STUDY</b>	<b>1</b>
THE STUDY .....	1
WHAT DREW ME TO THIS STUDY? .....	2
WHY HEIDEGGERIAN HERMENEUTIC PHENOMENOLOGY?.....	3
DISCLOSURE OF PRE-UNDERSTANDINGS AND ASSUMPTIONS .....	5
Forensic psychiatric service .....	6
Transition.....	8
SUMMARY AND OVERVIEW OF THE THESIS .....	9
<b>CHAPTER TWO: LITERATURE REVIEW.....</b>	<b>11</b>
INTRODUCTION .....	11
FORENSIC PSYCHIATRIC SERVICES .....	12
THE ROLE OF THE OCCUPATIONAL THERAPIST WITHIN A FORENSIC PSYCHIATRIC SERVICE .....	15
RECOVERY .....	16
TRANSITIONS.....	17
OCCUPATIONAL THERAPY AND TRANSITIONS .....	19
The role of the occupational therapist within transitions .....	20
TRANSITIONS BY FORENSIC PSYCHIATRIC PATIENTS .....	21
SUMMARY .....	24
<b>CHAPTER THREE: METHODOLOGY .....</b>	<b>26</b>
INTRODUCTION .....	26
PHENOMENOLOGY.....	26
My phenomenological philosophy .....	28
THE RESEARCH QUESTION .....	29
My assumptions and pre-understandings .....	30
THE RESEARCH PROCESS.....	31
Ethical Approval .....	31
IDENTIFYING POSSIBLE PARTICIPANTS.....	33
Inclusion Criteria.....	34
RECRUITMENT OF PARTICIPANTS .....	35
THE PARTICIPANTS .....	36
PROTECTION OF THE PARTICIPANTS .....	37
ANONYMITY AND CONFIDENTIALITY .....	38

THE INTERVIEWS .....	40
The use of a narrative story .....	41
DATA ANALYSIS .....	42
Reflexivity.....	44
TRUSTWORTHINESS AND RIGOUR .....	45
Credibility.....	46
Transferability.....	47
Dependability .....	48
Confirmability.....	48
SUMMARY .....	49
<b>CHAPTER FOUR: SIMON’S STORY OF TRANSITION.....</b>	<b>50</b>
THE STORY .....	51
SUMMARY .....	78
<b>CHAPTER FIVE: FINDINGS.....</b>	<b>79</b>
BEING-IN-THE-WORLD OF BEING FREE.....	80
The meaning of freedom .....	81
Free to hope.....	83
Freedom to make choices .....	85
The challenges of freedom .....	89
Fear of the loss of freedom.....	91
Summary .....	92
STEPPING STONES .....	93
Stepping towards freedom .....	93
Returning to the everyday .....	95
One step at a time.....	100
Summary .....	104
DOING WHAT YOU HAVE TO, TO PROVE YOURSELF .....	104
Proving “I’m ready” .....	105
Not questioning.....	109
Governed by rules.....	111
Each doing what is right for them .....	114
Summary .....	117
ASSISTANCE COMES IN MANY FORMS .....	118
Saying goodbye .....	118
Other people .....	120
Enjoying doing.....	126
Taking responsibility .....	130
Summary .....	133

<b>CHAPTER SIX: DISCUSSION.....</b>	<b>135</b>
INTRODUCTION .....	135
PROCESS .....	137
People.....	141
Place .....	145
Occupation .....	147
SUMMARY .....	154
IMPLICATIONS FOR PRACTICE.....	156
CONNECTEDNESS TO THE PROCESS.....	156
CONNECTIONS TO PEOPLE .....	158
CONNECTIONS TO PLACE.....	160
CONNECTIONS TO OCCUPATIONS.....	163
SUMMARY .....	165
<b>CHAPTER SEVEN: CONCLUSION.....</b>	<b>167</b>
LIMITATIONS TO THE STUDY .....	167
FUTURE RESEARCH DIRECTIONS .....	170
UNDERSTANDING ANEW .....	171
<b>REFERENCES .....</b>	<b>174</b>
<b>APPENDICES: .....</b>	<b>183</b>

## Chapter One: Introduction and Context to the Study

### The Study

This study focuses on the experiences of patients within a New Zealand regional forensic psychiatric service who are transitioning from a secure unit to an open rehabilitation ward. The interviewees within this study have all spent varying amounts of time, but more than three months, in the secure unit. They have all been assessed by their clinical team as requiring further rehabilitation within the specialist forensic psychiatric service but within an open ward.

This research seeks to understand how a forensic patient experiences and finds meaning, during this transition. Potentially interviewees could be interviewed at three stages; prior to spending any time at the open rehabilitation ward but after they knew they were being referred; during the transition plan, when the interviewee was spending time in both the open rehabilitation ward and the secure unit; and when the interviewee had been at the open rehabilitation ward for between two and four weeks.

Data analysis was informed by Heideggerian hermeneutic phenomenology (Flood, 2010; Heidegger, 1926/1996). This thesis presents an interpretation of the narratives, which aims to inform those health professionals, and specifically occupational therapists, who support and encourage those patients who engage in the transition from a secure unit to an open rehabilitation ward within a forensic psychiatric service.

## **What drew me to this study?**

My interest in this area developed from my previous work within a forensic psychiatric service and based in the secure admission ward. I was involved in helping develop transition plans for patients who were going to the open rehabilitation ward. These plans were developed in consultation with staff from both the secure unit and open rehabilitation ward but with very little input from the patient who was transferring. At times comments filtered back to staff that patients had felt, while they were in the transition plan, as though they did not belong in either the secure unit or open rehabilitation ward. Some experienced intimidation by patients in the secure unit, with pressure to bring in contraband items, and others were worried about the prospect of having an open door available and how they might handle that.

I was interested in what literature I could find that might help me alleviate the concerns of these patients. Interestingly, after initial investigations, I discovered that there was minimal research on the process and what a person transitioning could expect. Research focused on the experience of the person undergoing the transition within this speciality area appeared to be absent.

Many patients spend months or even years in a secure unit, where they have limited choices and minimal ability to direct their own destiny. They are directed when to rise, when to eat, take medications and what activities they are allowed to be involved in. Most importantly, they do not have the choice of leaving the unit when they would like. The risk of institutionalisation is very real for these patients. Once a patient enters one of these hospitals, the effects on his or her life are profound.

Moving to a less secure environment asks a lot of patients. They need to be able to place limitations on themselves, initiate self involvement in certain activities, and make choices they have not had to make in a significant length of time. Individuals who require further rehabilitation within a forensic psychiatric service (see page 12) are still deemed likely to pose a significant risk to the community and require close monitoring. Hence transitions must be successful to ensure patients are not a risk to society or themselves. Understanding the experience of transition from the person's perspective will enable health professionals to develop individualised transition plans. Such research that looks at the individual's experience of specific phenomena is broadly called Phenomenology. There are a number of branches of phenomenology; Husserl's phenomenology looks to describe an experience in detail, while Heideggerian phenomenology looks for the meaning within the experience (Walters, 1994). This research project will use Heideggerian phenomenology as a guide. The following section will outline why Heideggerian phenomenology is an appropriate methodology.

### **Why Heideggerian hermeneutic phenomenology?**

Van Manen (1997) believes that phenomenology should be chosen as a methodology when the phenomena under study requires a phenomenological understanding of lived experience. He also believes that appropriate studies for this methodology are ones that look at the essential nature of a lived experience. I believe this study strongly fits with Heideggerian hermeneutic phenomenology for a number of reasons. Firstly, this study is an in-depth investigation looking to describe and

interpret what the experience of transitioning from a secure unit to an open rehabilitation ward is, within a forensic psychiatric service. Transition is an everyday part of the human life world and for a forensic patient this is something they undergo at different stages in their return to ordinary life. Secondly, Heidegger (1926/1996) believed that people act purposefully in taking care of their world and give meaning to the events and objects of their world. 'Their world' has been termed to indicate that individuals perceive and construct their world from the experiences and understandings they have undergone. They have no other way of seeing their world. It is unique to them because it is constructed from their perspective. Lastly, Heidegger believed that to be able to obtain an understanding of any human experience one needs to be able to get inside the person in their 'being there'. The study has sought to achieve this with in-depth interviews providing patients narratives reflecting their 'being there'.

The aim of phenomenology is to reproduce a lived experience in a communicable expression of the essence of the experience, in which the reader can share. Through reflective reliving, gained from insight in the experience being captured in words, the reader can grasp the meaning of the experience (van Manen, 1997).

In this study I am researching the experience of transitioning, specifically between wards of two different levels of security which are within a forensic psychiatric service. I am looking at the meaning of the transition. This search for meaning requires a hermeneutic ability to make interpretive sense of the phenomena. Hermeneutic interpretation is a method of seeing the significance and meaning within an interviewee's experience. It is more than just a description of the person's experience.

Through exploring the interviewees' story I aim to gain an insight about how this experience has changed their sense of meaning within their world, and what new meanings may have been constructed out of this experience (Johnson, 2000).

This study does not search for factual truths nor does it build a model or a theory of the processes involved in the experience of transition. It searches to uncover hidden or veiled components which maybe hidden from those outside the experience. By identifying and considering these, new ways can open of seeing and understanding the patient undergoing transition.

### **Disclosure of pre-understandings and assumptions**

Heidegger suggested the researcher is as much a part of the research as the participants. The researcher's ability to interpret data is influenced by their pre-understandings, assumptions based on previous experiences. Heidegger also noted that there was no interpretive research that is free from judgements or influence by the researcher (McConnell-Henry, Chapman, & Francis, 2009).

I am very aware that I am influenced by my own place in time and by the various experiences I have encountered in my life. This will affect my preconceptions of what I think it is like for a person to undergo transition from a secure unit to an open rehabilitation ward.

I am a 41 year old female New Zealand registered occupational therapist. Prior to my training I completed a Bachelors of Science in Biochemistry and had travelled extensively, both nationally and internationally. In

addition I have changed jobs on a frequent basis, usually due to moving around the country. Though I have undergone numerous changes during my life, up until the point of training, to become an occupational therapist, I had limited awareness of how incorporating these changes into my life may have affected me.

### **Forensic psychiatric service**

I bring to this research project the experiences of an occupational therapist who worked for five years in a secure ward within a forensic psychiatric service. I have worked alongside both patients and other health professionals during the process of patients moving out of the secure unit to the open rehabilitation ward. The focus, for both me as member of staff, and the rest of the team, is about successfully getting patients moved to the new ward. The view towards the future, being in the community, is often acknowledged but not focused on because, for many patients, that move is a long way off.

I was involved in decision making processes when it came to identifying when a patient may need further rehabilitation. These decisions were not always met with positive responses by the patients. Their primary goal was to get back to the community and they viewed this extra step as hindering their chosen path. I have, at times, had to stress strongly within the multidisciplinary team my professional recommendation that particular patients be moved into the open rehabilitation ward rather than directly to the community. At times this can pose difficulties for both staff and patients.

Patients deemed to require further rehabilitation within the service usually have either legal conditions or have been assessed as still posing some risk to the community. I have knowledge and some understanding of how this particular population reacts to change and disruption. At times they can react unpredictably and violently if they do not understand what is happening. Moreover, many of the forensic psychiatric population have minimal or inappropriate coping strategies. Their verbal, reading and comprehension skills, for some patients, are inadequate. They can be limited in their skill base when needing to cope with change. As a result their response, often automatic, is one of violence.

Furthermore, this population has limited support systems. Due to extreme violence or offending, or both, they have minimal people in their lives that support them beyond health professionals. They are often reliant on the health professional to provide the emotional support they need when change is occurring.

From my training as an occupational therapist I believe the term occupation encompasses all the activities a person either needs or wants to do. As an occupational therapist I believe occupations encompasses more than paid employment. Occupations are the activities that a person engages in that are meaningful and important to them (Wilcock, 2002). These include (but are not limited to) leisure pursuits, self cares such as dressing or cooking and productive activities. I also believe engagement in occupations is very much linked to the people involved with the occupation and the environment in which they occur. A person will not engage in an occupation if they don't like the people who are involved in it or where the occupation occurs. I believe is this is the case within a forensic psychiatric service also. My experience has been even if a person

acknowledges they would like to engage in the occupation, if they don't like where they have to complete it or don't feel links to the people who are facilitating or involved in the occupation then engagement, by the person, is difficult to establish.

As an occupational therapist within this service my belief is that engagement in purposeful occupations is central to the health and wellness of individuals. Occupations need to be seen as important and meaningful to the person participating in them. The forensic psychiatric population can have occupations that are no longer appropriate or that they are unable to participate in. In my experience the lack of chosen occupations can cause friction between both staff and patients, patients with other patients and within the patient themselves. As an occupational therapist, I found it was important to connect to the person not only to engage them into meaningful occupation but to enable them to trust me.

### **Transition**

I have experienced my own transitions on a number of occasions. Student to clinician and clinician to researcher are two examples of professional transitions I have completed. I bring with me, into this research project, particular insight which has been informed by these experiences.

Through my own transitions I've come to realise how unsettling they can be. I am aware that I looked for things that were familiar during such times of change. When I moved my work location I looked to use the same supermarket, join the same gym franchise and attempted to keep the

same routine I had established. I realised that attempting to replicate a number of routines in the new location alleviated anxiety about the move.

When I commenced my new employment one of the strategies that I used was trying to connect in with the staff at the new job. In my previous place of employment I had made good friends, respected those I worked with and connected with my colleagues socially and it was important I tried to do that again in my new place of employment. Until I did I felt disconnected from my job with no commitment.

I accept and acknowledge these understandings shape my approach to this research.

### **Summary and Overview of the Thesis**

The focus of this study is the lived experience of patients who are transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service. As stated in the introduction to the study, the aim of this research is to seek to understand how a forensic psychiatric patient experiences transition. Therefore the purpose is to explore and reveal what that experience tells us about how transition occurs and what is required to ensure the process is successful. Finally the ultimate goal of the study is to improve the experiences of those transitioning and increase the success of the transition.

Successful transitions are critical for the community, forensic psychiatric services and fundamentally the patient themselves. My hope is that by gaining an increased awareness and understanding of the meaning of their experiences, health professionals who support those undergoing

transition will be better informed and be able to consult and collaborate around the needs of the person transitioning.

Chapter two will summarize the reviewed relevant literature which informed this study. It defines relevant terminology used within this thesis and describes the context and setting. Chapter three presents the methodological framework and details the methods used to carry out the research, the ethical considerations, process of data analysis and finally the strategies used to enhance the trustworthiness of the research.

Chapter four presents a composite story made from all of the interviewees own stories of transition. It will enable the reader to gain a rich impression of the experience of the interviewees.

Chapter five presents the findings from this research. It discusses the four themes and subsequent sub-themes that emerged from the data; being-in-the-world of being free, stepping stones, doing what you have to, to prove yourself, and assistance comes in many forms.

Chapter six is the discussion; here I reflect on the meaning that I have drawn from the findings. Finally, chapter seven is the conclusion, in which all of the strands of the thesis are pulled together to make the picture complete. Limitations of the study are identified and future research directions are proposed.

## Chapter Two: Literature Review

### Introduction

From my interests outlined in the introductory chapter I carried out an extensive literature search using a number of databases, including CINHALL (Cumulative index to nursing and allied literature), ProQuest, and PubMed. The initial search was for information relating specifically to experiences of patients within a secure ward transitioning to other environments. This was then broadened to look at any literature related to transitioning from within forensic psychiatric services but and not necessarily related to the person's experience of it. When this search criterion yielded minimal results the search was further widened to look at transition and transition plans for people with specific health issues, predominantly those with mental illness but not restricted to this.

Overall seven key themes relevant to this study were reviewed. Firstly this review will address the literature relating to forensic psychiatry, a speciality within mental health services. It will define what a secure unit and an open rehabilitation ward are within this service and look at why a person maybe referred to a specialist rehabilitation ward. Second, the role of occupational therapy within this service will be explored. Thirdly the concept of recovery is explored within the New Zealand context. Recovery, for this thesis, is defined. I will then move onto examining transitions in general. Transition, for this research project, is defined and it looks at the factors that influence and therefore impact on this process. It then looks at transitions and transfers within a forensic psychiatric service. Following this I broaden the review again to look at the

occupational therapists' role within transitions in general and then specifically within the forensic psychiatric service. Lastly, the review finishes with outlining the significance and relevance of the proposed research not only to occupational therapy practice but all health professionals who work with people who are undergoing such a transition.

### **Forensic psychiatric services**

Forensic psychiatric services have been introduced and developed internationally to provide specialist care for those people who are in both the psychiatric and legal systems (Gunn, 2003). There is no acknowledged definition that clearly describes a forensic patient however there is an obvious responsibility for forensic psychiatric services to provide services to those who are requiring psychiatric care in prisons, those who are mentally unwell and proceeding through the court system, and those who have been acquitted due to insanity or disability (Brinded, 2000). The environments in which these services are provided include hospitals, prisons and the community and deals with those who are deemed, often by society, dangerous. Gunn (2003) asserts these patients are one of the most stigmatised group of people in any branch of medicine (Gunn, 2003).

Brinded (2000) reports that prior to 1987 New Zealand did not have a specialist forensic psychiatric service, nor was it recognised as a subspecialty of general psychiatric services. In 1988, after a number of adverse events took place, a Commission of Inquiry was held. The Mason report shaped the future of the forensic psychiatric service nationally as it provided an outline for the development of a forensic psychiatric service

in New Zealand. The report paid specific attention to cultural issues, ensuring the provision of facilities and delivery of healthcare for Maori were addressed (Brinded, 2000).

The Treaty of Waitangi is the foundation document of New Zealand and there is an expectation that delivery of all healthcare services should reflect the principles of this document. Knowledge of the Treaty and its application in the delivery of forensic psychiatric services is vital in this country (Brinded, 2000; Wyeth, Derrett, Hokowhitu, Hall, & Langley, 2010).

There are varying levels of security within hospitals in the forensic psychiatric service. Secure units have been set up to cater for varying lengths of stay. Some are relatively short term, 18 months to two years, as admission or intensive care wards. They most commonly take their admissions via the corrections service and the courts. The other type of secure unit is long stay where client length of stay can last multiple years, and their admissions usually come from the secure admission or intensive care wards. Secure units have internationally a number of features in common. They have strict procedures regarding safety and security, and a high staff:client ratio. Furthermore there are airlocks on the doors which access the outside world, multiple locked doors within the unit, policies regarding who can access certain areas within the unit and strict procedures regarding identifying and managing potential weapons (Jacques, Spencer, & Gilluley, 2010; Kirby & Pollock, 1995; Lloyd, 1995). Often the process of deliberate rehabilitation begins in these settings. It is thought that the long term risk of a person will decrease if rehabilitation begins as soon as possible (Lindqvist & Skipworth, 2000).

It has been acknowledged however, by researchers and clinicians, that the most successful rehabilitation occurs in the least restrictive environment, as this is where the person is able to reclaim some level of autonomy and gain skills in supporting themselves (Lindqvist & Skipworth, 2000). A person who has spent time in the secure unit and is now ready for more intensive rehabilitation, but still requires a specialist forensic psychiatric service, may be referred to an open rehabilitation ward. Here they can undergo a variety of rehabilitation plans that are tailored to their needs (Nagi & Davies, 2010).

Forensic psychiatric service open rehabilitation wards have lower level of security compared to the secure units (Nagi & Davies, 2010; Pillay, Oliver, Butler, & Kennedy, 2008). Air locks are no longer there; and the door to the outside world is often open. There is a reduction in the staff:client ratio, and the intensity of daily procedures which have to be carried out in regards to assessing risk of violence, and those living there are able once again to access areas of the ward such as the kitchen and laundry without needing to get staff to unlock doors.

Different specialist health professionals work within the forensic psychiatric service, these include occupational therapists. Occupational therapists work both within the secure units and the open rehabilitation wards (Moore, 2004). The following section outlines the role that this profession has within the service.

## **The role of the occupational therapist within a forensic psychiatric service**

A fundamental concept in occupational therapy is that time spent engaged in meaningful activities (such as self-care, leisure, and productivity) can have a positive impact on health and well being (Wilcock, 2002). The participation in everyday occupations is a vital part of human development and lived experience. Skills and competencies, connections to others and communities, along with purpose and meaning within our lives are gained through the participation in occupations (Law, 2002). Occupational therapy's focus is on enhancing participation. Occupational therapists enable individuals and groups to participate in chosen, meaningful occupations which provide fulfilment and engage them into their everyday lives (Law, 2002).

Within forensic psychiatric service the occupational therapist provides detailed assessment of abilities in on- and off-ward activities (Moore, 2004). It is the use of the environment, everyday activities and the application of purposeful task engagement that forms the unique differences between occupational therapists and other professionals within this practice area (O'Connell & Farnworth, 2007).

The skills of an occupational therapist contribute important aspects to the rehabilitation of the mentally disordered offender. This is due to the focus on assessment of the person's current functioning, individual goal setting in collaboration with the individual, and intervention focusing on functional and daily living skills to increase quality of life and to prepare the individual for possible reintegration into the community (Rogowski, 1997).

## Recovery

The concept of recovery is increasingly becoming part of the vocabulary of psychiatric professionals (Lunt, 2002). Its concept is seen to be a move away from the traditional medical model towards an approach that empowers individuals. Recovery focuses on individuals' own life experience and their readiness to recover, with support and hope being central to the process (Anthony, 2000). Recovery is seen to occur when the people living with mental illness take an active role in improving their lives and when communities include those people who live with mental illness (Mental Health Commission, 2001).

Recovery principles were derived to guide the understanding of recovery and these have become part of the mental health standards in New Zealand. This means all professionals, working in the area of mental health in New Zealand, must integrate the recovery principles into their practice (Mental Health Commission, 2001).

Krupa and colleagues (2009) argued occupational therapy can play a significant role in psychiatric rehabilitation within the context to recovery (cited in Kelly, Lamont, & Brunero, 2010). Moreover, Kelly and colleagues (2010) found active engagement into occupations were significant in a person's recovery journey. Finally, Dowling and Hutchinson (2008) believe recovery and occupational therapy sit well together. Occupational therapy, as a profession, has an important part to play in the life of a person living with mental illness, empowering them to become the person they want through engagement in meaningful occupations that maintain health and wellbeing.

The overall goals of a forensic psychiatric occupational therapist include enabling the patient to pursue meaningful chosen occupations, providing interventions that promote functional independence and enhancing the person's ability to cope and adapt to his or her environment (Hatton, 2004). Consequently, I believe occupational therapy practice can be seen to fit with the principles of recovery. For the purpose of this thesis the definition of recovery will refer to the active journey a person takes when living with their mental illness to regain the life they would like to lead.

## **Transitions**

Transition has been well covered in both occupational therapy and other health professions' literature. It is described as a passage from one life phase, condition, or status, to another. Transition is not regarded as an event but rather as a reorientation people go through to incorporate change into their lives. Transitions are a result of, and result in, a change in a person's life, health and relationships. Transition occurs when people's current reality is disrupted and they are either forced or choose to change. They must then create a new reality for themselves (Kralik, Visentin, & van Loon, 2006; Rittman, Boylstein, Hinojosa, Hinojosa, & Haun, 2007). Transitions are seen as complex and multilayered. Often multiple transitions will occur at the same time. For example, when a person changes employment, they may also shift locations for their new work. They may elect to rent accommodation at the new location rather than buying a home as they had previously. Changes to relationships may have either triggered the look for a new job or may be a consequence of moving. Each of these examples are individual transitions that are

interconnected with each other to create the large overall transition of changing employment.

Transitions have a time frame which has an identifiable end point. Transition processes include the signs of anticipation, perception, demonstration of change, through a time of turmoil, distress and eventually to an end point where stability is once again obtained (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

There are a number of inter-related aspects important in the process of transition. Transition can only occur if the person is aware of change taking place. This relates to their knowledge, perception and recognition that a transition is taking place. There must be awareness that change is taking place; a lack of awareness may indicate the person has either not initiated the process of transition or may not be ready for transition. An absence of awareness that a transition is either about to or is taking place may not prevent it occurring but it does influence the degree of engagement a person takes into the process (Clingerman, 2007; Kralik, et al., 2006; Meleis, et al., 2000).

The literature emphasises the importance of engagement which follows awareness, and this is defined by the degree a person becomes involved in the process. The person is then immersed in the transition and undertakes activities that allow him or her to fully support the change. Therefore, the level of awareness the person has of the need to transition influences the level of engagement with the process. Engagement cannot happen without awareness. It is often after a person realises that their life is now different or they see themselves doing things differently that they then

deliberately engage with the transition (Clingerman, 2007; Kralik, et al., 2006; Meleis, et al., 2000).

There are a number of research projects within nursing literature which confirm these factors regarding transitions. However none of these relate to transition within a forensic psychiatric population. Clingerman (2007) completed research in transition experiences with migrant farm workers and identified a number of themes in the transition that are relevant to this research project. There were differences between actual and expected transition experiences, and the time between recognising transition was occurring and then engaging in it was critical. If not enough time was available then the success of the transition was affected. Furthermore, the way participants were involved in the decision making process impacted on the success of the transition. That is if they perceived they had minimal control or power over the process then their experience was affected detrimentally (Clingerman, 2007). Hall's (2003) research into positive self-transition in women child abuse survivors found very similar results. Having time to cognitively process and engage with a change in life circumstances was vital.

### **Occupational therapy and transitions**

Occupational therapy literature relating to transition and transition plans also describes transition as a discontinuity in a person's life space (Blair, 2000). Such a discontinuity requires a person to alter their routines, habits and often the way they complete their occupations. This requires a person to be aware of this change and to engage into it. For occupational therapists, occupation, and the personal meaning of it, is central during

life's transitions. The idea of an interruption in the pattern of everyday life and the implications on how it may disrupt engagement in occupations is of interest to occupational therapists (Blair, 2000).

Occupational therapy literature also views transitions as voluntary, when a person chooses to undergo the transition, such as entering study. While other transitions are seen as involuntary, a person undergoes a transition although they do not necessarily choose to, such as becoming a widow (Blair, 2000; McIntyre & Howie, 2002).

### **The role of the occupational therapist within transitions**

An occupational therapy role within transitions and transitional plans has been described in a number of research articles. Proctor and Kaplan (1995) described the role as defining function, defining independence, and assisting in coordinating the efforts of the team to help each client to meet his or her expectations. Myers (2008) identified the occupational therapist's role as supporting the person undergoing the transition with their engagement in occupations.

Occupational therapists claim they are best placed to provide this support because of their knowledge of task demands and how that task demand changes in diverse contexts. An understanding of activity analysis and environmental adaptation and modification provides occupational therapists with the ability to alter or modify the context or task in the new environment (Michaels & Orentlicher, 2004; Myers, 2008).

The review of occupational therapy literature and transitions did not find reference to the role an occupational therapist plays in transitions within a

forensic psychiatric service. Blair (2000) and Freeman and Blair (2004) suggest engagement in meaningful occupation is significant during transition and occupational therapists have an important role to play in facilitating this involvement. Therefore, research with a forensic psychiatric population which focused on the role of occupation within patients' transition would be beneficial.

### **Transitions by forensic psychiatric patients**

Information relating to transitions for patients within a forensic psychiatric service was scarce. Of the small amount of literature found most focused on specific groups of people within a forensic psychiatric service and none looked at transitioning specifically from a secure unit to an open rehabilitation ward within this speciality service.

Skelly (1994) used a Grounded Theory methodology to examine problems experienced by patients moving from a special hospital to a regional secure unit, that is, undergoing a reduction in security levels. He developed a theory of failure and looked at why this was the case. The participants in his study spoke of needed to "play the game" (p. 1060). They did not believe in what they "had to do" in the new ward. The participants understood there were expectations on them, such as complying with rules or performing certain behaviours, however they did not necessarily see them as beneficial. They understood they needed to comply or they would not get out. There was, for some of his participants, a feeling of threat. They believed that if they did not comply they would be returned back to their originating ward. Often these participants believed that if there were issues or trouble on the new ward they would

be automatically blamed. The participants then became more concerned about pleasing the staff and staying out of trouble than participating in the decision making process regarding their care.

Skelly (1994) concluded that not enough was being done at the originating ward in preparing them for their transfer. He recommended transfer planning should concentrate primarily on the systematic presentation of relevant information about the new ward to the patient rather than information to the new ward about the patient (Skelly, 1994).

Travernor, Travernor, and Crispin's (1996) research project only included patients who met the criteria for psychopathy and were moving wards. They collected retrospective data from day reports of incidents that occurred around the time of the move by patients. They divided the results into physical or psychological or combined events. They found there was an increase in events surrounding ward moves, mainly due to an increase in psychological symptoms. They proposed that aggression may be a response to feeling powerless and being unable to control their environment and believed it warranted further investigation (Travernor, et al., 1996).

From these early works, one specific transition plan was established. The Massachusetts Department of Mental Health established a forensic psychiatric transition plan which worked with mentally ill offenders in 1998 (Hartwell & Orr, 1999). The primary goal was to coordinate services and assist in community reintegration. It was established because there was recognition, by clinicians, that without monitoring and support after release the mentally ill offender would continue to cycle through social services, courts and prison. They aimed to establish a well-monitored

transition plan which enhanced public safety. A brief report evaluating this plan identified an area that might improve services and enhance clients functioning, specifically that treatment engagement strategies need to be improved for clients who have little interest in the services offered by the plan. Overall they believed that the forensic psychiatric transition plan was providing all the services required for re-entry into the community (Hartwell & Orr, 1999).

In December 2002 the Massachusetts Department of Forensic Transition team was regionalised. Again a research project assessed the effects of this regionalisation. The research recognises re-entry planning for those being released from corrections poses challenges especially since there is a high rate of recidivism or return to the criminal justice system (Hartwell, Fisher, & Deng, 2009).

Bjorkly (2004) found there was a shortage of publications on structured or individually developed clinical approaches which were criterion based and delivered in a stepwise fashion which increased the likelihood of successful transition from forensic psychiatric facilities to community living by the violent psychiatric patient. Bjorkly (2004) believed there may be a discrepancy between what is actually occurring clinically and what is in the literature. His belief is that rather than no individually developed clinical approaches being used to increase the likelihood of successful transition, they are not being reported. He called for further research to be completed as it is only through completing this research that the development of strategies for improvement can occur (Bjorkly, 2004).

Past research highlights that working with the patient who is about to transfer from a secure ward to an open rehabilitation ward should be the

primary focus for health professionals. This would ensure there is compliance with the plan that has been developed for them (Buckley, Noffsinger, Smith, Hrouda, & Knoll, 2003).

However it appears that most of the existing research in this area has been produced from the view point of the health professionals who are working in the area and what they deem to be priorities rather than from the experiences and priorities of the patient group. Focus of such research has been on treatment compliance of the patients rather than engagement into the treatment. There has been little research attention given to understanding and therefore enhancing engagement with this patient group in transition. Yet the literature presented in this literature reviews says that engagement with transition is important in ensuring the success of it. So, there needs to be research conducted with patients regarding their experience of transition and their engagement in it.

## **Summary**

The review of literature has highlighted that transition is a complex, multilayered process which requires a person to not only be aware they are undergoing a change but to engage in the process to ensure the success of it. The literature related to forensic psychiatric service transitions predominantly focuses on specialist areas within the service, such as looking only at people who meet the criteria for psychopathy, and those from Special Hospitals to medium secure units, or looking at the management of risk when people are undergoing transition. Personal experience of transitioning, by those undergoing this process in this service area, is lacking within the literature. To find out the person's

experience of transition the researcher will have to ask the person themselves.

The significance of such research is that it will allow the health professionals, particularly occupational therapists, to understand what it is like for patients to move from a secure ward to an open ward. Understanding their patients' experiences will allow those who are developing the transition plans to ensure they cater for the needs of each individual and engage them in it.

Therefore the research question is: What are the lived experiences of clients transitioning from a secure unit to an open rehabilitation ward, within a forensic psychiatric service?

The next chapter describes the guiding philosophy I used when conducting this research along with the methods, ethical considerations and processes I took to ensure quality within the research.

## Chapter Three: Methodology

### Introduction

This chapter describes the process of this research project that I took from the beginning to its completion. It starts with an introduction to the philosophical approach, phenomenology, which guided the research project and how this links to this research. The research question and research process is explored and presented; the explanations for their use will enable readers to follow the path I took and it should allow them to judge whether the project holds true to phenomenology, and whether there is rigor in the analysis and trustworthiness in the findings, which are also discussed.

### Phenomenology

The philosophy underpinning this research is Heideggerian hermeneutic phenomenology (Flood, 2010). Hermeneutics goes beyond description but rather looks for meaning which is embedded in experience. Interpretation is inherent to human existence; we look to reflect on the meaning an experience has within our own lives. Therefore hermeneutics is more about who we are, our sense of being, rather than what we have (McConnell-Henry, et al., 2009).

Heidegger's focus was on meaning from being. It begins with the interpretation of everydayness. He believes it is a process that we as humans use to make sense of our everyday lives (Heidegger, 1926/1996;

McConnell-Henry, et al., 2009). Heidegger believes humans can only *be* rather than think about how to be and humans only become aware of who they are by examining their actions. It is only by having the experience of being-in-the-world with others that humans learn ways of being (Critchley & Schurmann, 2008).

Heidegger (1926/1996), originally written in German, claimed that we as humans are so intrinsically rooted in our own world to the extent that our experiences are linked to social, cultural and political contexts. Heidegger refers to human existence as *Dasein* or being-there. *Dasein* stresses the fact that human existence is existence in the world. Heidegger's analyses always begin with analysis of being-in-the-world (Walters, 1994). The simplest way of being-in-the-world is referred to as *Sorge*. Translated to English this means *care*. Care is about being, it is about caring for other people and entities. While we as humans are free to make our own choices, this freedom is not absolute. Our choices are restricted by the daily lives that we live (Heidegger, 1926/1996; Walters, 1994). Care can be thought of as authentic or inauthentic. When people choose freely about their being-in-the-world then they are thought of as having an authentic life. If a person lives a life based on what others have said then this being-in-the-world is said to be inauthentic (Heidegger, 1926/1996; Inwood, 1997).

Osborne (1994) suggests that hermeneutic phenomenology as a research methodology examines and describes an experience by undergoing phenomenological reflection and writing. A description of the phenomena is developed and this leads to an understanding of the meaning of the experience (Flood, 2010).

By using Heideggerian hermeneutics for this study I am looking beyond the experience of merely moving from one ward to another. Issues like our own prejudices, defence mechanisms such as fear and anger, learnt and inherent behaviour and pre-assumed opinions and cultural, organisational and institutional ways of processing and coping with issues are all ingrained within humans and conceal being-in-the-world. I have attempted to go beyond these layers and to see the person within. By attempting to remove these layers I do more than getting a description of an experience but rather look for meaning within the human experience.

### **My phenomenological philosophy**

I described in chapter one where I am situated in this study. I outlined my pre-understandings that I have brought with me to this study. As an occupational therapist I am interested in human experiences and the ways of being in the world. I am interested in ways people engage in their meaningful occupations within their life-world, that is their lived world (van Manen, 1997).

My own personal values and beliefs fit with that of my profession's values and beliefs. I believe we are all occupational beings who have a basic human need to engage in our chosen occupations, and these can change over time. As an occupational therapist I believe the occupations we choose have meaning to us and link to our identity (Vrkljan & Polgar, 2007). They are central to who we are and are shaped by the environment we are within. The environment includes physical, social, cultural, organisational and institutional influences that make up our world (Reed, Hocking, & Smythe, 2010).

The study of everyday life is what Heidegger viewed as important. Occupational therapists are interested in what a person does in their everyday life and this is often seen as ordinary. Occupational therapy's primary focus on the everyday may now no longer be seen as mundane and unimportant (Wilding & Whiteford, 2005). Reed (1993) believed that the research methods used in occupational therapy should be compatible with the profession's holistic and humanistic philosophy (cited in Finlay, 1999). Heideggerian phenomenology is compatible with occupational therapy. It allows for a rich exploration of everyday aspects of life. It has great promise in occupational science and occupational therapy research because of the similarities of our philosophical and theoretical underpinnings (Wilding & Whiteford, 2005).

As explained earlier, transitioning is a part of everyday life. It is a process which humans undergo at different stages of their lives. It is also a process that occupational therapists have an interest in and a part to play to ensure successful outcomes. For these reasons the use of Heideggerian hermeneutic phenomenology is an appropriate guiding philosophy for this research.

### **The Research Question**

The question for this research project is "What are the lived experiences of clients transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service?" As explained in the introductory chapter, this arose for me through my own clinical practice working as an occupational therapist in a secure unit within a forensic psychiatric service.

I was involved with working with patients who after a period of time, were deemed, by their clinical team, “safe” to live outside the secure unit, however required further rehabilitation before being moved into the community. Due to certain risks associated with these particular patients, specialist forensic psychiatric rehabilitation was required rather than through the adult general mental health service.

I had no way of articulating to them what the experience would be like or how they might understand it. To explore this experience I needed to elicit the stories of this transition from the people who were undergoing it. I asked what the experience was like for the patients who were preparing, undergoing and completed this experience, so I could understand what it was like for them. I encouraged them to tell me their stories, so I could gain an in-depth description of their experience, as they lived it.

### **My assumptions and pre-understandings**

I came to this study with pre-understandings about myself, transition, forensic psychiatry and forensic psychiatric patients. As I stated in the introductory chapter, I needed to make explicit my own understandings, belief, assumptions and biases (van Manen, 1997).

The practice of bracketing has been described in an attempt, by the researcher, to acknowledge prior knowledge, beliefs or biases about the phenomena in question, so they can then put them aside, in order to complete the research without prejudice (Gearing, 2004). Heidegger recognised that there was difficulty with doing this and it posed problems. His belief was that all people are in the world of doing and cannot be

separated from who they are (Finlay, 2009; Laverly, 2003; LeVasseur, 2003). Instead Heidegger argued that the researcher is as much a part of the research as the participant and the researcher's ability to interpret the findings is dependent on their previous knowledge and understandings (McConnell-Henry, et al., 2009).

Therefore, by making my knowledge and understandings explicit not only to the reader but also to me, this will enable both parties to be aware of how they might influence the research process.

## **The Research Process**

In this section I describe the processes in detail I have used to enable the reader to follow and understand how I came to my findings.

### **Ethical Approval**

The process of obtaining ethical approval for this research was complex and in-depth. My preparations began at the planning stage of the research project. From my experience of working in this field, I knew I was researching a population who would be deemed by an ethics committee to be highly vulnerable and also a significant risk to others. For these reasons I began my consultation process early. I wanted to ensure I included aspects in the design that would enable participants to feel not only comfortable to engage in the research but safe when doing so. I wanted to ensure the project met the needs of the service as well as the population I would be researching. I consulted with the management of

the service I was conducting the research within and with local Maori who had been identified to me.

From my previous work experience I was aware of the high representation of Maori both within the forensic psychiatric service as well as the prison system. Therefore, it was vital that I ensured my research design met the needs of this group. I did not specifically plan to research Maori however I was aware that there was a significant likelihood that many of the participants would identify as Maori. I had a responsibility under the Treaty of Waitangi to ensure that Maori wellbeing was respected and incorporated into the design of the project (Wyeth, et al., 2010).

Using the information gained from the consultations I developed a research project that met the needs of all groups. I gained two letters of support from the groups I had consulted with regarding appropriate research design for Maori and I included these in my ethics application (Appendix A and B).

As a result of the consultation I included an option of having a support person for the participants during their interview. I developed an information sheet (Appendix C) and confidentiality form (Appendix D) for the support person. The support person could not be a member of the participant's clinical team or a close family/whanau member. Close family/whanau were not allowed as I wanted to ensure they were not put in a position of conflict if they heard information that maybe distressing to them, and because they had signed a confidentiality agreement they were not allowed to disclose it. Members of the clinical team were not allowed to be a support person, as I wanted the interviewee to be confident their

information was kept confidential and no information would go back, automatically, to their clinical team.

Initially my ethics application was approved by the School of Occupational Therapy, Otago Polytechnic, Postgraduate Forum as a requirement for the research project being undertaken as part of a Masters Degree in Occupational Therapy (Appendix E). Because I planned to select my participants from the Health and Disability sector I was also required to gain ethical approval from a New Zealand Health and Disability Ethics Committee. I gained this through the Upper South A Regional Health and Disability Ethics Committee (Appendix F). I sent a progress report to the committee in February 2010 as requested and received a letter confirming continued ethics approval (Appendix G).

### **Identifying possible participants**

Due to having previously worked in the service I used a third person to make initial contact with potential participants. I did not want potential participants to feel coerced or pressured into joining the research because of previous contact and knowledge of who I was. It was important they felt comfortable to decline to participate with the knowledge there would be no detrimental effects to them. I selected a person who worked across the entire forensic psychiatric service, who was known to patients and staff in both the secure unit and open rehabilitation ward.

As I was conducting this research in a location that was a distance from where I resided it was important that the staff within the service were aware of the research project and they also knew the criteria I was using to

select participants. I ran a number of presentations with the staff of all of the units not only to provide the rationale behind the research but also the inclusion criteria I was using for selecting participants. It was in the Multi Disciplinary Team (MDT) meetings that possible participants were identified.

### **Inclusion Criteria**

I had a number of inclusion criteria which helped the teams identify possible participants for the project. These included that they:

- Have been an inpatient or prisoner in a secure environment for a minimum of three months. In my experience once a person had been in a secure environment for this length of time effects of institutionalisation become apparent.
- Have been identified as requiring further inpatient rehabilitation at the open rehabilitation forensic psychiatric ward because the research focused only on those transitioning within the forensic psychiatric service.
- English did not need to be the participants' first language however they need to be able to communicate adequately in it. As this was a Masters research project I did not have funding for translators.

The MDT then discussed the appropriateness of the inclusion of the person to the research and notified my contact person.

## **Recruitment of Participants**

Potential participants were approached by my contact person and given a small introductory letter (Appendix H) which invited them to meet with me regarding the research. They were advised in this meeting with me they would only hear more about the research; they were not agreeing to be part of the project. If they chose not to participate further then I was not informed of them or their transition. When they selected to hear more about the research my contact person advised me and passed on their contact details. I then sent them a letter (Appendix I) advising when I would travel to meet them and where we would meet, along with the information sheet (Appendix J). By sending the information sheet with the letter it meant potential participants could read over what the research was about and to think about possible questions they may have.

During the initial meeting with the potential participant the information sheet was explained and any questions were clarified. I also brought with me the digital recorder and showed them how it worked. This enabled them to view it, ask questions on how it worked and hear what the recording sounded like. They were then given 24-48 hours to decide if they would participate in the research. Some participants elected to join immediately, however they were encouraged to take time to think about it before signing the consent form (Appendix K). At this initial meeting participants were also advised they could choose to have a support person with them during the interview. They were shown the information sheet and confidentiality form that would be given to the support person.

Van Manen (1997) states the researcher is to investigate what it is to actually be in and live an experience. Looking for the various elements in

the experience is important. The experience is to be explored in its fullness and all aspects, especially those hidden, are attempted to be uncovered to enable new understandings to be generated. For this reason data collection was possible at three stages of transition. Interviews occurred prior to commencing transition (the person was aware of their impending move to the open rehabilitation ward however had not spent any time there), during transition (the person was spending time in both the open rehabilitation ward and the secure unit) and after the process was successfully completed (the person had moved to living permanently at the open rehabilitation ward and had been there between two and four weeks). Although it was preferable that each research participant completed an interview at each of these three stages, it was neither necessary nor possible for all participants.

Potential participants were advised whether there was an option for them to participate in more than one interview. They were not expected to make an immediate decision whether they would participate in more than one interview at this stage. Eligible participants were asked after they completed an interview whether they would consider participating in another interview.

### **The participants**

Five patients (Appendix L) participated in a total of six interviews. The study includes interviews from all three stages; one interview prior to commencing transition, one interview during the transition and four interviews post transition were completed. The time spent after transfer to the open rehabilitation ward ranged from two to four weeks. Although

it would have been preferable to have equal numbers of interviews at each stage, three of the participants had completed their transition before being advised of the research project and one participant had not started their transition prior to data collection finishing.

A limited amount of demographic data was collected. All participants were male with an age range from early twenties to mid thirties. They had spent varying ranges of time in secure environments, from almost two years to five years. No ethnicity, diagnosis or offence information was collected as this was not seen as relevant to this specific research project, or compatible with ensuring confidentiality.

### **Protection of the Participants**

I employed many strategies to protect the participants. It was important that the participants were confident and comfortable with the processes I had set up to ensure the information they gave would not be linked to them. For this reason after my contact informed me of an interested person in the research they no longer had an active role in that person's recruitment into the project. I made direct contact with the participant to schedule the meeting and interview times. However, once recruited into the project my contact person did inform me when the participant moved through the three stages of the transition. This enabled me to know when to approach them again for the next interview. The participants had agreed to this on their consent form.

All participants were informed they could withdraw from the project without concern of detrimental affect to them. This project was

completely voluntary and they were the ones to decide if they wanted to participate. All interviews were digitally recorded and transcribed verbatim by myself. Participants were given the opportunity to choose their own pseudonyms at the time of their interview and these were used during the interview. Their chosen pseudonym was never kept with their consent form. I am the only one aware of which pseudonym corresponded with each participant and this information was kept separate from the transcripts. My supervisors were unaware of this information, which was important, because my second supervisor is employed by the service where my research project was carried out. All data is kept in a locked filing cabinet.

One participant was interviewed twice during the research project. They had a different pseudonym allocated for each interview they completed at the two different stages of their transition to the open rehabilitation ward. Allocating different pseudonyms to each interview allowed me to ensure confidentiality of the participant information and limit the ability of the data being associated with the particular participant.

### **Anonymity and Confidentiality**

Due to the nature of forensic psychiatric services, I was unable to guarantee anonymity of the participants. As part of safety and risk management requirements it was necessary for me to check in with the clinical team prior to commencing an interview with a participant. Therefore, the clinical team knew which people had been recruited to the research project.

I was able to keep the information gathered from the participants confidential. Participants were informed prior to consenting to the research and again prior to each interview that the information they gave within the interview would remain private, and that the data I collected would not be passed on to their clinical team. However they were advised that there were two situations where this confidentiality may be broken. If they were to disclose anything that may raise a significant concern for the safety of themselves, or safety of others, then I would inform their clinical team. The interview would then cease and I would advise them of what was going to happen next. All participants consented to this.

Disclosing participants' information when significant concern for the safety of the participant or others is standard practice within the forensic psychiatric service and was included to ensure the safety of both myself, as the researcher, and those the concern was for. During the initial consultation process, the management of the forensic psychiatric service acknowledged my previous clinical experience was sufficient to assess when this disclosure was necessary.

To protect both the participant and other people associated with the participant all quotes used within this thesis are presented with all identifying information altered or removed to decrease the possibility of the participant being recognized. For example when specific days, dates or timeframes were given these were changed.

## **The interviews**

Prior to conducting the research interviews I completed two pilot interviews with volunteers sourced from my place of employment. These interviews focused on a transition experience of the volunteer's choosing. These were digitally recorded and my primary supervisor listened to them to ensure I was asking questions in a manner that fitted with my methodology. These were not transcribed and were destroyed after I had received feedback. This was to ensure I remained focused on techniques consistent with the philosophical underpinnings of my chosen methodology.

As the researcher I conducted all of the interviews. I initially made contact with the staff on the ward/unit where the participant was still residing. As I was coming from a location a number of hours drive away I wanted to ensure that I would not be interfering with the ward routine and that the participant would be available to take part in the interview. I then sent the letter confirming the date, time and location directly to the participant.

Ensuring safety for both myself and the participant was crucial. I liaised with the clinical team prior to interviewing each person to ensure that it remained a convenient time for both the unit/ward and the participant. On one occasion an interviewee elected to cancel their interview and reschedule as they were not feeling mentally well enough to complete the interview.

All interviews occurred within the forensic psychiatric service site. One occurred in an interview room on the secure unit, the others occurred in an interview room in the open rehabilitation ward. At the beginning of each interview I re-introduced myself and went over the reasons for the

interview and asked if they continued with their consent to be part of the research. I reminded them the interview would be recorded and advised each would take between 30 and 60 minutes. I also reminded them of my possible actions if they disclosed any items of significant concern regarding either their or others safety.

### **The use of a narrative story**

Lai (2010) suggests "From a hermeneutic point of view, human life is interpreted in stories" (p.75). Lai's viewpoint is that stories are interpretations of life; life is seen as human when it is told in a story format. Lai (2010) states "A story is a reconstruction of life by which past experiences survive in a purer manner because the non-essential has been removed" (p. 76).

As part of the research each person was invited to tell their story about their transition thus far using open-ended questions. Initially I started with broad questions such as, "Tell me about your transition", "I would like you to tell me about what you are doing during this time", and "What are you thinking about during this time?" Prompts were used to gain a deeper description of the experience such as, "How did you feel about that?", "What were you thinking when that happened?", "What was that like for you?", "Why do you think you felt that?" and "Tell me what do you mean by good".

Participants, at times, had limited vocabulary to explain their experiences; responses were often in single words, which required me to ask further probing questions.

## Data Analysis

The purpose of phenomenological reflection is to find the meaning so I analysed the interviews using a thematic interpretive process which initially followed van Manen (1997) four existentials. These are lived space (spatiality), lived time (temporality), lived body (corporeality) and lived relation (relationality). These four existentials can be differentiated but not separated. They all work in unison to form what is known as the lifeworld, our lived world (van Manen, 1997). I was then guided by the seven steps devised by Diekelmann, Allen & Tanner (1989) cited in Wojnar & Swanson (2007). The following outlines the process of data analysis.

As I transcribed each interview verbatim, my first step in the analysis was to re-listen to the interviews with the full transcripts and make notes again of meaningful pauses, laughs and hesitations in the interviews. I then spent time going through these again to ensure I was beginning to understand the feelings being portrayed during the interview. It was during my third listening to the interview and re-reading of the transcript that I began writing notes on the right hand margin representing my analysis of spoken words, and my initial interpretation of the transcripts.

I wrote a composite story from the six interviews which demonstrated the shared lived experience of transitioning from the secure unit to the open rehabilitation ward based on the commonalities I had determined. Booth (1996) states that composite stories are appropriate to use when using fragmented narratives from a number of people. The composite story provides a fuller more holistic picture of what has occurred. They are also useful when dealing with issues of confidentiality (Gilbert, 2004). The composite story is presented in chapter four.

From this composite story the emerging themes became apparent. I wrote out interpretive summaries on separate pieces of paper and linked them to each of the participant's pseudonyms to start to see commonalities between the interviews. Common meanings or themes emerged when I began seeing the parallels between one interview analysis and another. Similar underpinnings appeared despite the differences in experiences of transition. One of the interviewees spoke of a very different experience of transition compared to the other interviewees.

Finally I elicited responses from my supervisors regarding these emerging themes and utilised this opportunity to reflect on my analysis. As in Hermeneutic interpretation, I began to see how the different parts made the whole and the whole was made up of different parts.

I found there were times when my analysis initially fitted within one theme to then find, after further analysis; it had shifted to another theme. Each time I did this my perspective shifted and broadened and my interpretations also expanded.

The main themes along with their sub themes are presented in the findings chapter (see chapter five). Flood (2010) proposes the findings from hermeneutic interpretive research should be presented in everyday language and as close to the lived experience as possible. I have therefore attempted to do this in the story and findings chapters (see chapters four and five).

After identifying the main themes I then returned to the story and findings and gradually became aware of my deep recognition of the links between the interviewees' experience of transition and the meaning of transition I

have derived from the interviewees' experience. These insights are outlined in the discussion chapter (chapter six).

This whole process took time as I wanted to ensure that the themes that were emerging did so naturally. Finlay (1999) states "phenomenological analysis involves a systematic but creative approach and a preparedness to engage in deep reflection" (p. 304). It must take time, because to rush the analysis would risk the researcher imposing their own predetermined groupings (Finlay, 1999).

### **Reflexivity**

Reflexivity can be defined as self-awareness, a disciplined self-reflection. Finlay (2002) states "Reflexive analysis in research encompasses continual evaluation of subjective responses, inter-subjective dynamics and the research process itself." (p. 532). The quality of this analysis is depends significantly on how it is completed. The researcher must maintain their focus on the participants, returning to themselves only as a way of creating awareness or insight (Finlay, 1998, 2002).

I used a digital recorder as a form of reflective journal during the data collection phase. At the completion of each interview I took time to record my feelings and responses that emerged during the interview. I spent time, immediately after the interview, pondering the origins of these and found by speaking to a recorder I was able to work through a number of the issues. I then would re-listen to these recordings up to a week later and reflect again on the responses and feelings I had during the interview. I then made every effort to limit their effect on the data interpretation. For

example, when an interviewee spoke of wanting to flush his medication down the toilet when he returned to the community I was aware of wanting to spend time talking with him about the benefits of medication and how that may impact on his ability to live in the community. The process of identifying these reflections and recording them allowed me to separate them from the interpretation I completed. I also received regular supervision which helped to ensure these feelings and responses were appropriately acknowledged and any impact on the research identified.

### **Trustworthiness and Rigour**

There has been much debate over issues of establishing trustworthiness and rigour within qualitative research, which remains a legacy from the scientific method of research (Koch, 1996; Koch & Harrington, 1998). One philosophical principle of hermeneutics is that there is acknowledgement that the researcher and the reader bring their own preconceptions to the analysis. The themes that emerge from the text will not always be the same for the researcher and reader and this is not expected because their preconceptions will be different. Readers may not share the researcher's interpretations but they should be able to follow the way the researcher came to their conclusions (Koch, 2006).

Thus in order to establish trustworthiness of the research project I have followed four criteria as suggested by Lincoln and Guba (1985): credibility, transferability, dependability and confirmability (cited in Koch & Harrington, 1998).

## **Credibility**

Credibility refers to confidence in the truth of the data and the interpretations made by the researcher. It is enhanced when researchers describe and interpret their own experiences and self awareness to do this is essential (Graneheim & Lundman, 2004; Koch, 2006).

Koch (2006) suggests the use of a journal to record content and processes as well as various reactions to interactions. The journal becomes the record of these and is the material that is used for reflection. I digitally recorded my verbal thoughts. Because I completed the interviews at a hospital some hours drive from my base I wanted to record my thoughts, feelings and insights immediately after I had completed the interviews. This then enabled me to listen and reflect on these at a later date.

Koch (2006) also suggests involving the participants in reading and discussing the construction of the findings to enhance the credibility of a study. After I had transcribed each interview it was posted back to the participants. At the initial meeting with each interviewee I had ensured the person would be able to read these. Due to my distance from the data collecting site it was not possible to return these transcripts in person. Interviewees were provided with a postage paid, addressed envelope to return the transcript with any changes on it they thought necessary. They were given two weeks to return the altered transcripts. They were advised if they did not believe changes needed to occur then they did not need to respond. No interviewee responded.

After data analysis and the story and findings chapter were completed, the chapters, along with the specific quotes to be used within the thesis for each participant, were sent back to them for consultation. The

interviewees were asked if the findings represented their experience and advised of the quotes to be used. They were asked to write directly onto the story and findings chapters any changes they would like and to cross out any quotes they did not want used. Again they were provided with a postage paid, addressed envelope to return any changes they wanted. No participants responded.

### **Transferability**

Transferability refers to the ability of the findings to be transferred to other settings or groups. That is, how well do the findings fit between two contexts. To enable the reader to do this the context of the research must be adequately described (Graneheim & Lundman, 2004; Koch, 2006).

I have endeavoured to provide a thorough description of the contexts involved in this research to enable the reader to make comparisons and therefore consider transferring findings to other contexts. I believe there are many similarities in the lived experience of transitioning by these forensic psychiatric patients that can be transferred to other people in transition. Though there are differences the meanings revealed from the forensic psychiatric patients' experience can be echoed in others undergoing transition.

In the introductory chapter I described the preconceptions, understandings and assumptions that I bring to this research. I have described how I am placed when completing the research. This chapter has explained the Heideggerian hermeneutic phenomenological methodology that I used in this research. I have described the methods used in selecting and interviewing the participants. The next two chapters will present the findings from the interviews; Chapter four is in the form

of a composite story and chapter five is the existential themes using quotes from the interviewees' stories to provide depth.

I believe I have made every effort to provide and describe contextual information to allow the reader to make judgements about similarity and transferability.

### **Dependability**

Dependability refers to the degree to which data changes over time and modifications made to the researcher's decisions during analysis. The process of auditing will allow rigour to be demonstrated (Graneheim & Lundman, 2004; Koch, 2006). Koch (2006) suggests a decision trail allows the researcher to provide an audit trail linkage. This entails giving explicit detail on decisions made regarding theoretical, methodological and analytical choices throughout the research.

I have made every effort to clearly articulate the details regarding my decision making during this research. This will then allow the reader to either agree or disagree with the decisions made.

### **Confirmability**

Confirmability requires the researcher to show how their interpretations have been arrived at via their inquiry. Guba and Lincoln (1989) propose confirmability is achieved when credibility, transferability and dependability have been demonstrated within the research. Essentially markers indicating decision making and influences should be present throughout the research, thus making the entire research an inquiry audit (cited in Koch, 2006).

I believe I have clearly articulated throughout the research my decision making to allow the reader to follow the path I took during this process. I believe I have demonstrated credibility, transferability and dependability and therefore have demonstrated confirmability.

### **Summary**

This chapter has taken the reader through the journey I undertook when completing this research. I introduced my chosen methodology, Heideggerian hermeneutic phenomenology. This methodology has enabled me to look into my own way of being, so that I, as the researcher, am able to identify where I sit within this research. I have provided signposts along the way to enable the reader to identify the decisions I have made when completing this journey. This will enable the reader to get a sense of the context in which the interviewees are situated. The reader should get a sense of the dependability of this research.

The next chapter presents the lived experience of transition to an open rehabilitation ward from a secure unit within a forensic psychiatric service, initially by telling a composite story of the process. The composite story portrays the sequence of events that occurred for the interviewees. The story begins in the secure unit, where the interviewees were informed of the move to the open rehabilitation ward. It finishes in the open rehabilitation ward after the interviewees have successfully moved permanently to the new ward.

## Chapter Four: Simon's story of transition

I would like to introduce you to the story of Simon. His is a composite story made up from the six interviews that were carried out as part of this research. His story incorporates the experiences of all participants in their transition from the secure unit to the open rehabilitation ward. I have chosen a name that doesn't relate the interviewees' names or to any of the pseudonyms the interviewee's chose. The tense I have used for the entire story is the present. This is because the interviews the story is made up from covers pre transition, transition, and post transition. As you read the story you should always have the impression that Simon is currently undergoing the particular stage you are learning about in the story.

At times I have created almost conflicting responses, feelings or experiences for Simon and that is because the story is drawn from six different interviews and I have tried to ensure an accurate representation of all the experiences. Moreover I have tried to make these conflicting responses, feelings or experiences obvious for the reader.

In certain parts of the story the quotes I have used to give insights into the story come predominantly from a few interviewees. This is because those interviews are pertinent to that part of the composite transition story.

To protect confidentiality I have removed the name of the secure unit, open rehabilitation ward, external services or organisations, specific people and towns or cities from the quotes I have used. These have been replaced by generic terms in brackets. For the same reason I have changed days of the week, months of the year and timeframes within quotes; these

haven't been bracketed. I decided to leave the quotes as close to verbatim as possible. Some of the English used by the interviewees is difficult to read but I believe it was important to record them as they were spoken. I have removed extra filling words only when it made the text impossible to read. Lastly, significant themes from the story, along with their subthemes have been drawn out and there are presented in the following chapter.

### **The Story**

Simon is in his mid twenties and has been in the secure unit for approximately 18 months. He arrived at the unit from prison, where he had been for approximately two years. He was transferred to the secure unit when he had become mentally unwell in prison and could not be managed there. While in the secure unit he remained a sentenced prisoner; he has approximately six months left to serve before being eligible for parole. Simon was advised by his clinical team that they would like him to spend some time at the open rehabilitation ward before being discharged to the community.

Simon has a variety of feelings about this news. Initially he was both angry and disappointed because he didn't understand or see the move as necessary; he just wanted to get out of the secure unit and back into the community, rather than go to the rehabilitation ward.

*Well it wasn't always a goal cause I didn't really want to go there. But now I've had things explained to me a lot better, you know I believe that it*

*will be a good stepping stone for me before I go back to the community.  
You know hopefully keep me out of hospital and prison.*

*Shrek*

However other feelings also included joy and acceptance.

*My thoughts would be like cool. Close to being a step away from being a free man again.*

*Jae*

*I just spend a few months there and they said did I want to go to (open rehabilitation ward) and said yep sweet as so then they let me in next week.*

*Anakin*

Simon still wants to be in the community in the future. Sometimes he is clear about what he would like to do in the community, ranging from places of employment, courses to complete and travel, while other times he is unsure. He just knows he wants to return to the community.

*Yeah, I want to go back to (continent). I want to leave, I want to leave New Zealand, Dad's in (city), I've been to (main NZ city) before, I lived in (main NZ city) for about a year and a half, I lived ten years in (main NZ city) and I want to go back to (continent), back to (country). I'll do some boxing over there professionally hopefully, get paid.*

*Jae*

Simon now believes the shift to the open ward would be helpful for him; he has to some degree understood the rationale. However, at times Simon fluctuates in his acceptance of the move and instead of actively supporting this move he feels more resignation.

*Awww yeah don't really care. Don't really mind it at the moment. I'd rather be in the community though.*

*Anakin*

Simon is aware that if he puts up too much of a disagreement then he will slow down his progression to the community.

Simon's mental state has settled and he wants to move as soon as possible. However while he remains a sentenced prisoner he is unable to progress permanently to the open rehabilitation ward.

*But I had to wait till I had permission to move. Or reach my parole date.*

*Casper*

Simon has applied for parole in the past and this was denied. In his most recent appearance he had been supported by the clinical team from the secure ward, who had outlined a detailed treatment plan, including going to the open rehabilitation ward.

*Yeah they umm they knocked me down. (Doctor) done a report that said I'd do another three months here and then go to (open rehabilitation ward) and they said it was too soon to go to (the open rehabilitation ward) at this stage. So I had a year to go at that time, at that stage.*

*Shrek*

The clinical team accompanied Simon to the parole hearing and helped present his application. It was again denied and though Simon was initially angry and despondent with the outcome he spent time reading the report and talking with staff about the outcome, and he again feels confident that his next application will be successful. He had interpreted this as being the case from the report.

*Well when they first said no I was a bit pissed off because I'd done so much hard work. But then we got their official, their official decision and they mentioned the hard work I'd done, that they agreed with the treatment plan, they just felt it was too soon at this time to allow me to do it full time. You know to be out there, no locked doors, a little more less supervision and stuff like that so but they did indicate that November would be a good time to come back to get it so we will be right this time.*

*Shrek*

Simon has been through this process of anticipation and disappointment a number of times before and realises that there is actually not a lot he can do. He has got to a point where he perceives he doesn't have a lot of influence in these meetings.

*I knew it was a 50:50 chance so I didn't get too strung up on it... They were either going to say yes or no.*

*Casper*

Simon commenced preparation for his eventual transfer to the open ward. He spends time outside the secure unit, accompanied by staff, accessing a range of community resources. Simon had to be resourceful when trying to ensure that he could get the leaves he now has permission to take. He

knows that if he can organise it early with staff he has a higher chance of leaving the unit than if he waits all day wondering if he would go.

*I'll get up at breakfast time and try to arrange my day in the morning before they have their morning meeting cause then they will know what I would like to do so it can be sorted out with other people doing things as well in that meeting. So you're not waiting all day wondering am I going to go, am I going to go. Cause when they come out at 9 o'clock they can tell you exactly what's going to happen cause they've talked about it. That's what I do first thing in the morning; tell them what I want to do. You know so that's good.*

*Shrek*

Simon believes he is successful in getting his leave because not only does he use the knowledge he has acquired from the skill development he had been involved in on the secure unit, but also because he has been in the secure unit for the longest period of time and the staff are aware of this.

*Well I sort of learnt this stuff. I've just finished doing umm social skills, advanced social skills, making communication and stuff like that, you know it helps. And I suppose, I'm pretty lucky as I'm the longest one here, that's here at the moment. I've been here 20 about 21 months so they know me really, really well and if they can get me out they always get me out.*

*Shrek*

It was while living in the secure unit that Simon first experienced re-entering the community. His first time to the supermarket was one of excitement and anxiety. He was nervous when faced with choices on the

shelves, working out the correct money at the checkout, and speaking with the cashiers.

*Like we went to Pac n Sav for the first time and it was like full of so much people it was like, don't want to be there. Yeah I got quite frightened. Quite anxious about it. Hmmm being about so much people. You know having to do your shopping and hand the money over and all that kind of stuff to other people is basic stuff but we don't get to do that in here. Normally someone goes and do it for you. So when you're doing it for yourself it's like Woooo, just a weird experience... But when I got to Pac n Sav it was just like full of people and I was like didn't, just felt really uncomfortable. You know on the ward here you've got ten other guys max you know and in the end it was like, it was packed, people everywhere. It was late afternoon on a Thursday. Oh I was yeah, a bit buzzed out by it.*

*Shrek*

It was also during this visit that Simon first experienced a ride in a car for many months. He also found this to be exhilarating. Gauging the speed of the car was confusing.

*Yeah I went to... the first time in the car for months, I felt like they were going real fast but they were only going 50 K's.*

*Shrek*

Simon continues to go to the supermarket. He enjoys this opportunity to get out into the community and be around other people.

*I enjoy going out and getting the food. I like going out in the car and buying stuff and going into public places, to the shop and being seen by*

*people and have good social skills and going to the shop , knowing what you want and what you're going to buy and go to the counter, pull up and say thank you to the various staff and give them money and you say, "Thanks very much have a good day".*

*Jae*

Due to his legal status Simon hasn't been to these places by himself. He is required to be accompanied by staff. Simon sees that each time these visits to the community go well it is progress to moving to the open ward. He knows he has to prove himself before he will be accepted into the open ward and then be able to move onto the community.

*It's like the better you cope out there, like you have umm your escorted leaves and then they slowly give you unescorted and the better you do the faster you get out of hospital. You know what I mean? If you can prove to them that you're ok and that everything's going ok then you can get out of hospital faster... You know like arrr like the doctor says that arr if you can't make it here you can't make it over there you know cause this is a stricter unit and if you can't live by the rules here, over there you're not going to manage because its more open and freedom and, you know. So it basically it's just learning to live with what you've got and be positive about it. Do all the rules, treatment plan, take medication. Yeah.*

*Shrek*

Simon enjoys the opportunity to go out into the community for many reasons. He enjoys being able to make his own choices about what he buys and he enjoys being out where others can see him.

*Being seen with other people. I like, I love it when people see me, instead of being inside all the time when no one sees me. I like to be seen... Why? Makes me feel good. I like it when people remember me.*

*Jae*

As Simon has increased the amount of time and places he visits, in the community, he is relaxing being there. He equates it to learning to drive again after a period of time away.

*It's a lot better yeah, umm a lot better yeah. I've been to the gardens a few times, I've been to (town), I've been to Pac n Sav a few times so it's actually getting better, a lot better, more confident, more relaxed, yep... Cause the more you do it, you know. The more you do it, you get used to it. It's like driving a car. You can stop driving for six years but once you get driving again, it comes back. So once you've been shopping a few times its normal now. Looking for the specials, getting the specials.*

*Shrek*

One thing Simon had to stop doing was disagreeing with other patients on the secure unit. He has realised that confronting other patients (even if he believes they are in the wrong) has a detrimental effect on his own progress. He doesn't want to be seen or viewed as a trouble maker as this could possibly lengthen or postpone his move over to the open ward. He "knows how the system works", commenting

*Some of the patients were, umm, not very well and they didn't think they were unwell but they are unwell. So I just tried to keep myself from telling them that just in case they yell at me. And that's how I got from, also another reason I got from the locked ward to the open ward cause I*

*didn't tell the truth to the, arrr, patients I was talking to... I didn't say hey that's wrong and if you keep doing that you're going to end up being here a lot longer. If I said that ooooh I'd be in trouble from that patient... I wouldn't say anything I'd just say, "Oh yes, okay, right", that was it. Cause if I said what I said it would help them actually get out of hospital a lot easier. Cause I know how the system works from the locked ward to here, but the people that have been in the locked ward that I was in last were in there for years and years, like four years, five years. The only way out, the only way out of this locked ward is arrr getting the right medication and arr being aware of what you're saying cause some, some patients will say weird things like "I'll be ascending soon". And I'll be thinking oww no! He's one of them so I kept myself quiet... When I did offend the patients, I just try and tell them the truth and it doesn't work, they still yell at ya, cause I learnt the system of how to get out of the locked ward to the open ward.*

*Richard*

Simon also believes that encouraging staff and being polite to them also helps him in his move to the open rehabilitation ward.

*Yeah, I give them comments when they are doing well. I say "you're doing good work"*

*Jae*

Simon has also begun attending activities, still within the hospital boundaries and on hospital grounds, but out of the secure ward.

*I go to (service) and paint, I've been going to (service) for two and a half years I think. So I've just been painting pretty much over there, pictures yeah.*

*Casper*

*Yeah it's good I do sewing on a Monday and woodwork on a Thursday, two hours of each...*

*Anakin*

*Every Friday, from nine to eleven thirty, Fixing bicycles, taking the brakes off, the tyres the chains, the brakes, the handle bars, all sorts, tyres... Ummm about five months ago. I've been doing it for five months...*

*Kee*

He is required to be escorted however he enjoys this opportunity.

*Umm one of the rules is, I'm not allowed to leave the grounds so I'm not allowed to go to (service) by myself any more.*

*Casper*

Simon gets a chance to complete art work, woodwork, bike repair and sewing at the service away from the ward. He would like to increase his time there. Sometimes his ability to attend this service is limited when staffing is limited.

There are a number of things he is looking forward to in the open ward.

*They do their own cooking over there. You have people on that cook tea every day, so I love cooking and I can't wait to do that, so that's a good*

*bonus. You can also do courses over there as well, that I've heard you know. There's a lot of free time over there so you know there's a lot of good stuff about it... Well you don't do your own tea here, we don't cook here. We do cook lunches from time to time but umm don't do dinners and the courses they run here are closed group on the unit. Over there you can go out to courses, like to Polytech and the Bridge Plan and stuff like that.*

*Shrek*

One of the things Simon dislikes immensely in the secure unit is the meals that come via "tray service" from a kitchen on the hospital grounds.

*It comes from; I think it's a kitchen by (road). It's a big kitchen up there that's where they cook the food. It goes in a big truck and the truck brings the food in and brings it in...*

*Jae*

*In the locked wards, they, um, sent food over from um this place called the kitchen; it was made at the kitchen*

*Richard*

Simon says that the food is often not hot and the menus are rotated which means there is limited choice and options.

*We get the same food there all the time. We go in three weeks of food. Comes with the same stuff and it comes every three weeks.*

*Jae*

*Food here at (open rehabilitation ward) is arr hotter.*

*Richard*

*Ohhh different food, better food over (open rehabilitation ward), cause over (secure unit) it's just the same old, same old stuff every fortnight or every three weeks. You know cheap food and it's always the same, but over (open rehabilitation ward) it's different, it's top quality food over (open rehabilitation ward).*

*Kee*

Simon is looking forward to getting back to cooking his own meals again. Cooking is relaxing for him and he uses it as a stress management in the secure unit.

*Cooking? Yes I like cooking, I love it. Something to do...*

*Jae*

However he sees this as a privilege because patients have to work their way up to being allowed in the kitchen.

*Cause it's a privilege. And umm and you find that the more privileges you've got, you're getting closer and closer to your goal so it makes you feel happy.*

*Shrek*

Simon sees this privilege as building trust with his clinical team, and specifically, his doctor. He believes by showing that he can be trusted he will have the doctor's support when he next goes to the Parole Board.

This will in turn convince the board to grant parole. Simon then sees this helping in his obtaining his final goal.

*Well he's given me trust you know. He's given me opportunities like, ummm, I got, since being here since prison I'm going out to the community. So, I'm building up trust with him to go to (open rehabilitation ward). You know so when it comes time for the Parole Board in March again, he can stand up knowing that I've done all this stuff and I've come back and haven't played up. And he can tell the board, "He's been going to the community. He has two hours every day in the community and nothing's happened, hasn't run away, always been here blah blah". It gets closer and closer to my goal. It's harder for them to say no to it.*

*Shrek*

There are a few things that are worrying him about the move. Firstly the fact the door will no longer be locked; it has been a long time since he has been able to go into the community whenever he wanted, and he is worried that he might re-connect with some of his prison buddies.

*The only thing I've got to get used to is the open door because I spend most of my time locked up, so, but it will be alright... Umm old associates, prison. Just old associates basically yep, just criminal associates basically I don't want anything to do with them...*

*Shrek*

Secondly, drugs are available at times to him on the open ward, and he is worried that he has to say no to these if he is to be successful in his move

out of the secure unit. He is aware of the consequences of not saying no: he knows that he would lose what he has already gained.

*Ohh the fact that some people bring drugs onto the unit hasn't been helpful. Umm but I stay away from it so it's still not helpful decision to have... I've got too much to lose, that's what I just tell myself, that I've got too much to lose, you know, it would set me back another 3 or 4 months before I got over there if that was to happen. I'd lose my walks and everything else, I'd have to get them back, go through all the stages again, arrr, I can't be stuffed... Yeah well sometimes it's here, so it can be a problem, but I just think of my walks and my leaves and stuff and don't do it. Yeah because if you get a positive test you're screwed, Lose your walks, lose your leaves, hmmm. Just too much of a risk. The risk just doesn't get round the positives.*

*Shrek*

For Simon, waiting is something he has done a lot of waiting for his parole date, waiting to hear he has been successful in his requests, and waiting for his transition to begin.

*Arr it's a long waiting time, waiting for parole date to come and yeah just waiting pretty much.*

*Casper*

*I don't know what's happening yet. I found out tomorrow. I'll know more tomorrow.*

*Anakin*

Simon has now been granted parole at his last hearing. Now that he has been successful, his transition to the open rehabilitation ward commences.

*And they said you're going to (open rehabilitation ward) and I said oh ok sweet as.*

*Anakin*

Simon finds this time of transition between the two wards both exciting and disappointing. He recognises that this period of time is about preparing him to live permanently in the open rehabilitation ward.

*Well I was a special patient so I still had to go through parole to move to an open ward where I was on (secure ward) so umm being able to leave the secure ward and being able to move to (open rehabilitation ward) to get it over, umm, it's quite hard to explain but, umm it was just a long transition period, umm, sort of getting me ready to go to (open rehabilitation ward) but I needed the permission of the parole board to, to move permanently.*

*Casper*

The thought of, and experiences of, more freedom was often what he spent time thinking about and working towards, during his build up to the transition. Being able to access the community and possible opportunities for the future was one of the biggest positives. Simon was initially disappointed after obtaining parole that he had a reduction in leave (and he viewed this as a backward step). He was confident it would be cleared up and he would return to his previous level of.

*Because of that property in between (outpatient service) and (hospital), where all the houses are being built. I'm not allowed to walk on that by*

*myself. So I have to be escorted all the time to (outpatient service). Where as in (secure unit) I didn't have to be. I was allowed to go by myself. So I've sort of gone a step backwards.*

*Casper*

Simon certainly finds that there is more freedom at the open rehabilitation ward compared to the secure unit however it still isn't the complete freedom he would like.

*I can't go to the pub. Can't do what I want to do.*

*Anakin*

Simon remains hopeful that this pathway will lead him back to the community, back to employment, and opportunities to live as he would like.

Initially the transition was difficult. He felt like a stranger in a new place and needed to prove himself to the staff. Once he was "no longer a visitor" he felt like he could relax around the staff.

*I think you have to know the staff before they are nice to you. At first you're just a stranger, umm you're an invited guest, but once you get used to them, they become good company and get along well. And if any trouble happens they'll break it up, "stop the fighting guys, break it up".*

*Jae*

Simon didn't feel this way with the other patients. He knew a lot of them from both being in prison as well as the secure. One thing he noticed was that they looked more relaxed and happy.

*It's good, laid back, doors are open, heaps more freedom, cooking, yeah stuff like that. They look so much happier over there than they did over here. When they were here they looked depressed, over there they look like they're over the bloody moon, they're more relaxed not so uptight.*

*Shrek*

Simon noticed that he was able to sit and watch TV and talk with the other patients in this environment more than in the secure unit.

*I have more power over the TV, because in (secure unit) there's (patient) who is always controlling the TV, you know. I never had a choice, never had a choice to watch TV because there was always someone else watching it, but over here, the guys are quite nice to me. So I get a good chance of what I want to watch.*

*Kee*

*Hmmm the people are really nice in the lounge. We enjoy watching TV together last night and we all got along.*

*Jae*

While he was still spending time in both the secure unit and the open ward, Simon was able to say good bye to the patients he knew in the secure unit. He believed this was important because it allowed him to move on.

*It was good, going backwards and forwards, enjoying my walks. I enjoyed my goodbye time in (secure unit) and my hello time in (open rehabilitation ward).*

*Kee*

*Telling people that I've known for quite a while, while in (secure unit), like (specific patients), umm a few of the other guys, make sure I tell them that I'm leaving, so make sure we enjoy our stay, my last week here, two weeks here, make sure we enjoy it before I, before I go for good, like (patient) and stuff. I've known (patient) for about 10 months now. So I'll make sure we have a good, a really good time before I go, before I leave them alone again for ages, never to be seen again probably... I've made some, good guys, really nice, nice people.*

*Jae*

Simon also recognises that he shouldn't make connections to the new people coming into the secure unit because he will only be leaving them.

*One guy called (name), he just came in about a week ago and I don't know if I should speak to him or not. Cause he seems like a nice person, I don't want to get too close to him cause I'm leaving. So I think the best thing for him is to leave him alone cause I probably will never see him again so I don't want to hurt him. So I'll just keep to the people I've known for a long time.*

*Jae*

He has an almost philosophical view of the fact he is potentially saying goodbye permanently to a number of people he has known for a long time.

*No it will be easy, cause people come and go.*

*Jae*

During this process Simon has had an opportunity to prove himself to the teams of both the secure unit and open rehabilitation ward. It has felt good to him that he was able to take this responsibility seriously and prove himself.

*The experience has been very good. I feel really nice, I feel confident doing this on my own. We've got nurses or doctors, I feel really nice about it that I can do these things myself, that they trust me with responsibility... To come here by myself, talk to the patients, talk to the nurses or other staff members by myself, I trust they trust me with that responsibility and I am a responsible person.*

*Jae*

During this time of moving Simon got an opportunity to increase the time he spent at the open ward. This was contingent on how he "fitted in". He was allowed to attend groups and then he was approved to join the ward for an evening meal before being permitted to stay a night. Simon enjoyed the opportunity to eat a meal which had been cooked on the ward rather than been brought in from the kitchen.

*Umm I've had two meals here, I had some vegetarian noodles and last night I had hamburgers and chicken burger and tonight we are having spaghetti on bolognese.*

*Jae*

At times Simon was unclear why an extended transition period was being used but he just wanted to move out of the secure ward so would do what staff asked of him.

Simon could identify a number of practical aspects which helped with his transition though at times was unsure of why they needed to occur. An example of one was when he had started the recreation groups at the open rehabilitation ward he was asked to bring towels with him to enable him to shower when the group was over. It was unclear to him why he had to bring the towels with him, rather than use the ones at the open rehabilitation ward. However the staff gave him a bag in which to carry the towels and he used it to carry other items when he was travelling to and from the open rehabilitation ward. He found the bag very helpful.

*What's really helpful is, that little bag that I carry is quite helpful. You know that little black bag that I carry around. It's quite helpful. I keep my towel in there and comb, brush my teeth, some shampoo, tobacco and umm that's all. Nurse gave it to me. Cause I needed to get some, I think it was for towels I think to bring towels with me, to go have a shower... I've been using it quite a lot, the bag, used the bag quite a lot. I've only had it for about 2 weeks now. I got it for free from the nurses.*

*Jae*

Another important part of making this process successful was that the plan is organised and staff in different wards communicated well about it. Not having to continually explain his arrangements is important.

*They did it well, like ummm I said to (staff) that I got, I got, I have to go to (open rehabilitation ward) from 1pm to 6pm and she just lets me out, and like she knows all about it. All the nurses know all about it straight away. That's what was so good. That's how they got organised cause*

*they all know. I don't have, I don't have to make sure the staff know already.*

*Jae*

One of the positive differences between the open ward and the secure unit that Simon identifies is about the environmental set up. In the open rehabilitation ward different areas of the ward are used for clearly distinguishable things. He doesn't have to spend all his time in one room for all the different daily activities.

*The kitchen tables and the chairs and the kitchen are not in the lounge. Because in (secure unit) there are tables in the lounge... Because it sucks being in the same room all the time. It's good to shift from here to there.*

*Kee*

One thing that was difficult and confusing for Simon was when he had to return to the secure unit for medication rather than being able to have it at the open rehabilitation ward. He was expected to return to take the medication and then return to the open rehabilitation ward again.

*Hmmm, let me think, the hardest thing was the medication you know, going backwards and forwards for the medication... That was the hard thing about it. Yeah going backwards and forwards for the medication because they didn't bring them in. So I had to go back there for my 2 o'clock medication and then come back.*

*Kee*

Simon successfully completed his plan and moved permanently to the open ward. He was excited to be able to now sleep in a "real" bed, on a permanent basis, rather than on a bed that was only a mattress on a plinth.

*On my first night. It's really soft like a water bed, compared to the one in (secure unit), it's hard, this one's like a water bed, real nice, I slept like an angel.*

*Jae*

*I like my bed, it's not, have I told you about my bed before? In (secure unit) we just had a little plastic thing, but here we got a proper, a proper sleeping bed, it's much comfy, it's really comfy.*

*Kee*

He was now able to lock his door when he wants rather than having to ask staff to do this which enables him to ensure his property is safe when he wants it to be.

*Arrr it was alright because you can lock your door and in (secure unit) yeah the doors didn't lock properly... Yeah I locked my door yeah, it looks after my stuff.*

*Richard*

*I couldn't lock the door there's no lock in the (secure unit). There's no lock.*

*Jae*

Since living in the open rehabilitation ward Simon has become involved in the cooking group and takes part in cooking the evening meal for the

whole ward, whilst learning more about health, eating and nutrition. He finds the process of cooking for the ward a social one. Simon though doesn't have the choice about what to buy as the staff do the grocery shopping during the week.

*They teach you how to budget your food, meaning you don't have to cook with meat, you can cook with vegetables and have a meal from that, a vegetable way, and the meat way as well, they balance it out. The food's hotter, nicer and you arr you get to talk to one another when you're preparing the food and stuff and that way you make kinda like friendships but over in the locked wards ohh I'm not a very social able person so it doesn't, oh the food over there was cold it was not tasting good yeah.*

*Richard*

Simon's week is not as busy as it was in the secure unit. There are a number of structured activities organised but this is less than the secure unit. Simon is surprised at how busy he actually is during this unstructured time. He has a number of activities he completes and he sees this as important in the staff's eyes.

*We do heaps of things here I think. I'm occupied quite often. More than I thought. I'm always doing something; don't have to remember what I'm always doing. We are usually doing something, we are usually not lazy, not that lazy, always doing something most of the time, always doing something.*

*Kee*

*Sleeping, watching TV going for walks, sooo ahhh, mostly I'd walk all the time and umm that's what the spare time that I have and that's positive umm instead of sleeping but if you go for walks umm yeah that's positive in the nurses' eyes.*

*Richard*

Simon is reliant on the staff to help him organise what he will do in his day and to tell him when he is able to have free time. He at times refuses to participate in the plans that are available to him, choosing instead to sleep, or "muck around" because he isn't allowed to participate in the activities he would like during the plan time.

*Ohh I don't go to them groups really. Just gym groups and stuff. I don't really go to them. Walking group or whatever sleep all day, I don't do pretty much; I don't do much at all. Ohh I don't really have a typical day. Just muck around. Get up bout nine. Go to the ward meeting; go back to bed till 12. Get up. Then, dunno, have lunch whatever, have a cigarette or whatever, just muck around, play cards whatever.*

*Anakin*

Simon has now increased his time at the activities outside of the hospital that he began at the secure unit. He still enjoys these and would like to increase his time further, as it gets him out of hospital. To a certain extent he will do whatever the staff tells him to do if he sees this will get him out of hospital quicker.

*Doesn't have any feeling. I have to live with it, it's their decision. Whatever they decide I have to go along with it.*

*Anakin*

Simon's leave has now increased to being unescorted; he can now walk to the local shops by himself.

*Arrr it's just been able to go you know down to the shops and anything like that. It's being able to say "hey look I'm just off here soon, I'll be back soon" sort of thing yeah. Whereas (secure unit) would be like "where you going" "what doing" it's a bit more controlled whereas here it's a bit more relaxed.*

*Casper*

For this approval to occur, Simon's progress needed to be discussed at a meeting which all the treating staff attended. For Simon it felt like "being in a waiting game"; he found it difficult to make plans, organise himself into activities or make decisions as he was "waiting" for the outcome of the meeting. Simon has a sense of resignation and a lack of emotional attachment to what the outcome maybe.

Simon sees a number of factors contributing to his successful move to the open rehabilitation ward. They began at the secure unit and continued through his transition and still continue now that he is in the open rehabilitation ward. Medication and treatment were significant factors in his transition. He explains:

*Two years ten months, ummm getting the right medication. Took a while for me to get the right medication. I didn't get the right medication till about February... If I, if I didn't have the right drugs I just, oh, I just look at the nurses and all I'd see was murmuring, babbling and I wouldn't understand what they're talking about. Because I understand what they are talking about, that's the reason why I moved from the*

*locked ward to the open ward. Because I ummm I've only just moved from there to here and that's one of the main reasons why it's made it a lot easier for me to ummm go from the locked ward to the open ward. Through getting the right treatment through the arrrr through the doctor, through the doctors.*

*Richard*

*Arrr I just trusted the nurses for a long time, put me on the right medication at first.*

*Jae*

*Umm, well, just the structure and the way the doctors are and the medication and stuff really. You know I've found, I've had a pretty shit upbringing and I've done a heap of different shit but since they've actually diagnosed me and given me medication things just like seem to be up here more then up and down like that all the time. If you know what I mean. Yeah. So it's like they got the right medication for me.*

*Shrek*

Staff were also significant in helping in this process. The support, information and knowledge helped make the process simpler.

*Umm they listen to what you've got to say. Then they think about the best way to deal with it and then they deal with it, so you're not on your own dealing with shit. You know what I mean aye? Yeah. So you've got stuff going on in your head and you talk to them about it and they*

*can rationale it out with you. And you know, so, yeah. They are pretty good here.*

*Shrek*

Keeping busy and being occupied helped Simon with the success of the move.

*Having hobbies. Like over in, the locked ward they have table tennis, chess and I have my umm video game. You just occupy yourself with the umm, you just occupy yourself with the umm with your hobby. That passes time quick. It keeps you well behaved and arrr yeah, hobbies.*

*Richard*

Looking back, Simon has conflicting emotions on the process of getting from the secure unit to the open rehabilitation ward. On one hand he sees it has been an easy process.

*Really difficult? Hmmm, nothings difficult about the move. Everything's been easy and been nicely organised by staff.*

*Jae*

On the other hand it has been difficult because the amount of work required by Simon to make this successful.

*Easy? Oh nothing's easy. You've got to really, really umm, cause I did a crime, it was never easy getting from the locked, from the locked ward to the open ward. You can't, there is no easy, yeah, it's just motivation*

*and awareness that made me get from the locked ward to the open ward.*

*Nothing was easy.*

*Richard*

Though Simon has now successfully transitioned to the open ward. He has lived fulltime in the open ward for over two weeks and knows that he has now officially moved out of the secure unit. He spends his day involved in his programme, relaxing with fellow patients, and at times, unhappy about still being in hospital. Though Simon lives entirely in this new environment, this isn't the end point for him. He has goals he would like to achieve in the future including work, where he would like to live and who he will spend time with. He knows this could take a number of months or even years to achieve but it doesn't stop him working towards this. He will continue to transition in his future.

## **Summary**

The composite story presented in this chapter follows the journey Simon took from first hearing about his intended move from the secure unit to the open rehabilitation ward, to living permanently in it. The interviewees' own stories had many similarities and these were combined to create this story. It demonstrates the multiple layers these interviewees dealt with to make the move. Chapter five will present the themes that emerged from the interviewees' experiences.

## Chapter Five: Findings

This chapter presents the data I collected as phenomenological themes revealed by the interviewees' experiences of their transition from the secure unit to the open rehabilitation ward as I have understood them. Quotes and statements from the interviewees are used to illustrate the themes described. The interpretation of the data shows my understandings of their experiences. I have continued to use the pseudonyms the interviewees chose to enable the reader to follow their individual stories.

Four themes, which emerged from the data, sit alongside the composite story presented in the chapter four. Each theme and its related subthemes are described in order of my assessment of their significance to the interviewees. The four themes and their related subthemes are:

- Being-in-the-world of being free
  - The meaning of freedom
  - Free to hope
  - Freedom to make choices
  - The challenges of freedom
  - Fear of the loss of freedom
- Stepping stones
  - Stepping towards freedom

- Returning to the everyday
- One step at a time
- Doing what you have to, to prove yourself
  - Proving “I’m ready”
  - Not questioning
  - Governed by rules
  - Each doing what is right for them
- Assistance comes in many forms
  - Saying goodbye
  - Other people
  - Enjoying doing
  - Taking responsibility

### **Being-in-the-world of being free**

From hearing they would soon be moving out of the secure unit, to being in the process of moving, to having completed their move, each interviewee described the meaning of freedom and feelings associated with it. The concept of freedom, and the prospect of gaining it, was one of the most significant factors for these interviewees during their transition. Freedom is not just equated to breaking loose from physical structures; it is also related to the emotional state and the ability to make choices. However, whilst the specific purpose of the increase in freedom related to

various reasons and goals, such as skill development and social outings, these were not as important to the interviewees as being off the hospital grounds or out of the confines of the secure unit and feeling happy about that.

In this section the interviewees describe the meaning of freedom, feelings associated with it and some of the aspects that they now have had increased because of their transition.

### **The meaning of freedom**

For most of the interviewees freedom was about increased options. With the anticipation of the locked door no longer being in place they believed they had more options for their future. For some it was to leave the unit and go to the café or the local shops, for others it was being able to begin planning what they might like to do in the future.

Casper had already completed his transition and was living (permanently) in the open rehabilitation ward. He describes his experience of freedom as being able to leave the open ward when he wants. Whereas this has not always been the case; when in the secure unit his access to the community was controlled.

*It's just been able to go, you know, down to the shops and anything like that. It's being able to say "Hey look I'm just off here soon, I'll be back soon" sort of thing yeah. Whereas (secure unit) would be, like, "Where you going" "What are you doing". It's a bit more controlled whereas here it's a bit more relaxed.*

*Casper*

For some the act of leaving the unit and spending time in the open ward was about emotional freedom. They described feelings of confinement both literally and emotionally when in the secure unit, whereas in the open ward they felt relaxed, unburdened and less oppressed. The act of moving and knowing the door was no longer locked was all that was needed for these feelings to change. Casper spoke about a sense of release.

*You don't feel so tight and locked down. Like, (secure unit) is a locked ward so you feel a bit locked down whereas here it's not so you feel a bit more, a little bit off your shoulders and that so a little more free.*

*Casper*

Shrek had not begun his transition to the open rehabilitation ward. He was aware of his referral but due to legal constraints was not yet able to start moving. Freedom for him was about being able to make choices; being able to decide what he wanted to do in the future and where he wanted to be.

*Over there you can go out to courses, like to Polytech and the Bridge Plan and stuff like that. So a little bit different in town, so yeah more freedom.*

*Shrek*

Anakin had completed his transition and was living permanently at the open rehabilitation ward. He said he had completed this process of transition to the open ward a number of times previously. He spoke a lot about the increase in freedom that he looked forward to and then gained by coming to the open rehabilitation ward. His definition of freedom was about:

*Being able to do my own thing when I want, how I want and when I want.*

*Anakin*

Freedom to the interviewees held different meanings. It predominantly meant being able to do what they would like when they would like. Some interviewees spoke of an emotional freedom. This was a sense of relief when no longer in the physical confinements of the secure unit.

### **Free to hope**

One of the opportunities freedom provided to the interviewees was to allow hope that their future might finally start to look the way they would like, seeing them back in the community engaging in the activities they want, when they want. Some were clear about what they would like to do with this freedom, like attending a local community high school or looking for work or returning to leisure pursuits, while others were not as clear but were able to see a future that involved being in the community. Richard had completed his transition to the open rehabilitation ward. He viewed the whole move to the open rehabilitation ward as preparation for him to moving to the community. While this was a hope he held when in the secure unit he was now freer to see it as a real possibility now he was in the open rehabilitation ward.

*Preparing you for the big move into the community, because, the closed wards were teaching you to move into the open ward but the open ward*

*that I'm in now is teaching you to move how to move out into the community.*

*Richard*

Casper also spoke of what he might like to do for the future. He was able to see that there were options for him. This involved both the concept of being independent and also the different occupations he might involve himself in.

*I can go to (community high school) ... I can do courses of anything. Maybe even look for work or anything like that if I'm allowed to. Just yeah more ... umm time out by myself. I'll be allowed to go out for a couple of hours into town [to do] something by myself. Maybe go to (community art service) by myself, unescorted yeah in time.*

*Casper*

For Casper having the freedom to hope enabled him to see that there was a future for him.

*That I can move forward and I'm not stuck in one place and can't go anywhere.*

*Casper*

Kee, who had completed his transition to the open rehabilitation ward, was hoping to return to past leisure and professional pursuits. Kee spoke a lot about his past boxing experience. He was unable to do this in the secure unit and was hoping he would be able to re-engage with training plans at his chosen gym. He had spent time looking at when they were going to be open.

*For my proper fighting and stuff. They're going to open up the gym probably after January, maybe mid January, they'll open up again, they having holidays from November to January, three month holidays.*

*Kee*

Jae, during his interview, was only into his first week of the transition and still in transition. He was spending time both at the open rehabilitation ward as well as the secure unit. His hopes were related to what he might get to do with the other patients in the open rehabilitation ward. He is also hoping that the freedom is actually better than in the secure unit.

*I'm thinking about – hopefully I get to go out with these guys as well. I hope they've got more freedom than at (secure unit). I hope they get to go out and stuff and they get to come back on time.*

*Jae*

Many interviewees were unable or unwilling, due to legal constraints or their own need to not look too far into the future, to look at timeframes about what they might like to do. During transition interviewees could anticipate returning to activities they had not been involved in for a long time such as sporting activities, travelling and work. For most of the interviewees freedom equated to being able to being able to do what they wanted when they wanted.

### **Freedom to make choices**

It was only when transfer to the open ward was complete that interviewees became free to make choices or decisions about everyday

activities that many of us take for granted, but which are limited in the secure unit. Learning to make these decisions and choices took time. Interviewees gained an awareness of what choices might be possible to make during transition, which consolidated by the time they had fully completed transition to the open rehabilitation ward. The interviewees were able to decide what to do in their free time, when to smoke cigarettes, when and what to have for lunch and how hot food is when it is eaten. These are all relatively insignificant decisions for many people however when these opportunities are rare, getting used to making them again takes time and thought.

An example of this was when the interviewees talked about their relationship with food. They highlighted how the process of obtaining, preparing, cooking and eating of food changed and developed as they moved from the secure unit to the open ward. Access to, and the ability to engage in everyday occupations related to food is restricted in the secure units, with restricted choice and opportunity to make decisions. Being free to cook food was important to all of the interviewees. Returning to, or even learning for the first time, cooking meals was a significant improvement in freedom. They became free to take control again, deciding when and what they might eat for lunch, how hot they might like to have their food; having the opportunity to cook was significant. When asked who decided what he could eat for lunch in the open rehabilitation ward, Kee responded:

*We decide. You can have noodles, baked beans, spaghetti and toast, anything that's in the cupboard. Even eggs.*

*Kee*

Access to cooking food in the secure units is viewed as a privilege by the interviewees. Shrek spoke of how cooking in the secure unit was something that needed to be earned; it was not an automatic right. He had earned it and this made him feel happy because he viewed this as getting closer to his goals and he was looking forward to returning to cooking once he was in the open rehabilitation ward.

*Umm oh they do all their own cooking and I love cooking so I can't wait for that, yeah, cause (in the secure unit) it's a privilege. And umm and you find that the more privileges you've got, you're getting closer and closer to your goal so it makes you feel happy.*

*Shrek*

Being free to choose when they were allowed to smoke a cigarette was also significant. Some said they hoped this would aid in their giving up eventually because they no longer felt like they had to smoke at every designated time. Jae and Kee explain why they prefer smoking cigarettes at the open ward.

*Umm cause they can smoke whenever they want instead of hanging out for ciggies all the time. So they smoke anytime they like.*

*Jae*

*The smoking, cause in (secure unit) we smoke every hour together and over here you can smoke anytime you like. So that's the good thing.*

*Kee*

With increasing ability not only to make choices but also having increased options to choose from, interviewees saw their world opening up for them.

*Arrrr good friends, and good staff, arrr and more choices. Cause now I can look at maybe doing (type of) school or anything like that. Options are opening up.*

*Casper*

However the freedom to choose was limited in the open rehabilitation ward. For example, being allowed to choose what they ate for lunch in the open ward was limited by what food was in the cupboards and what other people had already eaten before them. Though they were able to make choices about what they might eat they did not make choices about what was purchased in the grocery shopping for the whole unit or what might be cooked for the evening meal to be shared with the whole group. Though they were aware they did not have full freedom to make all the choices it did not appear to matter. The fact they were back in the kitchen making choices about their own meals again did.

*Umm the arrr house keeper, she's got a recipes and we, we arr work off those recipes.*

*Richard*

*I think the people do. They decide... The nurse she goes grocery shopping, buys some stuff and they get to decide what they do with the stuff and they cook whatever there is, and they don't decide what to buy. The nurses decide what to buy and they make up what's there.*

*Jae*

Anakin did see the increase in freedom in choices from the secure unit however he was aware he did not really have a choice about being in the open rehabilitation ward. When asked about why he thought he had transitioned to the open rehabilitation ward he replied

*Yep I have to. I've got no choice in it...*

*Anakin*

The interviewees all acknowledged the increase in choices available to them during their transition. However, their choices were limited and for at least one interview he viewed his being in the open rehabilitation ward as not his choice.

### **The challenges of freedom**

Interviewees recognised that with increased freedom came increased choices available. Leaving the confines of the secure unit they were, to some degree, free to make choices which would not be beneficial to their transition. Thus, freedom posed both challenges and opportunities for the interviewees. Interviewees just beginning transitioning and who had not yet spent time in the open rehabilitation ward stated that an open door could possibly pose challenges. They were concerned that they might be able to access past associates and previous activities that got them involved in the criminal justice system. Shrek was aware that the open door was a significant difference between the secure unit and the open rehabilitation ward, which meant those living there, could access the outside world when they wanted.

*It's an open unit. The doors are open all the time. They can pop outside you know, yeah well we are locked in here so. Over there well it's all wide open so. That'd be a bit different.*

*Shrek*

Shrek realised this would be different for him though did not believe it would pose a problem as he would be able to cope with it.

*Umm yeah, no it will be alright. Yeah it will be a bit different staying in a building that's not locked. Yeah I can cope with that... I've got no concerns. It will be just a bit different atmosphere. Take a while to get used to that, the doors been open and stuff yeah.*

*Shrek*

He also recognised that he did not want to return to associates he had spent time with previously, because he did not want to return to prison.

*Umm old associates, prison. Just old associates basically yep, just criminal associates basically I don't want anything to do with them.*

*Shrek*

Interviewees who had been through transition spoke of how such concerns diminished the more time they spent both in the community and in the open rehabilitation ward. For interviewees this progression was exciting, and they could see how the progression would work for them.

*Arrr Umm it was riveting and exciting, because I was locked up in the locked ward and it's really good to be in an open ward. I'm only just, I'm only just new. But if I went from the community to this ward I think it would be boring, but because I've gone from a locked ward to an open*

*ward it's not boring because I don't know any other way. So to me it's not boring here in this ward, it's boring over in the locked ward.*

*Richard*

It was also recognised that though there had been an increase in freedom from the secure unit it was still not at the level that they actually wanted.

*I can't go to the pub. Can't do what I want to do.*

*Anakin*

### **Fear of the loss of freedom**

Freedom is gained in progressive stages; freedom to leave the ward but only escorted, unescorted but on the grounds, one on one escorted community leave, escorted but in a group and finally to unescorted in the community. Interviewees were expected to achieve one before they could move onto the next. As restrictions lessened options for increased time off the ward increased. Casper explains how the staffing ratio differs between the secure unit to the open rehabilitation ward.

*(Secure unit) was just one on one usually, but here it's four to one, so you go out quite a bit more, arr you have one nurse and four patients.*

*Casper*

They were aware that their freedom could be lost very easily and for all of them this possibility was not worth the risk of participating in the activities they might otherwise do. They had too much to lose. Freedom could not be taken for granted. All of them had to learn how to control

their instincts and demonstrate their ability to say “No”. They needed to make good choices and were expected to do this even prior to going to the open rehabilitation ward. Saying “No” to drugs was the most significant for most of the interviewees. Kee spoke of how he viewed his ability to say no to drugs if he was offered any.

*It was easy, if I got some drugs I'd flush them down the toilet or down the sink... Cause if I smoke any drugs they will just send me back to (secure unit) so, [My choices are] to smoke it, not to smoke the drugs.*

*Kee*

The fear of losing the freedom already gained was significant to all of the interviewees. A number of the interviewees acknowledged that their behaviour greatly impacted on whether they progressed with increasing freedom.

### **Summary**

During the process of transition, including preparation and thinking about the completion, the meaning of freedom and its impact on the interviewees was significant. In-the-world of being free was a complex and intricate concept. The interviewees experienced a sense of freedom during their transition. For some, this was realised when they were able to make choices and decisions that worked towards what they saw as their goals for the future. However it was acknowledged their freedom was easily lost and dependent on their behaviour and attitudes.

## Stepping Stones

For these interviewees, transition was about taking steps towards achieving their goals for their future. This meant starting again and returning to the everyday instrumental activities of daily living. All of the interviewees were clear that they did not see the transition to the open rehabilitation ward as the final end point and that transition was in fact a stepping stone to their future life.

### Stepping towards freedom

A significant meaning of this experience for each and every one of the interviewees was that this transition to the open ward was not an end point. They all recognised and identified that transition was in fact a stepping stone to the community and onto the goals that they were all anticipating in their future. Some were identifying the goal of returning to the community within months, while others recognised this would take many years to occur. However, for all the recognition that this was not the end point in their transition was important. Anakin speaks his hopes for the future.

*To get my own house, go to (name of town) for Christmas and New Years, find some work, save up and buy a car.*

*Anakin*

He recognises that this is something he wants in the future, but it will not happen immediately; it will take time. He is less acknowledging of whether he is currently working towards this goal. For Jae it was about returning to the supported accommodation he had been in previously. By

going to the open rehabilitation ward he was a step closer to this goal and so for this reason he was excited at the prospect of going.

*My thoughts would be like cool. Close to being, close to being a step away from being a free man again, yep a step to more freedom, back to (supported accommodation).*

*Jae*

For Shrek it is about returning to previous work opportunities. It is something he knows and would like to go back to. He recognises that this transition to the open rehabilitation ward is not an end point but rather a stepping stone to future goals.

*I believe that it will be a good stepping stone for me before I go back to the community. You know hopefully keep me out of hospital and prison. After I've been there, and umm I want to work on a farm because I love the atmosphere. I love just being out in the nowhere, be a dairy farm as well so cause there's always heaps to do on a dairy farm, yeah that's basically about it really.*

*Shrek*

For Richard it was about preparing to enter the community. His view was that his time in the secure unit was about preparing him for the move to the open ward and now he was in the process of preparing for the community.

*Oh the move from the closed ward to an open ward, it gave me a form of*

*arr helpfulness in the way of working very hard to getting to an open ward to prepare myself to move into the community.*

*Richard*

For Casper transition is about ensuring that he continues to move forward. He is not in one place languishing and losing hope for the future. He can see that progress is happening.

*That I can move forward and I'm not stuck in one place and can't go anywhere.*

*Casper*

For all of the interviewees the transition they went through represented moving towards the goals they have for the future that the move to the open rehabilitation ward is not an end point for them.

### **Returning to the everyday**

For many, returning to the simple occupations that occurred everyday was an important part of the experience. Jae enjoyed the short walk between the secure unit and open rehabilitation ward when he went to and from the wards as part of his transition plan. It was returning to the simple things in life, that he did not have the opportunity to do since being in the secure unit.

*Hmmm, the short distance walk, it's not like a drive to the next hospital or anything, it's just a simple walk ... to (the open rehabilitation ward). I enjoy it, I enjoy every little bit of walking and stuff like that. I enjoy the*

*little things. I like drinking coffee sometimes. No more than two coffees a day.*

*Jae*

The ability to purchase, prepare and consume food are everyday activities that most people take for granted. Increased access to these activities needed to be earned during transition. For the interviewees food has more meaning than just the nutritional value it may offer. For Richard, it is not only returning to cooking but learning about it too. He sees this as an opportunity to prepare for his move to the community by gaining skills.

*I feel um it's good now that I've got a reason why. Cause I asked them last night. "Why are we cooking with vegetables?" and the nurse says well there's more than one way to have a meal, within your budget, instead of having meat you can have vegetables and stuff like that. It's to help you prepare you for when you move into a flat or supported accommodation or any of those things. Cause that's what they are preparing you for in the open ward, supported accommodation, a flat, umm yeah.*

*Richard*

Moving to the open rehabilitation ward allowed for such tasks as cooking their own meal as well as cooking for the others on the ward. Kee spoke of an opportunity where he had helped cook the evening meal for everyone.

*I was cooking yesterday. I was chopping up onions, chopping up the apples, put the sausages to umm, first we fried them on the pan, frying thing, not a pan it was like a little box and frying. We put, after we fried*

*them we put them in the bowl in the pot and then we mixed it with the juice, with the sauce, the apple and onion sauce and mixed it together until it was nice and boiled and creamy. And then we put the knife and forks on the table and put the plates on the thing and umm then I dun the dishes after the meal. Wiped the things, the bowls, stuff the plates, knives the forks, put it back in. It was alright, umm (nurse) was helping me, telling where to put the stuff cause it was the first time me doing the dishes.*

*Kee*

However though it was “scary” interviewees wanted to continue on with it. Returning to the occupations of cooking and shopping was a starting point in transition to the open rehabilitation ward.

Cooking for oneself in the secure units was not ‘a right’. This was because of many risk factors and how the units ran. Interviewees felt proud when they were able to access the kitchen in the secure units because it had many meanings; they were getting better, they had proved they could be trusted and they were moving on in their recovery. Conversely access to cooking in the open ward was not a privilege but an everyday activity that interviewees were expected to participate in.

Richard spoke about how his belief that being allowed to return to using everyday kitchen implements is related to trust. In the secure units sharp implements are locked away and in the open rehabilitation ward they are in the kitchen where the interviewees could access them. By being allowed to access these he was being shown he was trusted.

*So they have to be quite strict in that way but even though I'm in this open ward the difference from the closed ward is the closed wards um they used to count cutlery because you could use, oh, well, you get the point, when they, over here they don't use, they don't count the cutlery now because they trust everyone here.*

*Richard*

Preparation for transition began at the secure unit. Interviewees spoke of opportunities to visit the community while still in the secure unit. Shrek spoke about how he needed to be able to cope with the stress and responsibility of these visits. He had forgotten a number of the skills that had once been automatic and needed to relearn them. He spoke about riding a bike on the city roads.

*I go on bike rides as well with the OT, umm well I've just been off the property once and we went down (street name) down to the park down there. Just trying to get me used to traffic and that, and then when I go to (Park). Oooh it was real weird on the bike, cause I just didn't think to me to cross the road without looking where I was going cause you know you're not used to having to watch for cars.*

*Shrek*

Associated feelings at this time were often anxiety and apprehension, which were significant and needed to be worked through. Returning to "normal" activities, though once familiar, is initially challenging. Working out how to speak to members of the public, select items from a supermarket and travel in a car are all steps that needed to be taken on this transition journey.

Casper is currently involved in the programme that has been set up for him at the open rehabilitation ward. He is spending time in both the ward organised plan as well as off the ward. He has hopes for the future about how he might be able to increase time off the ward even more. He spoke about how he can see himself going back to school which he had not completed. These would be done in steps.

*I can go to (community college) and I can do umm, all in time, in forward time, (community college) umm I can do courses of anything. Maybe even look for work or anything like that if I'm allowed to. Just yeah more, umm, time out by myself. I'll be allowed to go out for a couple of hours into town something by myself. Maybe go to (community art service) by myself, unescorted yeah in time, arr I'm not too sure. But they do like sixth and seventh form art I think. I never did it at school.*

Casper

Having to plan out a day that has not got scheduled activities was also a challenge. Interviewees spoke of being “always busy” in the secure unit because the day was highly structured. Returning to having time to “relax” and enjoy time out was positive however many spoke of how staff helped structure their time as they were still learning to do this.

*The locked ward they had, they were making you do heaps of things everyday. When I came to here, it's much more laid back the open ward, oh it feels good. Because it's not, I'm just new here and arrr they're not forcing themselves onto me to doing more activities and in a way,*

*incorporate me into doing more activities instead of just forcing me into it.*

*Richard*

Others chose not to engage and spent time sleeping and watching TV instead. Anakin was involved in activities off the ward and appeared to enjoy them however, he did not involve himself in the activities organised by the ward.

*Sleep all day. I don't do pretty much; I don't do much at all...*

*Anakin*

All of the interviewees returned to everyday activities during their transition. The interviewees viewed food and its associated activities as being a highlight during this time, along with reengagement in activities in the community.

### **One step at a time**

The whole process of transition for each interviewee occurs in steps. Initially they heard they were going to go to the open ward and for some this was a welcome relief from the secure unit, an opportunity to leave the confining walls. For others it was not what they wanted to hear. Shrek tells of feeling angry and annoyed when first told of his referral. He had wanted to go directly back into the community.

*Well it wasn't always a goal cause I didn't really want to go there. But now I've had things explained to me a lot better, you know, yeah they explained it, cause I was ohh I'll be here for bloody ages and then go over there for ages, but,*

*umm (doctor) explained that it was a good process to build me back into the community rather than release me from here. You know so, I accept it.*

*Shrek*

Some needed to coming to terms with this referral. It just extended the time they were going to be in hospital. Preparation for transition was also an individual process. For some, an important aspect was being able to take one step at a time. Looking too far into the future was overwhelming, and though they were hoping to move to the community eventually what they wanted was to consolidate what they had achieved and move onto the next step in their own time. Looking too far into the future the interviewees felt overwhelmed and were unable to concentrate. It is more important to look at one day or the next to ensure that they continued on the planned path. Shrek preferred not to spend too much time thinking ahead because of all the things he had going on and he did not want to run the risk of compromising his transition.

*Just deal with each day, one day at a time you know rather, I just can't deal with thinking too far ahead. Too much stuff going on so I just try and deal with each day, get through each day and don't do anything wrong that could get me in trouble.*

*Shrek*

Interviewees recognised the preparation began at the secure unit was an important part of their transition. They needed to manage a number of skills and situations before they got to the open rehabilitation ward. They had a graduated introduction to staff, patients and the open rehabilitation ward. Assessment of readiness to make the final move occurred over differing periods of time. For example, they were invited to share an

evening meal with the other members of the open rehabilitation ward as a way of accessing how well the interviewee related to other patients and staff. The evening meal had become more than a source of nutrition it was also an assessment tool. It was an opportunity to see how the ward ran and to engage with the other patients. Jae spoke with excitement of being allowed to eat a meal which had been prepared in the kitchen of the open rehabilitation ward rather than from the hospital kitchen somewhere on the grounds and being able to sit and watch TV with the other patients of the ward. It was returning to the “normality” of this activity.

*The food's been really nice. Hamburgers, hmmm the people are really nice in the lounge. We enjoy watching TV together last night and we all got along.*

*Jae*

However, once at the open rehabilitation ward permanently, some of the interviewees state they needed time to adjust to their new environment.

*Umm Because I'm new here, I'm not rushing myself to doing arrr the activities, because I'm only new. I don't, I don't want to burn myself out and not do the activities. I just want, I just want take time so I don't burn myself out, fatigue myself, if I take my time and then work myself into it gradually I'll probably do the activities with arrr more motivation and umm more success to helping me get into the community again while I do those activities.*

*Richard*

Each interviewee took differing lengths of time to move from the secure unit to the open rehabilitation ward. They varied from over night to over

a year. Factors influencing this also varied; for some it was due to their legal factors. However the time spent between the secure unit and open rehabilitation ward was important.

*But umm it was just a long transition period umm sort of getting me ready to go to (open rehabilitation ward) but I needed the permission of the parole board to, to move permanently.*

*Casper*

Careful staging was seen as an opportunity to re-engage with people they had said goodbye to earlier, from the secure unit (and now in the open rehabilitation ward), and also a time to say goodbye to those still in the secure unit. They expressed their need to be able to do this.

*It was good, going backwards and forwards, enjoying my walks. I enjoyed my goodbye time in (secure unit) and my hello time in (open rehabilitation ward). Means time to move on, to another ward. It means I say bye to these people that I've known for a really long time, for a year and a half.*

*Kee*

Interviewees spoke of their experience of needing to go back to go forwards, referring specifically to their leaves which were initially reduced. Resignation was a common response. They knew that if they waited it out they would eventually be able to move onto the step in the process they wanted.

*I'm not allowed to walk on that by myself. So I have to be escorted all the time to (work rehabilitation service). Where as in (secure unit) I didn't have to be. I was allowed to go by myself. So I've sort of gone a step*

*backwards. Awww it's not a big issue but it might be a bit, bit of a hassle for the nurses having to drop me off and come pick me up all the time. So hopefully it gets sorted soon.*

*Casper*

Interviewees spoke of taking one step at a time during transition their transition. For many this was welcomed because they felt overwhelmed when faced with too many choices or decisions to make. Some interviewees chose not to think too far ahead as a way of coping with the change.

### **Summary**

All interviewees saw transition to the open rehabilitation ward as a step towards achieving their future community based goals. Whilst there are many steps to get to the open rehabilitation ward the actual move to the open rehabilitation ward is itself a stepping stone.

### **Doing what you have to, to prove yourself**

Transitioning from the secure unit to the open rehabilitation ward was essentially proving that these interviewees were ready to move to a less secure environment. This entailed showing that they were ready for the move, doing what they needed to look after themselves, and following instructions even though they might not understand or even agree with the reasons for them.

### Proving “I’m ready”

Proving themselves occurred at many stages and levels during the transition. They first had to prove they were ready to leave the secure ward. This included behaving themselves and not getting into trouble. It meant following the directions of staff and meeting the criteria in the different assessments they went through. Proving yourself ready was an initial step to getting out.

*It's like the better you cope out there, like you have umm your escorted leaves and then they slowly give you unescorted and the better you do the faster you get out of hospital. You know what I mean? If you can prove to them that you're ok and that everything's going ok then you can get out of hospital faster... The doctor says that arr if you can't make it here you can't make it over there you know cause this is a stricter unit and if you can't live by the rules here, over there you're not going to manage because its more open and freedom.*

Shrek

*Before you move from the closed ward to an open ward you have to go through certain risk assessments, through the nurses, the psychologists and the psychiatrists and the OT and you have to get their approvals as a team to move from a closed ward to the open ward. That's how it works. But as an individual person, myself, I had to pass all these assessments to get to this ward and arr this wards an open ward and I've been in the closed wards for a total of (time given) and I'm in this ward for a wee while as well but that's only just because I just got here myself.*

Richard

One of the first occupations that the interviewees did outside the secure unit was walking. It was important to get out of the secure ward and walking was their first outside experience. Escorted walks on the hospital grounds were the starting point for all interviewees. The number and length of walks varied for each interviewee; however the desire to get out and come back, showing they were trustworthy, was very important to interviewees. Factors beyond the interviewees' control, such as legal status, often dictated whether they were able to move onto unescorted leave on the grounds. Five of the six interviewees voiced the need for them to prove themselves with this before being able to move onto the open ward. They knew if they were unable to come back from the walks on time and without drugs in their system then they would lose their leave entitlements which would affect their transition to the open rehabilitation ward.

*Mostly I'd walk all the time and umm that's what the spare time that I have and that's positive umm instead of sleeping but if you go for walks umm yeah that's positive in the nurses' eyes.*

*Richard*

All interviewees described different occupations that they engaged in as part of their walks. Most spoke of going to the hospital café for either a drink or to access the internet. So these times were for more than just exercise.

*I go for my walks, 45 minute walks a day. I go to the café, go to check up on some games, and go send some emails.*

*Kee*

Ground leave eventually became community leave. Interviewees had to prove they were ready to spend time off the hospital grounds. Many stated they had to once again prove themselves in this environment before being able to transition. Their understanding was that they needed to prove they could behave and follow the “rules” from the secure unit so that they could then go into the community from the open ward. It was a test. Levels of supervision decreased when they moved to the open ward. This meant they were more able to leave the hospital grounds as they no longer needed to be supervised one on one.

*For me that get from the closed wards to the open wards I had to pass, certain um criteria's where the nurse, nursing team and staff allowed me to get extra leaves and as they built up I got closer and closer moving to an open ward. I worked very hard to make sure that I behaved well enough to get those leaves from the nurses, the doctors, psychologists and OT and um eventually I managed to go out into the community with escorted community leave and now I've got non escorted community leave.*

*Richard*

This posed challenges and difficulties for some though all were excited by the prospect. Shrek talks of the process he is going through to be allowed to get time in the community.

*So I've worked my way up to here. I just know I have to do so many walks a day, umm behave myself on walks and all that kind of stuff. I went to the next step of having escorted town leave. Yeah.*

*Shrek*

Jae talks about what skills he is proving he has for when he is in the community.

*I enjoy going out and getting the food, I like going out in the car and getting the cook, buying stuff and going into public places, to the shop and being seen by people and have good social skills and going to the shop, knowing what you want and what you're going to buy and go to the counter, pull up and say thank you to the various staff and give them money and you say thanks very much have a good day.*

*Jae*

Interviewees were required to prove that they could be trusted while unescorted from the secure unit because of the open door in the open rehabilitation ward. They had to prove they would not be tempted by illicit drugs or other substances, or acquaintances that may compromise their move to the open ward. Kee talks about what he believes have helped him prove he was ready to move to the open rehabilitation ward.

*Not doing any drugs, not running away, not running away on purpose.*

*Kee*

They had to prove they could listen to and comply with the rules and requests of the staff. Many interviewees could see the benefits of doing this and recognised the open doors could be the one area that posed challenges for them. Further, they needed to prove to the new ward that they were a person who would be wanted on the ward, which required proving themselves to staff and fellow patients. They needed to be able to prove they would not cause trouble and that they would follow all requests. Their perception was once they proved this then staff on the

open rehabilitation ward no longer saw them as visitors but in fact part of the new community.

*I don't want to stuff anything up. Want everything to go smoothly. They might mistake me for a naughty person and I'm not. Cause I'm the new person here. They you know, I have to be nice for a while, cause, I don't want, I don't want anyone to see me, I want every nurse to meet me here before I move in, that's what I want.*

*Jae*

Proving themselves was also about doing their time. This related to the rules the interviewees perceived they had to follow. If they followed them, then they moved quicker towards their goals.

### **Not questioning**

Interviewees at times recognised they were expected to carry out requests, follow directions, or be denied access to what they would like without really understanding the reasons why. Anakin's stock response to queries about why he thought something was to remove himself from the decision making and leave it with the clinical team.

*Dunno, doctors' decisions... Dunno, not sure.*

*Anakin*

Interviewees knew that it was vital that they complied and did not question rules or decisions made for them or they would not move onto the next step of their transition and this would have a detrimental effect on their progress towards their goals. Responses from the interviewees

ranged from understanding, acceptance and resignation, to displeasure and anger. Anakin's response to his need to transition to the open rehabilitation ward, rather than going directly to the community was distain (often Anakin's responses were more in what he did not say and the tone of voice that he used rather than in the words he did use during the interview). He directed his frustration at the clinical team as part of his response. When asked about the reasons for his transition his reply was

*Dunno, cause they want me here.*

*Anakin*

He believed that decisions were made by his doctors. When asked about how he felt about his transition his response again was with distain.

*I think they're fucking eggs*

*Anakin*

Anakin did not have clear goals about where he would like to be instead; his response was again of a derogatory nature.

*Out of this shit hole.*

*Anakin*

Some of the interviewees appeared not to question decisions made for them as part of their transition. They recognised there would be times when they were not able to articulate why they were completing something but they knew that it was important that they just followed staff requests. For Shrek this was quite clear. Not only did he need to

follow the directions of the staff but he also needed to be able to accept this; his attitude towards the rules being very important.

*But umm you know like arrr like the doctor says that arr if you can't make it here you can't make it over there you know cause this is a stricter unit and if you can't live by the rules here, over there you're not going to manage because its more open and freedom and, you know. So it basically it's just learning to live with what you've got and be positive about it. Do all the rules, treatment plan, take medication. Yeah.*

*Shrek*

All of the interviewees knew that they would have to do what they had to, to enable them to get what they wanted and this varied between interviewees. All were able to identify immediate needs and wants as well as more long term desires. Sometimes interviewees thought getting what they wanted was taking too long and was unnecessary however, they followed (sometimes reluctantly) the directions given to them. Doing what they had to included saying no to drugs, not causing trouble with staff or other patients and following their treatment plan.

### **Governed by rules**

Knowing and learning what the rules were was an important part of the experience of transitioning. Knowing what they had to do to make this transition successful was important to all interviewees. Richard explained it as learning a whole new set of rules. He had known what he needed to do to get from the secure unit to the open rehabilitation ward; now he was

in the process of learning the new rules associated with being in the open rehabilitation ward. He saw the other patients in the ward, who had been there longer than him as already knowing what these rules might be.

*They know how to get out of this, this part of the ward. I'm only just starting to learn it. Cause they're learning to, moving back into the community. I'm only just starting; I've come from a locked ward, teaching myself to go from a locked ward to an open ward. The guys here are setting themselves up into flats or supported accommodation.*

*Richard*

Often they expressed their need to just wait until they found out what it was that was expected of them. Rules provided structure and security to many of the interviewees. Casper explained this in terms of the rules he has from the parole board and has to adhere to while in the open rehabilitation ward.

*Umm well I've got a set of rules for my parole. Like I'm not allowed to leave the grounds without permission. Umm not allowed to use drugs or alcohol. Umm not to get into contact with the people I hurt. That's pretty much it.*

*Casper*

However, for Casper these are not seen as restrictions, rather as providing security, because he knows what is expected of him and what he has to do to ensure he continues to make progress.

*Arrr I think so yeah. A bit reassuring. Maybe just sticking to the rules sort of thing.*

*Casper*

For Casper, knowing the rules made the transition straight forward.

*Just the nurses and that, yeah. They lay down the rules and yeah pretty much straightforward.*

*Casper*

Knowing what the rules are means they have a better chance of ensuring the experience was both successful and they achieved what they wanted. All interviewees were familiar with the rules, even if they were not in agreement with them. They knew where they were when they had rules to follow and these varied. Rules ranged from whether an interviewee could leave the unit by themselves, enter the community, or whether they were allowed to use their Xbox outside of designated programme times.

*Well, I've got an X-Box, that's a video game console and a DVD player, umm I go for walks, I do groups, I go to the library and go to the community, umm I work on the arrrr on the work day, I go swimming, umm I watch TV when it's time to, and that's umm about two o'clock, cause all the nurses from day shift are moving on to umm going home and then the night shift kicks in and umm yeah we watch TV from about two to half past nine. Yep we've got a bed curfew which is half past ten so yeah we can watch TV from half two to half past ten, from Monday to Thursday, Friday and Saturday you're allowed to stay up till 11.30, half past eleven.*

*Richard*

Others described when they were allowed to engage in their chosen occupations, as this was stipulated in the rules.

*Oh I just worked on the ward cars and then moved on to doing staff cars, yeah it's good. It gives me something to do. Outside of group times.*

*Anakin*

*Yeah mainly cause It's group time usually on, I participate in group, and then I can play, after groups have finished and stuff then I can play the Xbox*

*Jae*

The notion of being compliant is an important one during this experience. Being seen to do what is right and behaving was vital if the transition was to be successful. The interviewees did not believe they had an option; if they were to continue to gain more privileges then they needed to do what they had to.

### **Each doing what is right for them**

Each interviewee expressed a certain level of resignation to the fact that people and organisations were in control of their destiny and that they had to accept this. As a result some interviewees actively decided not to be involved in decision making around their transition and to wait to be told what to do. This enabled them almost to remove themselves from the process, which could almost be seen as a protective factor. Not emotionally linking to the decisions or the process that they went through means they would not necessarily be disappointed with the result.

*Arr a little bit nervous but I knew it was a 50:50 chance so I didn't get too strung up on it.*

*Casper*

*I try to get that tomorrow see what happens after the meeting... Oh it's just going through a meeting. Just talk about it whatever. I don't really know.*

*Anakin*

Many of the interviewees experienced disappointment after waiting to hear about whether they were successful in their application for increased liberty. A way of coping with this disappointment was to get annoyed with the system.

*Well when they first said no I was a bit pissed off because I'd done so much hard work, umm they've knocked me back twice so far but umm this time when I go to the board I've only got two months to go so they are really backed into a corner now, they have to make a decision it's going to be yes or no cause I've only got two months anyway to serve, cause at the end of June they can't do jack.*

*Shrek*

For some interviewees there were external bodies that made decisions about when they were allowed to transition. Often part of what they had to do was to wait.

*Well I was a special patient so I still had to go through parole to move to an open ward (secure unit) a secure ward so umm being able to leave the ward of (secure unit) and being able to move to (open rehabilitation*

*ward) to get it over, umm, it's quite hard to explain but umm it was just a long transition period umm sort of getting me ready to go to (open rehabilitation ward) but I needed the permission of the parole board to, to move permanently.*

*Casper*

Taking their time was a concept expressed in various ways by some of the interviewees. This referred to what they got involved in during the process, what they spent time thinking about and planning for the future. The main reason was about ensuring this transition process was successful.

*Oh it feels good. Because it's not, I'm just new here and arrr they're not forcing themselves onto me to doing more activities and in a way, incorporate me into doing more activities instead of just forcing me into it.*

*Richard*

*I don't really think about that much really. I know it's going to happen and it's there but I just try and deal with each day as it come, just deal with each day, one day at a time you know rather, I just can't deal with thinking too far ahead. Too much stuff going on so I just try and deal with each day, get through each day and don't do anything wrong that could get me in trouble.*

*Shrek*

Controlling their reactions to fellow patients and listening to staff as they explained reasons behind decisions was important. For some interviewees it was right to talk to staff when they knew something was not right for

them while others believed it was about not talking to staff. Their decisions related to how they believed it might impact on their freedom and progression towards it.

*If you try and conceal what you're doing yeah and if you do that you end up staying in hospital a lot longer. If you're honest you get to go from the locked ward to the open ward. I was supposed to be in the locked ward for (number of years) Umm I came here in (two months less) so I umm yeah I got two months, I was here two months earlier because of being honest with the nurses, the doctors and the whole team.*

*Richard*

Interviewees identified that part of doing what they had to was about recognising that they would need to do things for themselves for the transition to be successful. During the process of both preparing for, and moving to, the open rehabilitation ward the interviewees realised that they could influence the process by controlling themselves.

### **Summary**

Doing what you have to, to prove yourself is about how these interviewees proved to those in power that they were trustworthy, capable and ready to move to a less secure environment. To do this they needed to know what was expected of them. There were rules that they were required to follow, which outlined to the interviewees how they should behave. Interviewees recognised that their attitude towards the transition and others who were involved in the process also impacted on the process and the speed with which it occurred.

## **Assistance comes in many forms**

The interviewees experienced support, or the lack of it, in many different forms during the process of transitioning from the secure unit to the open rehabilitation ward. They were aware of what helped them during this process and were aware that they were central to it.

### **Saying goodbye**

It was important that the interviewees had an opportunity to say goodbye to those who were staying back in the secure units, not just the other patients but the staff also. For some it was important that they stayed in the “good books” of those they were leaving so they made an effort by spending time with these patients before they left. They recognised that they were moving on and that there was a good chance that they would not see some of the patients they had shared a living space with again, for a long time if at all. This did not appear to cause much concern however, they still believed it was important to say goodbye.

*Telling other nurses that I'm leaving and telling people that I've known for quite a while, while in (secure unit), like (names), make sure I tell them that I'm leaving, so make sure we enjoy our stay, my last week here, two weeks here, make sure we enjoy it before I, before I go for good. Like (patient) and stuff. I've known (patient) for about 8 months now. So I'll make sure we have a good, a really good time before I go, before I leave them alone again for ages, never to be seen again probably.*

*Jae*

Jae did not believe it would be difficult to say goodbye to these people because it is something that happens on a regular basis for those in the secure unit.

*No it will be easy, cause people come and go.*

*Jae*

For Kee it was being able to say goodbye to the staff he had come to know while in the secure unit. He had known some for a number of years and during the process of his transition he was able to say goodbye to them. So for him it was important to have the time to do this. Usually it happened while he was spending time in both the secure unit and the open rehabilitation ward. He explains what he means by his “goodbye time”.

*Means time to move on, to another ward. It means I say bye to these people that I've known for a really long time, for a year and a half. Like (names) umm a few other good nurses that I get along with.*

*Kee*

For Richard leaving behind the other patients in the secure unit meant he was closer to his goals. He spoke of his belief that talking to those in the locked ward helped him in his move to the open rehabilitation ward. This was because he could see they were still unwell and that they needed to be where they were. It was important for him to leave these people behind and be with people who were moving on like him.

*Yeah talking to the other people in the ward, the patients, I'm not going to say what they've said cause that's personal, some of the things they ummm say, you just try and like not upset them. You sort, you sort of go*

*with them cause they could go, yes because they been there for a lot longer in the locked ward then when they talk to me I know the reason why they are there... Hmmm I notice the difference from the locked ward to this ward. In a way I know they're sick, in the head, they don't see it themselves, being sick in the head, they think it just, that's the way, that's the only way and then I umm I keep quiet and realise that they're still going to be there even when I probably leave here if they don't change their mentality and I'll be moving into the community and they will probably still be in the locked ward if they don't change their mentality.*

*Richard*

### **Other people**

Interviewees recognised there were many people that aided in the process of transition.

*Everyone, staff, doctors, patients, from everyone pretty much. Yeah everybody contributes.*

*Casper*

All interviewees have previously had some contact with patients who were already at the open rehabilitation ward. They had already gone through their transition and were important for all interviewees in helping make their preparation for, and transition to, the open rehabilitation ward successful. These links to their fellow patients, especially at the open rehabilitation ward, were recognised as important. They were able to relate to someone who understood what they were going through. Shrek

spoke how he anticipated by already knowing patients who had moved from the secure unit to the open rehabilitation ward would be of help to him in the future.

*I already know people over there. Yeah so I will see familiar faces. They've come from here, it's not like you're going somewhere where you don't know nobody, it's always good where you know some people. Helps things a little bit.*

*Shrek*

Casper spoke of how having people he knew from his transition period helped settling into the new ward.

*Arr, you know being welcoming and saying I yeah welcome yep, yep. Plus I knew like a few people before I came during my transition period. So it made it a bit easier as well. It just made it easy. You know not coming to a strange place where strange people are. I already knew them and it made it a lot easier.*

*Casper*

It was the patients who had already completed the transition who encouraged the interviewees as they moved over. Some interviewees could recognise the changes these patients had undergone and they hoped that one day they would also change so saw contact with those who had successful transitions as supportive. Shrek speaks of how he had met up with those already in the open rehabilitation ward, while they were sitting outside of the open rehabilitation ward. They have told him about what happens there and his perception is that their mood has improved.

*Oh I've been outside, talked to the boys outside, I haven't been into the ward though. Been outside on the seat but haven't been into the ward itself. They look so much happier over there than they did over here. When they were here they looked depressed, over there they look like they're over the bloody moon, they're more relaxed not so up tight, yeah.*

*Shrek*

He then goes on to say he anticipates this will be the same for him.

*Same thing, yeah, same thing*

*Shrek*

The patients already in the open rehabilitation ward appeared relaxed and happier to the interviewees, they therefore presumed this would occur for them when they moved to the open ward. This in turn gave them hope. Jae recalls how he knows the patients from the secure unit and has already been talking to these patients about the open rehabilitation ward and has developed a hope that the ward will be “nicer” than the secure unit.

*I already know them from (secure unit)... Seem much nicer over here and seem like they won't get in my way or anything. Hopefully won't annoy me too much. They are much nicer over here I think. I've asked the guys and they said it's much better over here.*

*Jae*

Jae believes the patients at the open rehabilitation ward are going to be good company.

*I think about the guys that are here, they're good company, seem like*

*good guys to talk to, good company.*

*Jae*

Casper believed the other patients contributed to helping his transition be a success. He recognised that they had been through this process too and they understood what he was going through. This was an important part of the experience.

*Just not really causing any trouble just everyone getting along. Yeah understanding where everyone comes from, where I'm coming from.*

*Casper*

It was also in the process of completing everyday occupations where these interviewees had an opportunity to talk with their fellow patients. They found that there were opportunities to develop friendships where previously they had difficulties. Casper spoke of how he did not socialise with the other patients at the secure unit but finds it easier to speak to the patients at the open rehabilitation ward.

*I guess I really only had like a couple of friends at (secure unit). That I talked to, where as here I talk to everyone pretty much. Yeah different people.*

*Casper*

Cooking was often more than just about cooking food to eat. This occupation was used to develop many skills during the process of making food for themselves as well as cooking for others. It helped develop their social skills because they worked alongside one another and with staff. They practiced how to work cooperatively with others, and needed to be

able to listen to staff as they helped them. Interviewees recognised the power of working with others. Richard relates this to when he is preparing food at the open rehabilitation ward.

*You get to talk to one another when you're preparing the food and stuff and that way you make kinda like friendships but over in the locked wards ohh I'm not a very sociable person.*

*Richard*

The staff, at both wards, also played an important role during transition and for many interviewees it was successful. Most of the interviewees spoke of how the staff helped make the process of transitioning helpful. The staff that let Casper know what he needed to do.

*Just the nurses and that,yeah. They lay down the rules and yeah pretty much straightforward.*

*Casper*

Staff were able to help Shrek clear his head when he was overcome with his illness.

*Umm they listen to what you've got to say. Then they think about the best way to deal with it and then they deal with it, so you're not on your own dealing with shit. You know what I mean aye? So you've got stuff going on in your head and you talk to them about it and they can rationale it out with you. And you know, so, yeah. They are pretty good here.*

*Shrek*

Staff were the ones that picked up when Richard was not well and then brought it to the attention of both himself and the doctors. He saw this as being helpful in his transition.

*Umm when you're doing something peculiar they'd point it out to you and then they'll tell the doctor and then you have a meeting and then you tell the doctor what you what you done and then they re-evaluate you in your treatment plan. If you ummm do something peculiar, they'll find ways to fix it. Without umm letting other people know that that's whatthey see. They make sure you are aware that you are doing it, doing the peculiar behaviour.*

*Richard*

Anakin had an alternative view and experience of staff. Although he thought some staff were helpful he did not believe this was the case for everyone.

*Oh some of them were different. Some of them were good, some of them were eggs.*

*Anakin*

Staff provided most of the information interviewees gained in relation to the transition. One of the things that the interviewees recognised as being helpful to them in the transition was not only getting clear and timely information but being given enough time to be able to process it and come to both an acceptance and understanding of the information. This was a vital part of the process. It was important that the staff spent time explaining the reasons behind decisions as many did not agree initially

that this was a necessary step to the community. Shrek spoke of how having this option explained to him was important.

*Yeah they explained it, cause I was Ohh I'll be here for bloody ages and then go over there for ages, but umm (doctor) explained that it was a good process to build me back into the community rather than release me from here. You know so, I accept it.*

*Shrek*

It was a challenge for some when they were advised that they were being referred to the open rehabilitation ward. They did not want to go; they did not see the relocation as being necessary. However for most of the interviewees, with time and explanations, were able to accept and understand the reasoning behind why their clinical team was encouraging the move.

### **Enjoying doing**

At the open rehabilitation ward there was a return to more ordinary occupations of daily life. Washing their own linen and clothes, cooking meals and tidying their room were as much a focus as the recreation groups and other organised activities. One of the main activities off the open rehabilitation ward that all of the interviewees were involved was in a work rehabilitation service. They had all commenced their engagement into this service from the secure unit, continued attending during their transition to the open ward and it remains a main activity they are involved in. All expressed their enjoyment of this occupation. It was important they continued this during their transition and many found it

helpful. Access to the service did provide challenges for some because though initially they were able to go unescorted this changed to escorted when they got to the open rehabilitation ward.

*I go to (work rehab service) and paint and do sculpture there. Arr yeah I've been going to (work rehab service) for two and a half years I think. So I've just been painting pretty much over there, pictures yeah, umm one of the rules is, I'm not allowed to leave the grounds so I'm not allowed to go to (work rehab service) by myself anymore.*

*Casper*

The interviewees often saw themselves in a worker role and it was important this was not removed. They continued on with the same days and times during the transition and many then increased the duration at this activity once they were permanently in the open rehabilitation ward. Kee had begun attending the work rehabilitation service prior to his transition to the open rehabilitation ward. He has continued this throughout his transition and still maintains involvement, now he is permanently at his new ward. He talks about how he enjoys this opportunity and how the shower he has after returning makes him feel good.

*I think of it as good, something to do. Feel good cause I've got to have a shower straight after I come back, cause these guys go to work, they come back and they don't have a shower. They just sit down on the couch with their dirty clothes. But me I change my clothes straight away and have a shower straight away.*

*Kee*

Other off-site activities include, but are not limited to, swimming, art plans, bike riding, the gardens and visiting the library. A number of interviewees expressed their enthusiasm for these outings and their anticipation for future ones.

*Yeah apparently they go to like (town) and (town and stuff like that, so I'm looking forward to that.*

*Shrek*

All interviewees spoke about the different activities and occupations they were involved in during this transition. The role and purpose of the occupations had different meanings for the interviewees. Being attached to occupations helped in the process of transition, the main occupation being cooking and eating food.

All of the interviewees spoke of how “being busy” or “being occupied” was important and that the occupations they were involved in “gave them something to do”. Anakin speaks about how he has commenced car cleaning, initially completing just ward cars but has progressed onto others.

*Oh I just work on the ward cars and then moved on to doing staff cars, I made a 180 bucks in (locked ward). Just cleaning cars. 180 bucks in nine days, yeah it's good. It gives me something to do.*

*Anakin*

Richard speaks about how he views the activities he does. It is about helping prepare him for his eventual move to the community and it is important to be busy because the time then goes faster.

*When you do your activities it takes your time off the time and it makes it easier to move through to the next the next level of, umm, accomplishments, which is to the community, umm, yeah, the activities are designed to occupy the time positively in the way of moving into the community to occupy to find a way to occupy your time through the day. It's designed to umm help you pass the time in a positive way, in a motivated way and in a comfortable way so it's not too hard on the patients when they move into the open ward and eventually into the community. The activities are designed for that purpose, that's why they try and try and umm prepare you to do, yeah.*

*Richard*

Kee speaks of his surprise of how busy he actually is.

*We do heaps of things here I think. I'm occupied quite often. More than I thought. I'm always doing something. Don't have to remember what I'm always doing. We are usually doing something, we are usually not lazy, not that lazy, always doing something most of the time, always doing something.*

*Kee*

Interestingly this is in contrast to the point that the interviewees all stated the aspect they enjoyed about being in the open rehabilitation ward was that it was less structured and less busy. The need to be “occupied” and to have “hobbies” was identified by these interviewees as being an important component to making their transition successful. Not having time that needed filling was important. Down time was a way of getting into trouble. Keeping busy was also seen as a way of proving they were

ready to move onto the next step. Richard gave details about what, when and how he participated in occupations. There were rules on when he could participate in his chosen occupations and it appears the structure of this was supportive to him.

*Arr well, I've got an X-Box, that's a video game console and a DVD player, umm I go for walks, I do groups, I go to the library and go to the community, umm I work on the arrrr on the work day, I go swimming, ummm I watch TV when its time to, and that's ummm about two o'clock, cause all the nurses from day shift are moving on to ummm going home and then the night shift kicks in and ummm yeah we watch TV from about two to half past nine. Yep we've got a bed curfew which is half past ten so yeah we can watch TV from half two to half past ten, from Monday to Thursday, Friday and Saturday you're allowed to stay up till 11.30, half past eleven.*

*Richard*

Even though interviewees spoke of enjoying the relaxed nature of the open rehabilitation ward with less structure they spoke of needing to keep busy and this helping with their transition.

### **Taking responsibility**

Interviewees spoke of how they believed their own attitude towards the transition was an important factor in making the transition a success. Shrek stated he believed that it was not just about following the rules but having a positive attitude towards them that was important.

*So it basically it's just learning to live with what you've got and be positive about it.*

*Shrek*

Casper believed he was very much central to his successful transition. He recognised that there were difficult times however it was his attitude that had a significant impact.

*Me, you know being positive and, yeah, umm just not letting it get to me too much, just, yeah, arrr pressure and anything like that.*

*Casper*

Acknowledgement of other factors which helped their transition was also important. All of the interviewees acknowledged that the medication they are on, and that they were taking it, helped in the process. It was an important factor in getting access to the open ward. Anakin acknowledged this when asked what he saw as helping this process.

*Dunno, me taking my medication probably.*

*Anakin*

When asked, he refused to further explore why he thought medication helped.

*Dunno, Ohh yeah I don't really want to talk about it.*

*Anakin*

However, whether he truly believed it helped is questionable. When asked what he would like to do in the community he stated

*Flush the medication down the toilet.*

*Anakin*

For Richard being on the right medication was a significant factor in his transition. He believed if this had happened earlier then he may have been able to transition earlier.

*Getting the right medication. Took a while for me to get the right medication. I didn't get the right medication. So your symptoms are under control arrr and once they're under the control, then you can prove to the nurses you are ready to move on to the next level. But you've got to do it cautiously, getting the right medications and then the nurses can talk to you and you understand what the nurses are saying. Because, arrrrr if the nurses were talking to me in the state that I was before I got to the right drugs I wouldn't know what the nurses were talking about. Because I got the right drugs, I know what the nurses are talking about and the doctors and the OT and the house keeper. If I, if I didn't have the right drugs I just, oh, I just look at the nurses and all I'd see was murmuring, babbling and I wouldn't understand what they're talking about. Because I understand what they are talking about, that's the reason why I moved from the locked ward to the open ward. Because I umm I've only just moved from there to here and that's one of the main reasons why its made it a lot easier for me to umm go from the locked ward to the open ward. Through getting the right treatment through the arrrrr through the doctors.*

*Richard*

Interviewees acknowledged their attitude played a part in their transition. By having a positive attitude towards what was occurring helped them both cope with and participate in the transition. Some of the interviewees acknowledged the medication they were taking helping make the transition successful. However for one interviewee this is questionable.

### **Summary**

During the process of their transition the interviewees were able to detail different factors they experienced that helped their process. Fellow patients, both in the secure unit and open rehabilitation ward played a part, as did staff. Interviewees were aware they had a part to play in this process and their own attitude was vital. The different occupations that the interviewees engaged in also provided support.

In this chapter I presented my analysis of the interviewees' experiences of transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service. I quoted extracts from the interview transcripts to provide depth to these themes. The four key themes that were explored are:

- Being-in-the-world of being free
- Stepping stones,
- Doing what you have to, to prove yourself
- Assistance comes in many forms

What came apparent during the process of presenting the material was that the division of themes is somewhat arbitrary. Many of the experiences represent more than one theme. While analysing the experiences of transition, for these interviewees, it became clear to me that this process was more than just moving from one ward to another. The four key themes could be looked upon as being independent of each other however as part of the experience of transitioning for these interviewees they are also interrelated. Implications of these findings are explored in chapter six.

## Chapter Six: Discussion

### Introduction

The purpose of this study was to generate an understanding of the lived experience of a person transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service. Gaining a clearer understanding of the experience could help inform the practice of those health professionals who support forensic psychiatric patients to make this transition.

The process of transition occurs throughout life for every human being. People transition from adolescence to adulthood, student to worker; they move geographical locations and adjust to a disease or accident; or in my case transition from clinician to academic researcher. These transitions may be voluntary or be forced upon us; whichever way it is a process to be gone through. Help with this process comes in many forms and is often sought by the person undergoing the change, especially if they recognize they are going through it. As described earlier in the literature review, awareness that change is occurring and engagement with that change is vital for the transition process to be successful.

People in forensic psychiatric services, like the majority of the population, undergo a variety of transitions. Many are forced upon them and their perception, often based on reality, is that they have limited control over these processes. Transitioning from a secure unit to an open rehabilitation ward does require a person to be aware of the changes occurring and to be able to adapt both to the way they do something, as well as how they think about it.

In this chapter I will present the meanings I have interpreted from my understanding of the experience of transitioning from a secure unit to an open rehabilitation ward. It will show what these interviewees' experience says about transition and relate it to transition success. I will discuss the relationship of these insights to other literature and identify what is new in this study. Finally I will outline implications for practice for those supporting patients in forensic psychiatric services who are either anticipating, may be beginning, or are in the process of making this transition.

This study sheds light on many aspects of transition. Significantly, I believe there is the need for demonstrated connectedness to the process of transition by those undergoing it. This connectedness is generated when those experiencing transition are able to form connections to people, place and occupations. I will argue that connectedness, to these three key areas, is the key to effective transitions and that staff can help facilitate these connections to ensure transition is successful.

The Oxford English Dictionary (Simpson & Weiner, 1989) defines connectedness as "The state or quality of being connected" p 745. That is, how well a person is connected to an identified subject. Connections or being connected refers to the emotional link a person has to the identified subject. For this thesis, connectedness refers to how well a person is connected to the three key areas of people, places and occupations and therefore the transition process.

Connections are important when making changes in our lives. McIntyre & Howie (2002) found in their research into adapting to the transition into widowhood, that social connections and engagement into meaningful,

routine occupations were significant when adapting to this new state. Social and occupational connections provided grounding to the multiple changes that were occurring within women's lives and provided a focus when things that were happening were not in their control.

Hill (2006) also explored a sense of belonging as connectedness in the American Indian worldview of mental health wellbeing. She asserts that a basic human need is to have a sense of belonging in regards to connectedness and this relates to people (both individually and within a community), the environment and what we do.

In the following sections I will explore connectedness to the process of transition and then separate out the three key areas and explore connectedness associated with them. I will present how connections to these three areas are often inter-related rather than occurring separately and finally how connectedness to people, place and occupations influences connectedness to the transition process.

## **Process**

For those completing the transition to the open rehabilitation ward, I believe, there is a need that they have a connectedness to the process of transition. I believe the body of literature regarding transitions supports this, as seen in the literature review. The literature states not only do those undergoing transition need an awareness this process is occurring they must also actively engage into the process. They must also take an active role in decision making and have adequate time to do it (Clingerman, 2007; Kralik, et al., 2006). I have deduced this to refer to

connectedness. When a person engages in their transition, making decisions and incorporating change into their lives I believe they are demonstrating a connectedness to transition.

Charleston & Happell (2005) found in their research into the connectedness of nurses to the perceptorship experience, that it was accomplished when they were connected not only to themselves but also to others (such as colleagues), where they were, what they did, and the system. All of these factors were uniquely inter-related to achieve connectedness. They also found that the ability to achieve connectedness was influenced by time. I believe Charleston & Happell's research demonstrates connectedness to the overall perceptorship experience being generated when the participant is connected to the other inter-related factors, such as the people they were involved with, where they were and what they were doing. I believe Charleston & Happell's findings are directly related to my research. Some interviewees' spoke of connections to other patients and staff, to the activities and tasks they were involved in and this aided in the connection to their transition. One interviewee portrayed a dismissive connection to what they were doing and the people they were spending time with so did not appear to have generated the same level of connection to the transition process.

From my findings, it is evident that the interviewees communicated a need, and anticipation, for connectedness to people, places and occupations during this transition process. Through their experience of being-in-the-world of being free, stepping stones, doing what you have to, to prove yourself, and assistance comes in many forms, interviewees described a need for both reconnecting and dissolving of connections to past experiences, places and people. Casper spoke of his desire to perhaps

engage in occupations again. For example, returning to high school and going to a community art service by himself was something he hoped for. He recognised the increase in freedom allowed him to connect to these occupations along with the places they occur. Jae spoke of his excitement of going to the open rehabilitation ward because he was making a step towards freedom, towards returning to supported accommodation. His connection to the process was linked with his connections to both the open rehabilitation ward, as a step, and the final place where he wanted to be, supported accommodation. Shrek spoke of wanting to disengage with associates from his past. This was a concern for him during his transition. He wanted to prove himself to the staff that he was able to make this transition successfully. His experience demonstrated many connections to people. Staff and the other patients were important in giving information to him. Both he and Jae wanted to prove themselves to staff within the forensic psychiatric service by not engaging in drug taking. They recognised this would be detrimental to their transition and didn't see taking drugs as being worth it. They had to dissolve the connection to drugs to be successful in their transition.

All of the interviewees described their desire to eventually live in the community. None of the interviewees saw the move to the open rehabilitation ward as being their final one. Most of the interviewees described connections to the other patients and staff, at the open rehabilitation ward as being helpful to them. These connections were important as they provided the support during the transition. Another significant connection the interviewees identified was with the open rehabilitation ward itself. They saw it as a stepping stone to the community and spoke of how they had engaged into the routines that

occurred within it. Many of the interviewees spoke of their pleasure in engaging in, and returning to, occupations that occurred both within the open rehabilitation ward and outside of the hospital grounds. Richard spoke of being engaged in a work rehabilitation service outside of the forensic psychiatric service. He hoped he would increase his time with the service in the future. Jae, Shrek and Kee spoke of their pleasure regarding re-engaging with cooking again. It was an occupation they enjoyed and during their transition they were able to become involved in the tasks associated with cooking.

Anakin, however, communicated a different experience. He spoke of his disdain for some of the staff within the open rehabilitation ward, his lack of involvement in structured activities that occurred within the open rehabilitation ward and his belief he was only there because staff had directed him to be. I became aware; if there were minimal or no obvious connections to people, place and occupations then connectedness to the transition was not evident. Anakin didn't demonstrate a connectedness to his transition. It became apparent to me that the other interviewees had developed quality connections to people, place and occupations which in turn aided their state of connectedness to their transition. This I believe increases their likelihood of a successful transition outcome.

The three elements, (people, place and occupation) cannot and should not be taken as separate entities. They are very much inter-related and the quality of connections to one impacts on the quality of connections to another. For example, connections to place and occupations can be, and often are, inter-related. Some occupations occur in specific places and if a person is not connected to that place then they may very well have trouble connecting to the occupation. Cipriani, Haley, Moravec & Young (2010)

also found connectedness was generated when researching experience and meaning of altruistic group activities. Through the group activity their participants became connected to the people within the group, this created a sense of community. This in turn connected them back to the occupation they were completing. Connectedness was related to a number of factors and all were required to achieve the state of connectedness.

Most of the interviewees' experience of their transition demonstrated a connectedness to the process. This was apparent when their connections to staff and patients, the open rehabilitation ward, and the occupations they were either required or wanted to participate in, were evident. I believe connections to these three key elements are essential in the establishment of connectedness to the process. The next sections will explore each of the three key elements and outline why connections to these elements are necessary for successful transitions.

### **People**

People were important because most of the support for this transition comes from people. Staff played a significant role in this process. This includes nurses, doctors, occupational therapists, psychologists, social workers and any other professional that plays a part in the transition. Feelings that are associated with the interactions from staff are recognized. Sincerity, compassion, friendliness, providing direction, their relaxed nature and an ability to listen and hear, are all identified attributes that help interviewees in their transition.

Interviewees connected to some staff and not to others, this in part related to how they perceived staff viewed them. Interviewees needed to prove themselves to staff. This however was challenged when the interviewees believed they were not being listened to or they did not understand why the request was made. This affected how the interviewee connected with the staff. Connections to staff were important to how the interviewee viewed their transition.

These findings are consistent with research completed by Happell (2008), who looked at the effectiveness of mental health services. She found that the support provided by staff was identified as a major factor in recovery and promoting social connectedness. Her participants viewed support more valuable than medication and other strategies; being listened to and being taken seriously by staff were important factors in Happell's participants' recovery.

Other connections to people that the interviewees viewed as important were the patient group in the open rehabilitation ward. This group understood what they were going through and what was to come. They gave encouragement, information and friendship during this process. The patients and interviewees did not talk about the transition; it was almost an invisible process. By "hanging" out with the group they gained support. Having their cigarette breaks, coffee breaks and watching TV together enabled them to connect with each other. It was also important to disconnect with the patients, from the secure unit whom they were leaving behind. Wanting to disconnect from the patients from the secure unit was about recognizing they had moved on, that their recovery was more advanced than those they were leaving behind. There was recognition that those that were being left behind in the secure units

needed to stay there and had further work to do. Interviewees were moving on and were in the process of reconnecting to patients they may have known previously. What was important now was they were in the open rehabilitation ward.

There is a body of literature which supports the importance of social connections. Social engagement and community participation is central to social relationships. Engagement in such activities is associated with positive outcomes in a variety of health markers. By providing opportunities for social events, places to meet and leisure activities social interaction is facilitated (Richard, Gauvin, Gosselin, & Laforest, 2009; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007). Having people to socialize with who appreciate the complexities and challenges from personal experience is also an important factor in facilitating social connectedness (Alvarez, Rosen, Davis, Smith, & Corrigan, 2007). Connectedness is more than just identifying with the other members of the group; it incorporates a sense of belonging to the larger group. It is feeling having something in common with them and having an interest in what is happening to the group (McNeely & Falci, 2004; Richard, et al., 2009; Wynn, Stewart, Law, Burke-Gaffney, & Moning, 2006).

Furthermore, there is substantial literature that supports the importance of connectedness to people. Wynn and colleagues (2006) draw attention to creating social connections for youth with disabilities who are transitioning to adulthood as they believe it is key for successful transition. McNeely and Falci (2004) emphasize social belonging and teacher support as being essential when developing school connectedness with adolescents. Richard and colleagues (2009) highlight the importance of the older adults ability to stay connected to others and their level of

social participation. Alvarez and colleagues investigate the importance of how fire fighters from September eleven stay connected to others (Alvarez, et al., 2007).

There are similarities within this literature present in this study. Attitudes of staff and how they provided support was highlighted by interviewees. Having people to socialize with who recognize and understand the complexities of what the interviewee has gone through was also important. Opportunities to engage socially were important; watching TV, drinking coffee and smoking cigarettes provided these openings for the interviewees of this study.

Despite the importance and development of social connectedness, no literature was found that addressed how connections to people impact on transitions or how connections to people are inter-related with connections to place and occupations. McNeely and Falci (2004) highlighted the importance of how social connections facilitated connections to place. Their study looked at how connections to teachers were a factor which facilitated connections to school for adolescents. They found that when the adolescents felt connected to their teachers they in turn developed connections to school. These findings have significance for this study. The interviewees' connections to the staff at the open rehabilitation ward influenced how they then connected to the open rehabilitation ward. Jae reported feeling like a visitor to the open rehabilitation ward at the beginning of his transition due to how the open rehabilitation ward staff interacted with him. However this feeling changed once he had connected to the staff.

It is also evident that recent studies do not address how social connections impact on those undergoing transitions within a forensic psychiatric service. Consequently, this group have unique characteristics and requirements which are not featured in current literature. This study shows significant findings such as the interviewees' references to developing connections with the patients from the new ward sitting beside the need to disconnect from previous patients in the secure unit. It was important that these interviewees did both rather than just focus on the development of new social connections. They essentially needed to disconnect from people in the secure unit to allow them to disconnect from the secure unit which in turn enables them to create the new connections.

### **Place**

This research highlights that interviewees require connections to place; to their physical as well as their social environment. This incorporated two different environments for the interviewees, the community and the open rehabilitation ward.

Interviewees required a connection with the open rehabilitation ward. It was evident in some interviews that this had been created, however for at least one person, that connection was very tentative. Interviewees did recognize that connection needed to be worked on and began when they were in the secure unit. The quality of connectedness was dependent on their connections with both staff and patients.

Connecting or reconnecting to the community was the primary focus for all of the interviewees. Whilst, for staff, this was not the main focus for the transition, it was however where all of the interviewees eventually wanted to be. For some there were specific places they wanted to be. For most it was not about a specific place but the community in general or more specifically freedom to access it. All of the interviewees had some level of connection with the community. Some recognized that permanent continuous access to the community would take time to achieve and others believed they should have already gained this freedom.

Reconnecting with the community poses many challenges and requires a graduated process. This was recognized by some but not all interviewees. Reconnecting to expectations about how to behave in the community and what to do and where to go were things that all interviewees wanted. This began in the secure unit and continued on to the open rehabilitation ward. Interviewees were expected to be able to engage in a number of the expected socially acceptable behaviours before going to the open rehabilitation ward. Reconnecting with the community, that is, with an open environment, has many emotional ramifications. Acknowledgement of these emotions is important.

These findings also correlate with other research. However the context differs as current literature focuses on developing connectedness and a sense of belonging with school. School bonding contributed to positive academic outcomes and social competence (Svavarsdottir, 2008). McNeely and Falci (2004) also found that strong school bonding was associated with a reduction in criminal activity, alcohol and drug abuse, and dropping out of school. Developing a positive environment within the school and participation in its activities helped develop a positive

school connectedness, which in turn created positive health outcomes (McNeely & Falci, 2004; Svavarsdottir, 2008).

The preceding literature underlines how the two elements of people and place are inter-related when developing connectedness to both of them. School is an institution which requires connectedness by its students to ensure positive, healthy outcomes for them (Svavarsdottir, 2008). Social support (empathy, praise and attention,) aids in developing connectedness and a sense of belonging within the school. Engagement with teachers is also believed to be a factor of connectedness which protects the student from at risk behaviours (Bonny, Britto, Klostermann, Hornung, & Slap, 2000).

Though this literature relates specifically to adolescences and school I believe the evidence of developing connections to place being inter-related with connections to people is relevant for the forensic psychiatric patient when transitioning to the open rehabilitation ward. How well the patient connects with the staff and patients of the open rehabilitation ward may well in fact influence how well they connect to the open ward as the place they will now live.

### **Occupation**

A predominant theme in occupational therapy literature is the connection between “the doing” and the individual’s experience of satisfaction and their health and wellbeing (McIntyre & Howie, 2002). A growing body of literature looks at connections between occupation, and health and wellbeing. There is an understanding now that a basic human need is

engagement in purposeful occupation which goes beyond that of paid employment, and the need for money (Mozley, 2001). This is also true for the forensic psychiatric patient. They too have a need to be engaged in purposeful and meaningful occupation. The interviewees from this study communicated this during their interviews. Richard believed it was having hobbies to engage in and keep him occupied which helped him during the transition.

Participation in occupation is meaningful when there is a feeling of choice or control of activity. For this to occur there must be; focus on the activity and not the consequences; an awareness of challenge in the activity; and a sense of mastery. Participation in occupations is affected by environment and people. The environment and people can either facilitate or provide barriers to participation in occupations (Law, 2002). From my experience many of the occupations the forensic psychiatric patient engages in are affected by not only, where they are living but also the people with the responsibility for providing their treatment. This is especially true when they are in the secure unit. Access to the kitchen to cook meals is tightly controlled as they are unable to use everyday kitchen implements such as knives due to safety reasons. One interviewee regarded cooking in the secure unit as a privilege to be earned. Others spoke of their leaves to walk from both the secure unit and open rehabilitation ward. Choosing where they walked was determined by others. The ability to walk unescorted was dependent on whether they have been granted this right from their clinical team.

Occupational performance is shaped by the dynamic relationship that occurs between occupation, person, and environment. Occupational performance requires the ability to balance occupation, the challenges of

the environment and self. This causes conflict at different periods during the lifespan (Law, et al., 1996). For this reason, identifying and then addressing these challenges, I believe is important, when the forensic psychiatric patient is undergoing their transition. The interviewees from this study identified a number of perceived and actual challenges the environment posed when in transition to the open rehabilitation ward. Shrek voiced his concern of re-engaging with inappropriate associates from his past and his concern was returning to prison and both Shrek and Jae spoke of having to say no to drugs to ensure their transition to the open rehabilitation ward continued. They recognised this was vital if they wanted to retain the advances they had made. Occupational therapists have a unique understanding of how engagement in appropriate and meaningful occupations has a direct link to health and wellbeing. They also understand the inter-related connections between people and place with engagement in occupations. For that reason I believe occupational therapists are well placed to provide the necessary assessment, support, and guidance during the transition.

Blair (2000) asserts occupation is central to life transitions. Participating in occupations helps those who are transitioning, connect to places and people. Similar occupations completed in different environments will aid in the connections to that place. Meaningful occupations in different environments will enable connections to the people there. I believe occupation provides a stepping stone to developing connections to people and environment. The findings support my belief. A number of the interviewees spoke of how engaging in cooking and eating meals at the open rehabilitation ward helped connect them. Richard was aware that while learning to cook he also was socially interacting with the others

around him. The process of cooking helped connect him to the other patients. This in turn helped him connect to the open rehabilitation ward. Jae spoke of his enjoyment of coming for a meal at the open rehabilitation ward during his transition. This enabled him to begin developing connections with the patients and staff as well as the open rehabilitation ward.

For many reasons there are times when chosen occupations cannot be completed as they usually might (Frank, 1996). The ability to adapt to an occupation is known as occupational adaptation, and research on occupational adaptation is found within the occupational therapy and occupational science literature. Frank (1996) suggested an occupational science definition of adaptation: "Adaptation is a process of selecting and organising occupations to improve life opportunities and enhance quality of life according to the experience of individuals or groups in an ever changing environment" (p.50). From my experience, forensic psychiatric patients can have concrete ways of thinking and the ability to organise and select appropriate and relevant occupations in a changing environment is poor. During transition both the physical and social environment changes for the patient which can cause many challenges. I believe it is important staff recognise the potential difficulties and incorporate support and guidance during transition.

Schultz & Schkade (1992) believe that it is the occupation that provides the means for individuals to adapt to change. They believe that when events such as major life transitions occur, then for the process of occupational adaptation the person needs to be functioning at a high level for positive mastery to occur. Therefore, based on this literature, the interviewees would require the ability to adapt (both themselves and their occupations)

for a successful transition to occur. From my experience forensic psychiatric patients require support and development by staff to adapt due to their concrete ways of thinking. If their existing methods of adaptation are not adequate difficulties will occur within the transition.

Many of the interviewees of this study spoke of how the staff had supported them in their transition. Kee commented he enjoyed the time he spent between the secure unit and the open rehabilitation ward. He believed his programme had been the right length of time for him and he had spent time engaged in occupations at the open rehabilitation ward prior to moving permanently there. Casper believed, though his transition programme went for a long time, it was also an important time in preparing him for the open rehabilitation ward and what the patients did there. I believe the time spent in the transition programme is an important time in teaching and supporting patients to master their abilities in adaptation.

Connecting and reconnecting to occupations was important, for the interviewees, as part of transition. It started in the secure unit but continued, often at a different level, in the open rehabilitation ward. Interviewees engaged in occupations they were both familiar with and new to them. The new occupations were recognized, often by staff, as being important and beneficial. Interviewees were required to engage in these occupations even though, at times, they didn't understand or view them as necessary. For example, returning to cooking began in the secure unit but was restricted. Access to the supermarket and having the ability to choose what they would eat on a regular basis was limited. However moving to the open rehabilitation ward allowed connections to these occupations to be re-established. It was important for these interviewees

and they experienced a sense of hope and joy by participating in them. Many of these occupations required tools, such as knives, not easily accessed in the secure unit so the patients needed to prove they could be trusted with this increased freedom.

The anticipation of reconnecting to community based occupations was also highlighted. They had a sense of anticipation that they might once again re-engage in work, or to try for the first time some type of education. Interviewees need to be able to adapt themselves, and their occupations, as they could no longer complete them as they would prefer, or as they had in the past.

Interviewees were required to adapt as their occupations changed over the course of their transition. They waited with anticipation for the occupations to change, and were able to recognize that the changes were contingent on their behaviour and attitude. Walking was a good example of an occupation that changed. The main focus for the interviewees was that they got out of the secure unit. The focus was not walking for health and wellbeing or to go somewhere specific, however, much this may have been a positive outcome. These interviewees were very connected to their walking and focused on increasing not only their leaves but decreasing the level of supervision that occurred during leaves. This graduated return to everyday occupations was seen as a stepping stone to returning to the community.

The development of connectedness to occupation is also inter-related with people and place. McIntyre & Howie (2002) saw an integral connection between “doing” and social relationships. Occupational adaptation was fostered by the active engagement in the meaningful occupations of

everyday things. Therefore, they believed that meaningful occupational engagement facilitated the adaptation process. This is supported by the interviewees from this study. Jae and Kee both spoke about their pleasure at returning to being in the kitchen. They enjoyed being able to share a meal with other patients which had been cooked on the open rehabilitation ward. They took pleasure from cooking meals they knew as well as learning new skills from both staff and other patients. Shrek spoke with anticipation regarding returning to everyday cooking. Preparing, cooking and eating are meaningful occupations to these interviewees and I believe, by being actively involved with these occupations again aided in their mastering their occupational adaptation.

Cipriani and colleagues (2010) stated that when people are faced with restricted opportunities to engage in occupations of their own choice, which may lead to loss of autonomy and choice, people can become less motivated and to engage in the occupations which are available to them. Anakin's experience of transition shows difficulty adapting to the change in occupations. He believed he did not have the choice about when he should be able to engage in his chosen occupations. He refused to participate in the structured programme, reporting he didn't do much at all, however he did communicate enthusiasm for both his car cleaning and the work rehabilitation service he had chosen to engage with. His lack of engagement in available structured occupations in the open rehabilitation ward, I believe, is because of a lack of connections to those occupations. The reasons for this lack of connection I believe are multifaceted and inter-related. A lack of choice regarding what and when he can engage in his chosen activities may in part be responsible. I also believe his lack of connection to the structured programme occupations is also related to his

lack of connection to the open rehabilitation ward and the people within it.

Through the process of transition the interviewees gained increasing opportunities to make choices and increase engagement in a variety of occupations. Many of their preferred occupations were adapted due to safety considerations of the forensic psychiatric service. Interviewees had limited control and choice regarding the services policies so were required to adapt themselves. For example all interviewees wanted to walk outside the secure unit by themselves but were required initially to be escorted by staff. As they progressed through transition some gained access to hospital grounds unescorted but still required staff to accompany them to the community.

Occupational therapy acknowledges the power engagement in meaningful occupation, within the person's environment, has for that person (Law, 2002). I believe the profession recognizes the skills needed, by a person, for occupational adaptation so is well suited to aid in area with forensic psychiatric patients transitioning.

## **Summary**

The interviewees spoke of having to perform behaviours, (taking prescribed medication, not taking illicit drugs, and participating in chosen occupations outside of structured plan time), though they didn't understand or necessarily agree with the reasons. They knew if they didn't comply then they would either lose the privileges they had already gained, such as increased freedom during their walks, or their transition to

the open rehabilitation ward would stop. Skelly (1994) study, as outlined in the literature review, found similar findings regarding having to “play the game” (p. 1060) when moving wards for forensic psychiatric patients. I believe the findings from Skelly links with connectedness to the process of transition. Interviewees who had developed connectedness were prepared to do what they had to, while the interviewee who had not developed a connectedness to the process expressed his anger at these requirements. Anakin’s experience of transition I believe, demonstrates a lack of connectedness to the process. He appeared angry and annoyed about his situation, about the reason for being at the open rehabilitation ward. He isolates himself from others and does not engage with the staff other than to wait to be told what he has to do next. His motivation to engage in occupations that are offered is minimal, especially if the ones he wants to engage in are limited.

What is not covered in the existing literature is how the forensic psychiatric client develops the connectedness to transition. A significant finding of this research is that the experience of transition is linked to the quality of connectedness to the transition process by the interviewees. The connectedness to the process is in turn linked to the connection to people, place and occupations.

The purpose of this study was to explore and then gain an understanding of the experience of transitioning from the secure unit to the open rehabilitation ward. It was not to generalize the findings to the forensic psychiatric population. I have however gained insights into what may help make these transitions more successful and have included them in the implications for practice.

## **Implications for Practice**

The implications of the findings of this study are significant for health professionals working with people within a forensic psychiatric service, as they will aid professionals in supporting patients through transition to an open rehabilitation ward. Occupational therapists, I believe, have unique understandings in relation to the three key elements of occupation, people and place. Engagement in occupations is influenced by the places where they occur, the people that are involved with the chosen occupation and the challenges the occupation provides (Law, et al., 1996) It is however, important that all health professionals working in this area have an awareness of what may help in ensuring this process is successful.

The following are a range of strategies, policies, approaches and information which could provide and enhance ways of improving connections to people, place and occupations which will facilitate connectedness to the transition process.

## **Connectedness to the Process**

There are a number of aspects to consider and all should focus on ensuring the development of connectedness to the process of transition by those making the move. Preparation for transition should start in the secure units. The preparation needs to address the concerns and fears that those transitioning have about going to the open rehabilitation ward. Some possible concerns that those transitioning may have, will be about the open rehabilitation ward itself, the people they will be engaging with and the occupations they will be expected to be involved in.

Recognizing each person completing the transition as unique is important. Recognition of the amount of work that they are doing in this process is also important. One transition programme will not fit all. The transition programme should include levels of support and information and input from others that is personalised for the person transitioning. Policies need to be developed to ensure the primary focus and considerations should be about the person transitioning rather than the requirements of the units and wards. For example, ensuring patients medications are brought to the open rehabilitation ward rather than having them return to the secure units to take them. This would then aid in the development of connections to the open ward, the staff and to the occupations within the open rehabilitation ward.

It is important for all staff to recognize and understand the changes that occur during transition and that those patients making the move from a secure unit to an open rehabilitation ward are expected to adapt to this change. It is also essential staff recognise and acknowledge transition to the open rehabilitation ward is a beginning point for the patients rather than an end point. Transition does not finish at the open rehabilitation ward. Information given to the person transitioning about the process by the staff should acknowledge this and demonstrate how going to the open rehabilitation ward fits within their recovery.

The following sections focus on ways in which connections to people, place and occupations can be increased.

## Connections to people

Staff are integral to the transition. Having a connection with staff at both the open rehabilitation ward, as well as the secure unit, helps foster a connectedness to the process. Approachable, friendly, relaxed nature and consistent are all staff qualities which interviewees valued. It is important that staff, are able to connect with the person undergoing the transition. An interviewee spoke of feeling like a visitor until they had got to know the staff at the new ward. Consequently the provision of opportunities for informal and relaxed interactions with staff at the new ward is a good way to help promote relationships with both staff and the patients. This would therefore promote connections to the people in the new ward. Staff's approaches (be it positive or negative) to the patient greatly influences the connections the person, in transition, will form with them.

Most of the information that comes regarding the transition, and what to expect, comes from the staff. By ensuring the person undergoing the transition has the information (about what to expect, the process they will undergo and possible timeframes) is presented in a way that the person comprehends will help foster connections to the staff. Interviewees spoke of their need to understand why they were being referred and why the process is proceeding in a specific way.

The other group of people that are important for the person transitioning to connect with is the patient group at the new open ward. Interviewees recognized this group of people understood where they were coming from because they had been through the process themselves. They often were the ones giving "insider" information to the new transitioner and this has the potential to either encourage or hinder the process. Interviewees

recognized that these patients had come from the secure units and many of them already knew these people previously. Having familiar faces was helpful by make the process less intimidating. A study completed by Alvarez and colleagues (2007) highlighted the importance of having opportunities to relax and engage with people who understood the complexity of the changes their participants were going through. Therefore I believe the most important opportunities for developing these connections with people comes from the relaxed informal interactions. Occasions for the new person to interact both informally and in a relaxed manner with the other patient group at the open rehabilitation ward would be beneficial. An interviewee spoke of coming to dinner during his transition plan and how much he had enjoyed that. A graded approach, such having the transitioner come for dinner with the new ward and then increasing the amount of time either side of dinner where the person can relax and spend time with the new patient group, to this would help build confidence and familiarity with each other.

Involving the new person with the open rehabilitation ward during structured occupations, such as the ward programme, also allows them to generate connections to both staff and patients at the new ward. Instead of staff alone selecting the structured activities the person should attend, where possible, I believe the patient who is transferring should be actively involved. Encouraging the patient to be part of the decision making process would help foster connections to the open rehabilitation ward and the people within it.

Along with generating connections there is the need to disconnect from both staff and patients from the secure unit. Having the opportunity to say goodbye and to adequately finish their time in the secure unit is

important. Interviewees in this research study reported this as being important. The development of a transition group may help address this. From my experience often only one person at a time is in a transition programme from the secure unit to the open rehabilitation ward. However, there are multiple patients who have been identified as needing eventual transfer to the open rehabilitation ward. Involving those who will eventually go through the transition process at an early stage, I believe, would be beneficial in facilitating connectedness to the process.

Possible areas that could be addressed during this transition group could be; looking at appropriate and meaningful ways of saying goodbye to those the person is leaving behind, providing information about the running of the open rehabilitation ward which could include initial introductions to the staff and their roles, acknowledging and addressing the fears and concerns those who are transitioning may have about leaving the secure unit and moving to the open rehabilitation ward and the emotional ramifications of returning to the community.

I believe building confidence and trust in the process of the transition will be helped by fostering the connections to the people the person is going to spend most of their time with at the open rehabilitation ward. It will also aid in the facilitation and development of connections to place and occupation.

### **Connections to place**

The interviewees all viewed the community as the place they wanted to be in the future. For many of them connections to this environment was

already there. What was needed was ensuring these connections were appropriate and sustainable. Some of the interviewees had not been into the community for a significant period of time. The thought of being able to enter the community when they wanted caused some level of concern because they were worried they may contact past associates which got them into trouble in the first place. Graded access to different parts of the community, which starts at the secure units, would help build their confidence. For example, increasing lengths of time in the community and opportunities to visit a variety of different locations aids in helping a person feel more comfortable.

Fostering the development of goals for the future that involve the community would also help this person see what the future could hold. Some of the interviewees were general when speaking about their future. They knew they wanted to be in the community but had no specific goals. A few interviewees did have specific areas they would like to focus on in the community. Encouraging those who were transitioning to look at goals based in the community and how transitioning to the open rehabilitation ward could fit with these goals may help foster connections to both the open rehabilitation ward as well as the community. Goals could include where they would live, what they might like to do in the community in regards to work and leisure. The transition group identified in the previous section could be a good place to begin with this focus.

Visiting the community had begun for all of the interviewees before they had begun spending time at the open rehabilitation ward. Therefore, for some it was difficult to understand why they then needed to go to the open rehabilitation ward. However, it appeared easier for the interviewees

who had significant legal constraints and had spent longer in the secure unit because they understood the number of procedures they needed to go through.

Creating connections to the open rehabilitation ward is, I believe, necessary to forming a connectedness to the process of transition. Gaining an understanding of how the open rehabilitation ward could fit into their recovery is important in developing these connections. Ways of facilitating connections to the open rehabilitation ward could be; early introductions to staff at the open rehabilitation ward and staff at both the secure unit and open rehabilitation ward are involved in the transition group. I believe staff are integral in achieving connections to the open rehabilitation ward. Staff relationships with the person transitioning will influence the connections generated to the open rehabilitation ward, therefore fostering relationships between staff and patient should be a focus. Ensuring the patient who is transitioning believes they are welcome at the new ward and that they are integrated into the new ward should be a focus of staff.

Graded exposure to the open rehabilitation ward was important in developing a connection to it. Spending time hanging out with the other patients, having their own bedroom, involvement in the activities (cooking and vacuuming) that occur there, relaxing with the staff and being involved in the care and upkeep of the ward are all ways that these people can develop connections to it. Returning to “normal” activities such as cooking and vacuuming can be seen as important in facilitating these connections. Some of the interviewees reported their experience of doing this as being a positive experience of their transition. I believe connections to the open rehabilitation ward were demonstrated when the interviewees

spoke with enthusiasm and pride about what they were doing within the open rehabilitation ward.

By nurturing and encouraging real connections, not just with the community but with the open rehabilitation ward, will help foster and develop the connectedness needed to the transition. The person undergoing the transition needs to believe that going to the open rehabilitation ward is an important step in their recovery rather than going because they have been instructed to. Generating the connections to the open rehabilitation ward is linked with their connections to other people and occupations.

### **Connections to occupations**

Throughout the process of transition all of the interviewees spoke of the different occupations they were involved in prior, during and post transition. All had spoken about the occupations that occurred off the hospital grounds as being very important. Blair (2000) states that occupation is crucial to life's transitions and that engagement in it helps overcome many of the obstacles transition can pose. I see this as being the case for this group of people too. Engagement in purposeful occupations can give focus and meaning to their daily routine and helps the process. All of the interviewees spoke of their desire and pleasure of engaging with food and cooking again. Many did not have a lot of experience or knowledge about cooking and relied on the staff and others to help them. However, this was not seen as a problem, it was important to be returning to this normal everyday occupation. Therefore finding ways for these people to connect to appropriate and beneficial occupations should be

central to the transition process. Occupational therapists, as discussed in the literature review, are placed to work alongside a person to help them select and engage in appropriate occupations. They should begin facilitating connections to appropriate and beneficial occupations in the secure unit. They should facilitate and encourage, where possible, the person who is transitioning, to make choices about appropriate occupations. Occupational therapists should also advocate, on the behalf of the person transitioning, to ensure the person has opportunities to make choices regarding their occupations. Clear and timely communication between occupational therapists of both the secure unit and open rehabilitation ward is required to ensure occupations selected in the secure unit can be continued in the open rehabilitation ward, both during their transition and once permanently at the new ward.

Many of their everyday occupations may still require adapting during this process. The rate at which these occupations need to be adapted and how they are performed may differ for each person. For example, accessing knives in the kitchen, escorted or unescorted walks, determining who washes the towels, or who decides on what food to be purchased for meals. Being mindful of how much the occupation is adapted, and providing support and direction will help the person to develop connections to these newly adapted occupations.

Engagement in occupations often started in the secure unit. The interviewees spoke of connections they already had with the occupations that occurred outside of the secure unit. Fostering these already developed connections and ensuring they continue during the transition will help provide continuity and structure for the person transitioning. All of the interviewees spoke of their desire to increase time spent in

engaging in the occupations outside of the secure unit so they saw them as both beneficial and important. Staff from both the secure unit and open rehabilitation ward should be involved with this. Clear and timely communication between the secure unit and open rehabilitation ward would ensure these occupations would continue.

Engagement into occupations that the staff deemed as important but the interviewee did not result in a lack of connection, to either the occupation or the staff or the place. As Cipriani and colleagues (2010) found, when there was a lack of opportunity, for their participants, to engage in occupations of their own choice a lack of motivation to engage in occupations that were available resulted. Therefore, it is important that those transitioning have a sense of control and decision making around what they can be involved in and what they can do. Of course due to safety and legal requirements there may be limits to this but it is important that the person completing the transition has the belief that they do in fact have some say in what they are doing. Providing choices to those transitioning, when the plan is being developed, is central, such as: choosing which occupations they might like to engage in may help foster a connection to this occupation along with the place the occupations takes place in and the people they engage with while participating in it.

## **Summary**

It is important to recognize that People, Place and Occupation should not be viewed as separate entities. Generating and enhancing connections to one may very well require the generating of connections to another. Connections to people will be important when facilitating connections to

either place or occupations and vice versa. By ensuring that each person has connections to these three elements will help ensure a sense of connectedness to the process of transition. When the person has established this state of connectedness to the process of transition then they will see how this move is an appropriate stepping stone in their recovery and they will view the freedom they have both gained and are still in the process of gaining as positive steps in their recovery. There will be recognition that, though there are some things they do because they have to, there is a purpose and point to them, and finally they will be able to recognize the aspects that helped them in the process.

The amount of time to process the information given to them will vary and the length of time taken for the transition to occur will be dependent predominantly on the legal aspects for each person. However, when possible the transition process should be dependent on the needs and requirements of the person rather than the needs and requirements of the units involved. As this is a complex transition in a complex setting there needs to be an understanding of what is needed by acknowledging and seeing connections between people, place and occupations. Staff can then practice in ways that help foster the connectedness required to the process of transition to ensure success.

## **Chapter Seven: Conclusion**

Transitioning is a process which is part of everyday life. It is a process which most people will have gone through multiple times throughout their lives. The patients within a forensic psychiatric service undergo transitions throughout the process of returning to an ordinary life. They undergo this process when they are required to move from a secure unit to an open rehabilitation ward.

The focus of a forensic psychiatric service is multilayered. Facilitating the recovery of the patients within the care of the service is primary. Moreover, ensuring the safety of the community is maintained is also important. Therefore ensuring transitions are successful is important, not only for the patient but the community as well.

In this study I wanted to understand the patients' experience of transitioning between the secure unit and the open rehabilitation ward of a forensic psychiatric service, and to understand how this process affects them in their everyday life. This chapter concludes the research by examining limitations to the study, recommendations for future research and a reflection on my understandings from my lived experience of this study.

### **Limitations to the study**

There were a number of limitations to this study. First, all the interviewees were male. The service where this study was conducted has

mixed gender wards, however it is usual for the majority of the population within this forensic psychiatric service to be male. Second, during the data collection phase of this research there were only males in transition from the secure unit to the open rehabilitation ward. There are, at times, women within this service who undergo transition. The findings may have been different if they had been included. From my experience women have less representation on the wards and can isolate themselves when on the ward and feel intimidated. Investigating if this has an impact on transition would be beneficial.

In addition, the study included five participants who completed six interviews. This is a smaller number than initially planned. Originally up to ten interviews were sought, however, during the data collection phase there were not a sufficient number of patients undergoing transition to secure ten interviews. Had this number been larger more detailed findings may have been obtained.

Another limitation regarded patient ethnicity. From experience there are high numbers of patients identifying as Maori who are within the New Zealand forensic psychiatric services. I did not collect specific data regarding ethnicity or look at cultural influences. It would be useful for this study to be replicated using a Maori researcher looking specifically at Maori and if culture influenced the transition experience.

A further limitation involved source sites. This study only included patients from one service. Therefore the findings of this research only relate to one specific regional service. Their experiences all relate to one service's approach to transitions. Had this research been completed over multiple sites, and gathered data from participants about different

processes, then the findings may have shown different insights. Thus it would be useful for this research to be replicated across a number of sites, with more participants, in particular woman and a mixture of cultures.

Another limitation may have been that I am an occupational therapist who had worked within this particular service within the last two years at the time of data collection. Some of the participants knew me as I had worked with them in a clinical capacity. As they were aware of my focus when I worked with them they may have attempted to ensure they gave me answers they believe I wanted to hear. They might also have been more forthcoming because of our previous relationship.

Furthermore, whilst I was there in the capacity of a researcher, I am also an occupational therapist. The questions I asked may have been inadvertently shaped towards areas that I have a professional interest in, (for example activities of daily living occupations, particularly cooking,) so interviewees may have been diverted away from other areas that would have contributed valuable understandings to their experiences.

A final limitation of the study is not meeting face-to-face with the interviewees for feedback on their transcripts and the findings. Due to the distance between where I reside, and the location of the service I used in this research, I chose to post back both the full transcripts and my initial findings for consultation with the interviewees. Though I provided postage paid, addressed envelopes I didn't receive any feedback from any of the interviewees. The interviewees may have had difficulty reading the information or comprehending what they were being asked to do. Had I met with each person face to face I may have discovered differences and been able to adjust my interpretations accordingly.

Despite these limitations the research, I believe, stands as useful in informing health professionals on the lived experience of patients transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service.

### **Future research directions**

Further studies looking at the phenomenon of transitioning within a forensic psychiatric service may reveal further insights into the experience of a person having to undergo this process. This could be opened up to include more than one specific service and could include both national and international forensic psychiatric services. Including the experiences of interviewees from a wider range of forensic psychiatric services would provide further depth to the findings.

Further investigations into how connections to people, place and environment in the context of transition should also be conducted. As a connection to the process is seen from this study necessary in ensuring a positive outcome for transition it would be beneficial to investigate how these connections can not only be developed and nurtured but also maintained in the new situation.

Based on the understandings from this study, future research which explored the forensic psychiatric staff perceptions of connectedness and its relationship to transition would be also helpful. Investigating whether staff believed there was a link between connections to the transition and successful outcomes would add to a more in-depth understanding. Looking at the patients' perception of connectedness and its link to

transition could provide insights into what may be beneficial in a transition plan to be used with the forensic psychiatric population who are in transition. Investigating if increased connectedness to the process of transition leads to increased success in transition with forensic psychiatric patients would also be beneficial.

Further research, based on these findings, which would be beneficial, is the development of, the possibility of developing, and then assessment of a transition programme which is implemented with a group (from the forensic psychiatric population) who were moving to a reduced level of security would be beneficial. The programme could include education for staff and patients regarding the links between connections to people, place and occupation and the success of transition. Facilitation of the establishment of connections to; the people identified as important to the success of the transition; the occupations the patients will engage in during and after the process; the place where the patient will be spending their time, would be a main focus of the programme. This could be started with a small pilot group and then rolled out to a larger population if successful.

### **Understanding anew**

I would like now to return to my own understandings and assumptions that I made explicit in the introductory chapter. I recognised that these previous experiences helped determine how I viewed my world and in turn influenced the interpretation that I gave to the data from this research. My knowledge and understanding of my experiences, both with

the forensic psychiatric population and transition, led me to the conclusions that I presented.

I now see the links to connectedness in my own experiences with transition. Links to the people I interacted with, the places I was involved in, and the occupations I engaged in were all important for me to engage in a successful transition. As I found in the reviewed literature (see chapter two), awareness of transition is the first step in the process and engagement into the process is the next. Through this research I have learnt that connectedness to the process of transition occurs when connections to people, place and occupations is evident. When there is a connectedness to the process of transition evident then engagement into adapting to the change associated with transition is observed. However, this connectedness is complex and multilayered. It requires appropriate and quality connections to people, places and occupations and each of these can be seen as inter-related, not separate.

This thesis adds new meanings associated with the experience of transition by the interviewees. The success of transition is seen as very much related to the person's connectedness to the process of transition. This is inter-related to the person's connections with the people they are involved with, the places the person is expected to spend time in, and the occupations the person completes, either with people or in the place they spend time. Hence this thesis contends that if these three elements have quality connections established then the likelihood of connectedness to the process is increased and therefore success is more likely.

Furthermore, if this connectedness to transition is established then the forensic psychiatric population will see the freedom they have gained and

are in the process of gaining, to be helpful in returning to an ordinary life. They will acknowledge that gaining increased freedom takes time and is another process which they are required to go through. They will have a better chance of acknowledging the transition to an open rehabilitation ward as a step towards their future, and see that it is a stepping stone and should be viewed as that. In addition there will be times when they are required to do what they have to, to help themselves and to maintain their wellness during transition. Finally, the recognition of what helps during transition would be evident to patients and staff if it has been made explicit to them.

Keeping the community safe and ensuring an individual is progressing forward in their move to regaining an ordinary life are fundamental to successful transitions from the secure units. This research identified that creating opportunities for real connectedness to the process of transition ensures the patient sees increased freedom gained as a stepping stone to the future they hope for.

## References

- Alvarez, J., Rosen, C., Davis, K., Smith, G., & Corrigan, M. (2007). "Stay connected": Psychological services for retired firefighters after 11 September 2001. *Prehospital & Disaster Medicine, 22*(1), 49-54.
- Anthony, W. (2000). Decade of the person. *Psychiatric Rehabilitation Journal, 24*(1), 1-2.
- Bjorkly, S. (2004). Risk management in transitions between forensic institutions and the community: A literature review and an introduction to a milieu treatment approach. *International Journal of Forensic Mental Health, 3*, 67-76.
- Blair, S. (2000). The centrality of occupation during life transitions. *British Journal of Occupational Therapy, 63*(5), 231-237.
- Bonny, A. E., Britto, M. T., Klostermann, B. K., Hornung, R. W., & Slap, G. B. (2000). School disconnectedness: identifying adolescents at risk. *Pediatrics, 106*(5 part 1), 1017-1021.
- Booth, T. (1996). Sounds of still voices: Issues in the use of narrative methods with people who have learning difficulties. In L. Barton (Ed.), *Disability and society: Emerging issues and insights*. Harlow: Longman.
- Brinded, P. (2000). Forensic psychiatry in New Zealand: A review. *International Journal of Law and Psychiatry, 23*(5-6), 453-465.
- Buckley, P., Noffsinger, S., Smith, D., Hrouda, D., & Knoll, J. (2003). Treatment of the psychotic patient who is violent. *Psychiatric Clinics of North America, 26*, 213-272.
- Charleston, R., & Happell, B. (2005). Attempting to accomplish connectedness within the preceptorship experience: the perceptions

- of mental health nurses. *International Journal of Mental Health Nursing*, 14(1), 54-61.
- Cipriani, J., Haley, R., Moravec, E., & Young, H. (2010). Experience and meaning of group altruistic activities among long-term care residents. *British Journal of Occupational Therapy*, 73(6), 269-276.
- Clingerman, E. (2007). A situation-specific theory of migration transition for migrant farmworker woman. *Research and Theory for Nursing Practice: An International Journal*, 21(4), 220-235.
- Critchley, S., & Schurmann, R. (2008). *On Heidegger's being and time*. New York: Routledge.
- Dowling, H., & Hutchinson, A. (2008). Occupational therapy -- its contribution to social inclusion and recovery. *A Life in the Day*, 12(3), 11-14.
- Finlay, L. (1998). Reflexivity: An essential component for all research? *British Journal of Occupational Therapy*, 61(10), 453-456.
- Finlay, L. (1999). Applying phenomenology in research: Problems, principles and practice. *British Journal of Occupational Therapy*, 62(7), 299-306.
- Finlay, L. (2002). "Outing" the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.
- Finlay, L. (2009). Exploring lived experience: Principles and practice of phenomenological research. *International Journal of Therapy & Rehabilitation*, 16(9), 474-481.
- Flood, A. (2010). Understanding phenomenology. *Nurse Researcher*, 17(2), 7-15.
- Frank, G. (1996). The concept of adaptation as a foundation for occupational science research. In R. Zemke & F. Clark (Eds.),

- Occupational science: The evolving discipline* (pp. 47-55). Philadelphia: FA Davis.
- Freeman, L., & Blair, S. (2004). Transitions: Some implications for occupational therapy. *Mental Health Occupational Therapy, 9*(1), 13-16.
- Gearing, R. E. (2004). Bracketing in Research: A Typology. *Qualitative Health Research, 14*(10), 1429-1452.
- Gilbert, T. (2004). Involving people with learning disabilities in research: issues and possibilities. *Health & Social Care in the Community, 12*(4), 298-308.
- Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*, 105-112.
- Gunn, J. (2003). Reflections on British forensic psychiatry in 2003. *Mental Health Review, 8*(3), 35-38.
- Hall, J. (2003). Positive self-transitions in women child abuse survivors. *Issues in Mental Health Nursing, 24*, 647-666.
- Happell, B. (2008). Determining the effectiveness of mental health services from a consumer perspective: Part 1: Enhancing recovery. *International Journal of Mental Health Nursing, 17*(2), 116-122.
- Hartwell, S., Fisher, W., & Deng, X. (2009). The impact of regionalization on reentry service outcomes for individuals with severe mental illness. *Psychiatric Services, 60*(3), 394-397.
- Hartwell, S., & Orr, K. (1999). The Massachusetts forensic transition program for mentally ill offenders re-entering the community. *Psychiatric Services, 50*(9), 1220-1222.

- Hatton, J. (2004). *The profile and work practices of occupational therapists working in forensic mental health and prison settings in Australia and New Zealand*. Unpublished Honours Thesis, James Cook University, Townsville.
- Heidegger, M. (1926/1996). *Being and time: A translation of Sein und Zeit* (J. Stambaugh, Trans.). Albany: State University of New York Press.
- Hill, D. L. (2006). Sense of belonging as connectedness, American Indian worldview, and mental health. *Archives of Psychiatric Nursing*, 20(5), 210-216.
- Inwood, M. (1997). *Heidegger, a very short introduction*. New York: Oxford University Press.
- Jacques, J., Spencer, S., & Gilluley, P. (2010). Long-term care needs in male medium security. *British Journal of Forensic Practice*, 12(3), 37-44.
- Johnson, M. E. (2000). Heidegger and meaning: Implications for phenomenological research. *Nursing Philosophy*, 1(2), 134-146.
- Kelly, M., Lamont, S., & Brunero, S. (2010). An occupational perspective of the recovery journey in mental health. *British Journal of Occupational Therapy*, 73(3), 129-135.
- Kirby, S., & Pollock, P. (1995). The relationship between a medium secure environment and occupational stress in forensic psychiatric nurses. *Journal of Advanced Nursing*, 22, 862-867.
- Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation. *Journal of Advanced Nursing*, 24(1), 174-184.
- Koch, T. (2006). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, 53(1), 91-100.

- Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing*, 28(4), 882-890.
- Kralik, D., Visentin, K., & van Loon, A. (2006). Transition: A literature review. *Journal of Advanced Nursing*, 55(3), 320-329.
- Lai, C. K. Y. (2010). Narrative and narrative enquiry in health and social sciences. *Nurse Researcher*, 17(3), 72-84.
- Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3), 21-35.
- Law, M. (2002). Participation in the occupations of everyday life. *American Journal of Occupational Therapy*, 56(6), 640-649.
- Law, M., Cooper, B. A., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 63(1), 9-23.
- LeVasseur, J. J. (2003). The Problem of Bracketing in Phenomenology. *Qualitative Health Research*, 13(3), 408-420.
- Lindqvist, P., & Skipworth, J. (2000). Evidence-based rehabilitation in forensic psychiatry. *The British Journal of Psychiatry*, 176(4), 320-323.
- Lloyd, C. (1995). *Forensic psychiatry for health professionals*. London: Chapman & Hall.
- Lunt, A. (2002). A theory of recovery. *Journal of Psychosocial Nursing*, 40(12), 33-39.
- McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice*, 15(1), 7-15.

- McIntyre, G., & Howie, L. (2002). Adapting to widowhood through meaningful occupations: A case study. *Scandinavian Journal of Occupational Therapy, 9*(2), 54-62.
- McNeely, C., & Falci, C. (2004). School connectedness and the transition into and out of health-risk behavior among adolescents: A comparison of social belonging and teacher support. *Journal of School Health, 74*(7), 284-292.
- Meleis, A. I., Sawyer, L. M., Im, E., Messias, D. K. H., & Schumacher, K. (2000). Experiencing transitions: An emerging middle-range theory. *Advances in Nursing Science, 23*(1), 12-28.
- Mental Health Commission (2001). *Recovery competencies for New Zealand mental health workers*. Wellington: Mental Health Commission.
- Michaels, C., & Orentlicher, M. (2004). The role of occupational therapy in providing person-centred transition services: Implications for school based practice. *Occupational Therapy International, 11*(4), 209-228.
- Moore, E. (2004). How to assess and investigate a patient within a forensic psychiatry setting. *Criminal Behaviour and Mental Health, 14*, S37-S42.
- Mozley, C. G. (2001). Exploring connections between occupation and mental health in care homes for older people. *Journal of Occupational Science, 8*(3), 14-19.
- Myers, C. (2008). Descriptive study of occupational therapists participation in early childhood transitions. *The American Journal of Occupational Therapy, 62*(212-220).
- Nagi, C., & Davies, J. (2010). Addressing offending risk in low secure mental health services for men: a descriptive review of available evidence. *British Journal of Forensic Practice, 12*(1), 38-47.

- O'Connell, M., & Farnworth, L. (2007). Occupational therapy in forensic psychiatry: A review of the literature and a call for a united and international response. *British Journal of Occupational Therapy*, 70(5), 184-191.
- Pillay, S. M., Oliver, B., Butler, L., & Kennedy, H. G. (2008). Risk stratification and the care pathway. *Irish Journal of Psychological Medicine*, 25(4), 123-127.
- Proctor, D., & Kaplan, S. (1995). The occupational therapist's role in a transitional living program for head injured clients. *Occupational Therapy in Health Care*, 9(1), 17-35.
- Reed, K., Hocking, C., & Smythe, L. (2010). The interconnected meanings of occupation: The call, being-with possibilities. *Journal of Occupational Science*, 17(3), 140-149.
- Richard, L., Gauvin, L., Gosselin, C., & Laforest, S. (2009). Staying connected: Neighbourhood correlates of social participation among older adults living in an urban environment in Montreal, Quebec. *Health Promotion International*, 24(1), 46-57.
- Rittman, M., Boylstein, C., Hinojosa, R., Hinojosa, M. S., & Haun, J. (2007). Transition experiences of stroke survivors following discharge home. *Topics in Stroke Rehabilitation*, 14(2), 21-31.
- Rogowski, A. (1997). Forensic Psychiatry. In J. Creek (Ed.), *Occupational therapy and mental health* (pp. 459-477). United Kingdom: Churchill Livingstone.
- Schultz, S., & Schkade, J. K. (1992). Occupational adaptation: Toward a holistic approach for contemporary practice, part 2. *The American Journal of Occupational Therapy*, 46, 917-925.

- Simpson, J. A., & Weiner, E. S. C. (Eds.). (1989) *The Oxford English dictionary* (2 ed., Vols. III). Oxford: Clarendon Press.
- Skelly, C. (1994). From special hospital to regional secure unit: A qualitative study of the problems experienced by patients. *Journal of Advanced Nursing*, 20, 1056-1063.
- Svavarsdottir, E. K. (2008). Connectedness, belonging and feelings about school among healthy and chronically ill Icelandic schoolchildren. *Scandinavian Journal of Caring Sciences*, 22(3), 463-471.
- Travernor, R., Travernor, S., & Crispin, Z. (1996). Life events and psychopathy: Influence of sudden ward environmental change on psychosocial functioning in psychopathically disordered special hospital patients. *The Journal of Forensic Psychiatry*, 7(2), 393-399.
- van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. Canada: The Athlone Press.
- Vrkljan, B. H., & Polgar, J. M. (2007). Linking occupational participation and occupational identity: An exploratory study of the transition from driving to driving cessation in older adulthood. *Journal of Occupational Science*, 14(1), 30-39.
- Walters, A. J. (1994). Phenomenology as a way of understanding in nursing. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 3(3), 134-141.
- Ware, N. C., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2007). Connectedness and citizenship: Redefining social integration. *Psychiatric Services*, 58(4), 469-474.
- Wilcock, A. (2002). *Occupation for Health* (Vol. 2). London: College of Occupational Therapists.

- Wilding, C., & Whiteford, G. (2005). Phenomenological research: an exploration of conceptual, theoretical, and practical issues. *OTJR: Occupation, Participation & Health*, 25(3), 98-104.
- Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology. *Journal of Holistic Nursing*, 25(3), 172-180.
- Wyeth, E. H., Derrett, S., Hokowhitu, B., Hall, C., & Langley, J. (2010). Rangatiratanga and Oritetanga: responses to the Treaty of Waitangi in a New Zealand study. *Ethnicity & Health*, 15(3), 303-316.
- Wynn, K., Stewart, D., Law, M., Burke-Gaffney, J., & Moning, T. (2006). Creating connections: A community capacity-building project with parents and youth with disabilities in transition to adulthood. *Physical & Occupational Therapy in Pediatrics*, 26(4), 89-103.

## **Appendices:**

The names of the District Health Board, secure units and open rehabilitation ward along with the names of other services have been removed from the following documents to ensure the confidentiality of the participants is maintained.

District Health Board

2 December 2008

To Whom It May Concern:

This letter is in regards to a discussion held with Penelope Kinney about People experience transferring from a secure ward to an open ward.

Consultation was held with Te Pora Ehau: Te Pakeke Maori Mental Health Team with in Hospital.

Te Korowai Atawhai will support where necessary the participation of Tangatawhaiora that may take part in this research.

Yours sincerely



Te Pora Ehau  
Te Pakeke  
Mental Health Specialist Services



8 December 2008

Penelope Kinney  
School of Occupational Therapy  
Private Bag 1910  
Forth Street  
Dunedin

**Re: What are the Lived Experiences of Clients Transitioning From a Secure Unit to an Open Rehabilitation Ward Within a Forensic Psychiatric Service?**

Tena koe Penelope,

Ka nui te mihi tenei ki a koe me tou roopu o ka Kairapukorero ki te hapai o te kaupapa whakahirahira mou, moku mo tatou katoa. Ko Rapuka Korero te mea nui. No reira tena koe me te roopu o ka Kairapukorero, tena koutou katoa.

After some deliberation due to the extra ordinary circumstances of where you are based and in view of your working relationship with Te Korowai Atawhai, I am happy to say that your research was submitted for assessment by Te Komiti Whakarite. I am also pleased to let you know your research raises no cultural concerns that would impact Maori negatively. We have reviewed your research and are happy to support your research application to the Ethics Committee.

Te Komiti Whakarite recognises the effort that you have made with regards to the following:

- The researchers have ensured the participant giving their informed consent understand they may withdraw from the study/research at any time and that this will not affect any health treatment they may be receiving or seek in the future.
- Dissemination of the study/research findings in a summary form to participants.
- Allowing a support person to accompany the participant during research interviews/visits/sessions can provide an increased sense of security for Maori participants.

- We appreciate you acknowledge your research impacts Maori. We believe all health research conducted in New Zealand is of relevance to Maori and therefore impacts Maori wellbeing.
- The research process being consistent with the provisions of the Treaty of Waitangi.
- Input from Maori (Te Pora Ehau) at the planning stage.
- Continuing to consult with Te Pora Ehau, ensuring the needs of Maori are being met.
- Methods of dissemination of relevant groups.

We wish you all the best with your research.

Heoi ano

A handwritten signature in black ink, appearing to read 'Tahu Potiki Stirling', with a long horizontal flourish extending to the right.

Tahu Potiki Stirling  
Chairperson  
Te Komiti Whakarite



## Information Sheet

### – Support person

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#### **Project Title:**

**Clients experiences of moving within a forensic psychiatric service.**

#### **What your role as a support person involves**

As a support person you will accompany the participant to the interview and remain for as long as the participant wants you to. You will be there to provide support. You will not answer the questions for the participant but he or she may want to clarify something with you before they give their answer to the researcher.

#### **This will also involve maintaining confidentiality**

Maintaining participants' confidentiality is a very important part of completing research. This means it is important that what is spoken about in the interviews remains confidential. Any information gained from the research is not to be disclosed or put in a document to the participant's treating team or any other person.

If anything is said that raises safety concerns, then the researcher will be the person responsible for informing the treating team. You will be told this is going to happen. If you have any concerns or questions which arise from the interview immediately or at a later date you are to contact the researcher as soon as possible.

If you are approached by either members of the participant's family/friends or treating team you are to refer them to the researcher to have any questions answered.

Below are the contact details of both the researcher and supervisor to enable you to either contact them or send family and friends to.

Penelope Kinney, Researcher, School of Occupational Therapy, Otago Polytechnic, Dunedin. 0800 762 786 ext 8187

or

Sue Galvin, (service name removed to protect participants confidentiality)

Before starting an interview as a support person you will be required to sign the following confidentiality agreement form which states you are aware of these conditions.



**Confidentiality Agreement – Support person**

I have read the above information as well as the information sheet for the participants and understand what the project is about and what is required of me as a support person. All my questions have been answered to my satisfaction.

I know that:

- My role as the support person is to provide support to the participant and not to answer questions for them
- I not allowed to disclose any of the information I have heard during the interviews to any other person
- I am not to document any of the information I hear during the interview in the participant’s clinical notes or any other files
- I am aware that if safety concerns have arisen during the interviews it is the researcher’s responsibility to inform the treating team. I will be told if this is going to happen
- If I have any questions or doubts about what I have heard I will discuss these with the researcher at the earliest possible convenience
- If I am approached by the clinical team, or by family or by friends of the participant I am to direct their questions to the researcher who will respond to them

I agree to the above conditions.

..... (name of support person)  
..... (signature of support person)  
..... (date)  
..... (name of researcher)  
..... (signature of researcher)

**This project has been reviewed and approved by the Upper South A  
Regional Ethics Committee**

# Appendix E

SCHOOL OF OCCUPATIONAL THERAPY  
OTAGO POLYTECHNIC  
Forth Street, Private Bag 1910, Dunedin, New Zealand  
Telephone 03 479 6043  
Cell ph 021 735 239  
Email merrolee@tekotago.ac.nz  
Homepage <http://www.otagopolytechnic.ac.nz>

5 December 2008

Penelope Kinney  
106 Marlow St  
Musselburgh  
DUNEDIN 9013

Dear Penelope

**Re: Research proposal: What are the lived experiences of clients transitioning from a secure unit to an open rehabilitation ward within a Forensic Psychiatric Service?**

Thank you for forwarding your ethics application with the changes made as suggested by Postgraduate Forum. I have reviewed your application today.

I believe the application is fully prepared, and am confident that it will progress well through the committee. I look forward to hearing the outcome of the meeting, and any feedback that you may have to assist the learning of the committee (given this is only the second application we have reviewed in this format).

The Postgraduate Forum looks forward to hearing about the progression of your study.

Yours sincerely

Merrolee Penman, NZROT, MA(Educ)  
Principal Lecturer/Postgraduate Programme Manager

cc: Linda H. Wilson

19 February 2009

Ms Penelope Kinney  
Otago Polytechnic  
School of Occupational Therapy  
Private Bag 1910  
Forth St  
Dunedin 9054

Dear Ms Kinney,

**What are the lived experiences of clients transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service?**

**Investigators: P Kinney, Dr L Wilson (supervisor)**

**Ethics Ref: URA/09/01/003**

The above study has been given ethical approval by the **Upper South A Regional Ethics Committee**.

#### **Approved Documents**

Participant information sheet and consent form version 2 dated 2 February 2009  
Information sheet for support person (please insert 'version 1, 15.12.2008' in footer)\*  
Confidentiality Agreement for support person (please insert 'version 1, 15.12.2008' in footer)\*  
Invitation letter (please insert 'version 1, 15.12.2008' in footer)\*  
Appointment confirmation letter (please insert 'version 1, 15.12.2008' in footer)\*  
Interview guide (please insert 'version 1, 15.12.2008' in footer)\*

\* For our files, we will require final copies of these documents.

#### **Accreditation**

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

#### **Progress Reports**

The study is approved until **1 September 2010**. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in February 2010. The report form is available at <http://www.ethicscommittees.health.govt.nz>. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

**Amendments**

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely

A handwritten signature in cursive script, appearing to read 'Alieke Dierckx', written in black ink.

**Alieke Dierckx**  
**Upper South A Ethics Committee Administrator**

Email: [alieke\\_dierckx@moh.govt.nz](mailto:alieke_dierckx@moh.govt.nz)

**Upper South A Regional Ethics Committee**

Ministry of Health  
4th Floor, 250 Oxford Tce  
PO Box 3877  
Christchurch  
Phone (03) 372 3037  
Fax (03) 372 1015

Email: [uppersouth\\_ethicscommittee@moh.govt.nz](mailto:uppersouth_ethicscommittee@moh.govt.nz)

17 March 2010

Ms Penelope Kinney  
Otago Polytechnic  
School of Occupational Therapy  
Private Bag 1910  
Forth St  
Dunedin 9054

Dear Ms Kinney,

**What are the lived experiences of clients transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service?**

**Investigators: P Kinney, Dr L Wilson (supervisor)**

**Ethics Ref: URA/09/01/003**

Thank you for the progress report for the above study, which was considered by the Upper South A Regional Ethics Committee at its meeting on 15 March 2010.

Congratulations on your progress to date. Ethical approval is confirmed until 31 December 2010. We look forward to receiving another report from you then.

Yours sincerely



**Alieke Dierckx**  
Administrator  
Upper South A Ethics Committee  
[Alieke\\_dierckx@moh.govt.nz](mailto:Alieke_dierckx@moh.govt.nz)

# Appendix H



My name is Penelope Kinney and I am an occupational therapist in Dunedin. I am carrying out a research project which is titled:

## **What are the lived experiences of clients transitioning from a secure unit to an open rehabilitation ward within a forensic psychiatric service?**

(Name) at (secure unit) has given this letter to you because you are a person who is either going to be shortly undergoing this move, in the process of moving to (open rehabilitation ward) or have recently finished moving to (open rehabilitation ward). I would like to invite you to join this research project. I am interested in asking you questions about the move, what you did and what you thought about during this time, it will be an opportunity for you to tell me your story in private without worry your treating team will hear the answers. I won't be asking any questions about your medications, illness or offences. This is completely voluntary and is in no way associated with your treatment.

I have an information sheet which gives you all the details about what the project is about, what you would be required to do and what will happen to the results. I would like to meet with you to go over this sheet, answer any questions you may have, and then ask you to make a decision about joining the research. If you agreed to participate we would then complete the required consent form before beginning any interviews.

Please feel free to take a few days to think about this, (name) will come back and see you and ask if you would like to find out more. If you think you would like to hear more about this project (name) will then make contact with me and I will arrange to come and visit you on the ward. She will only contact me if you agree.

Thank you.

Yours sincerely

Penelope Kinney  
Occupational Therapist  
Masters in Occupational Therapy student

# Appendix I



(Insert current date)

(Insert relevant address)

Dear (insert name)

Thank you for agreeing to meet and talk to me about this research project. I will meet with you -

**Place:** (insert ward and room)

**Date:** (insert date)

**Time:** (insert time)

I have included an information sheet for you so that you can read through it before I come and visit. I will go through this and answer any questions you may have when I see you during that visit.

Thank you

Yours sincerely

Penelope Kinney  
Occupational Therapist  
Masters in Occupational Therapy student

## Information you might need about the project

---

### **Background information**

My name is Penelope Kinney and I am an occupational therapist. I am completing my Masters degree and this study is a Masters Thesis. I used to work at (secure unit) and you may recognise my name or I may have worked with you. When I was working on the ward I used to be involved in helping develop plans and programmes for people moving from (secure unit) to (open rehabilitation ward). I am interested in the point of view of the person making a move like this. I found very little written material about this from a patient's experience (as the person moving) and this is why I would like to complete this project. I think this might help develop better plans for people when they move.

### **Project title:**

Clients experiences of moving within a forensic psychiatric service.

### **So what is the aim of this project?**

I hope to learn more about the experiences of patients transitioning from a locked secure unit to an open rehabilitation ward. I am keen to hear from you what your experiences have been and what it was like for you. This will allow the staff, (and occupational therapists in particular), to understand what it is like for patients to move from a secure ward to an open ward. By understanding these experiences, staff who are developing the transition plans will be able to ensure they cater for the needs of each individual.

### **Who has been asked to be part of this research?**

All patients who have been on a (secure unit) for three months or more and who have been referred to (open rehabilitation ward) are being asked if they would like to participate in this research. Your decision to be part of this research is completely voluntary.

### **What does this mean for me?**

The benefits that will occur from this research will primarily be about ensuring that new transition plans being developed in the future will take into account the needs of each individual. However there will be some individual benefits such as having an opportunity to talk to someone not associated with treatment about your experience, to be able to look back at your experience and talk about the transition as you would like.

### **What will I have to do?**

Should you agree to take part in this project you will be asked to participate in interviews before, during or after your transition depending on the timing of your transition and my availability. This means you may be asked to complete up to three interviews however you can choose to withdraw after one interview.

I will ask questions about your experience of moving between the two wards and the thoughts you have about this. The questions will focus on how the move was for you, what you did and what your experience was. This study is not about your treatment or dealing with your illness. You will be able to stop at anytime, not answer questions or change your answers if you want to.

### **Where will the interview take place?**

I will meet and talk with you in either the visitor or interview room of the ward you are currently on when the interview is to take place.

### **Can I have someone with me during the interview?**

Yes you can. You are welcome to have a support person who will sit with you during the interview. This person **will not** be from your treating team (ie it will not be your nurse, occupational therapist or any other team member). This is so you can feel free to say what ever you think. It also cannot be a family member or close friend, for the same reason as before. It could be a consumer advisor, chaplain or patient advocate. I can give you their names and help you contact them if you would like.

This person will be in the interview with you to provide support although he or she won't be answering any of the questions for you. Your support person will also need to sign a confidentiality form before joining.

### **How will my confidentiality be protected?**

So that you feel comfortable in answering the questions as you want I will ensure the things you say during the interview will remain private. They will not automatically be shared with your treating team or be written in your notes.

If at any stage you tell me information that raises concerns about your safety or the safety of others, then I will tell this to your treating team. I will tell you if I need to do this.

I promise to protect your privacy except where your own safety or that of someone else is at risk.

### **What will be collected and how will it be used?**

I would like to collect information about your experience of moving wards. This will be done by sitting down and talking to you, for about an hour at a time. It will be recorded, using a voice recorder and I will take notes at the same time.

I will provide you with a written copy of your interview and I will have any quotes I would like to use in my thesis on the first page. You can choose not to be quoted if you want. You will not have to explain your reasons.

Results of this project may be published but any information included will in no way be linked to you.

I will give you a summary of what I find. This will not be available for at least a year because it will take me that long to finish writing up the project. With your permission, data from this study may be used in future related studies, which have been given ethical approval from a Health & Disability Ethics Committee.

### **Data Storage**

The data collected will be securely stored in such a way that only I will have access to it. The data will be stored in a locked filing cabinet. My project supervisors might see the information I collect but they will not know who it comes from.

### **Can I change my mind and withdraw from the project?**

You can decide not to participate. You won't have to explain and nothing will happen because you decide not to join in. If you choose to be involved, you can change your mind and stop participating in the project at any time, without having to give any reasons. You can also withdraw any information that has already been supplied until two weeks after each interview has been completed.

You can refuse to answer any particular question, and ask for the voice recorder to be turned off at any stage.

### **What if I have any questions?**

If you have any questions about the project, either now or in the future, please feel free to contact either:

**Penelope Kinney**, BSc, BOccTher, PGDip, Masters in Occupational Therapy student  
School of Occupational Therapy, Otago Polytechnic, Dunedin 9054. 0800 762 786 ext 8187  
or

**Sue Galvin**, (service removed to protect participants confidentiality)

Any additional information given or conditions agreed to will be noted on the consent form.

**If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.**

**Telephone: (NZ wide) 0800 555 050**

**Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)**

**Email (NZ wide): [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)**

## Consent Form

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### Project Title:

### Clients experiences of moving within a forensic psychiatric service

I have read and understood the information sheet about the project and Penelope Kinney has explained it to me. I have had time to think about it and have had all my questions answered. I understand that I am free to ask for further information at any stage.

I know that:

- My participation in the project is entirely voluntary and I am free to refuse to answer any particular question
- I am free to ask for the voice recorder to be stopped for a period of time and be restarted only if I wish
- I am free to stop participating at any time
- I am free to ask for a support person (see information sheet) to join me at the interviews if I wish
- I can choose to withdraw information provided in an interview within two weeks of that interview, without giving reasons and without any concern it may impact on my treatment
- If I say anything during the interview/s that raises concern about my safety or others safety then Penelope Kinney will tell this to my treating team. I will be told when this will happen
- The recordings on which the results of the project depend will be retained in secure storage for seven years after which it will probably be destroyed. If it is to be kept longer than seven years, my permission will be sought
- I can choose not to be quoted if I decide.
- I consent to the use of my data for future related studies, which have been given ethical approval from a Health and Disability Ethics Committee.
- The results of the project may be published or used at presentations in the service or at academic conferences or but the information won't be connected with my name
- I will receive a copy of the research findings
- Penelope Kinney will be told about my transition plan to help her decide when to interview me

I agree to take part in this project under the conditions set out in the Information Sheet.

..... (name of participant)  
..... (signature of participant)  
..... (date)  
..... (name of researcher)  
..... (signature of researcher)

Penelope Kinney BSc, BOccTher, PGDip, Masters in Occupational Therapy student

**If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.**

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Email (NZ wide): [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)**

**This project has been reviewed and approved by the Upper South A Regional Ethics Committee**

## Appendix L

<b>Participant</b>	<b>Stage of transition at time of interview</b>	<b>Length of time in a secure unit</b>	<b>Age</b>
1 - Richard	After transition	Approximately 3 years	Late 20's
2 - Casper	After transition	Approximately 5 years	Late 20's
3 - Jae Kae This participant was interviewed twice. Different pseudonyms were used for each interview	During transition After transition	Between 1 and 2 years	Early 20's
4 - Anakin	After transition	Between 2 and 3 years	Late 20's
5 - Shrek	Prior to transition	Approximately 2 years	Mid 30's