**Preparing for a physical activity intervention in a secure psychiatric hospital: reflexive insights of entering the field**

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**Abstract:**

The medical model for treating severe mental illness has been critiqued for its insensitivity to the subjective and contextual facets of patients’ illness and recovery experiences. For many, mental health service efforts are a function of the social and institutional contexts in which they occur. Understanding this therapeutic context is therefore critical to planning effective care strategies. In this confessional tale, the first author reflects on one-year (>300 hours) within a medium secure psychiatric hospital - a process carried out to inform the future design of a physical activity intervention. Drawing upon reflexive journal entries, conversations across the research team, and personal introspection, three broad methodological insights are offered; 1) becoming a reflexive researcher, 2) negotiating ‘the self’ in a mental health context, and 3) cultural means to logistical ends. Researcher reflexivity is a challenging and effortful process that can lead to unforeseen insights about the research setting. Practicing reflexivity supported the first author towards an awareness of her own stigmatised attitudes to mental illness and how they might affect the research process. Immersive fieldwork is time consuming and presents a raft of methodological difficulties, but it supports deep and nuanced insights unavailable through other methods. When seeking to effectively tailor intervention strategies to the unique needs of a given healthcare setting, this added depth and nuance is valuable. Health intervention work that draws on immersive qualitative methods, rather than tokenistic forms of “patient public involvement”, is better equipped to deliver strategies that are not only efficacious but also effective.

Keywords; confessional tale, reflection, reflexivity, journal, severe mental illness, physical activity, fieldwork

**Introduction**

Severe mental illness (SMI) describes a range of enduring and debilitating disorders such as schizophrenia, bipolar disorder and major depressive disorder (Vancampfort et al. 2016). Individuals with complex SMI, or whom pose a risk to themselves or others, can be detained under the Mental Health Act (NHS Federation, 2012) and may be treated within a psychiatric inpatient hospital setting. Such settings aim to offer a safe and secure rehabilitative environment for individuals with SMI (Galappathie, Tamim Khan & Hussain, 2017). The medical model of clinical practice, whereby illness is diagnosed according to the presence or absence of observable symptoms, dominates secure mental health services (Rowe, 2016). To this end, healthcare professionals work to reduce or eliminate the number and/or intensity of symptoms through a range of evidence-based treatment strategies (Craig et al. 2008). Although this medical approach to mental health care is ubiquitous, healthcare professionals have questioned its insensitivity to the lived experience of patients (Rubin & Rubin, 2005). An alternative ‘humanistic’ model to care (Hewitt & Edwards, 2006), characterised by a holistic approach to both treatment and recovery, recognises that mental health treatment is better conceptualised as an interpersonal process, rather than a discrete medical procedure (Elkins, 2009). The mental illness experience, and therefore also its treatment and recovery, are complex, subjective and embedded in the individual’s social context (Fitzpatrick & River, 2018).

Understanding the SMI experience as personal, relational and cultural, corresponds with a turn to more interpretivist forms of research that are attuned to the social contexts in which mental health care occurs (Peter, McAllister & Rubinstein, 2001). The reductive focus on observable symptoms, emblematic of traditional medical SMI treatment research, can be complimented by methodologies sensitive to how patients make sense of the health care they live through (Berwick, Nolan & Whittingon, 2008). Attending to how SMI patients socially construct their treatment may therefore provide important insights on the efficacy and effectiveness of care interventions. This type of interpretive approach is radically different to the widely-used practice of “patient and public involvement” (PPI). PPI entails consulting patients, carers and the public on issues relating to health research design, delivery and dissemination (Ashcroft, Wykes, Taylor, Crowther & Szmukler, 2016). Although PPI is considered a marker of best-practice in health research (Blackburn et al. 2018), critics argue it can be tokenistic (Jennings et al., 2018) and often offers a de-contextualised ‘snapshot’ of patients’ needs (Staniszewska et al. 2011a). To many, the utility of PPI is undermined as it is rarely capable of deep insights into the experience of care setting culture. This critique is especially pertinent when considering research into secure psychiatric settings, which are known to be unique environments with a distinct organisational culture (Johnson, Day, Moholkar, Gilluley & Goydor, 2018).

Exploratory qualitative methods are considered useful in initial stages of mental health research, specifically within populations or settings in which previous work is sparse (Palinkas, 2014). Semi-structured and extended interviews are most common within mental health research (Palinkas, 2014), however, are limited in their usage and effectiveness of gaining an insight into an environment or culture. Consequently, a methodology that incorporates a thorough exploration of an existing culture may provide a more holistic insight that cannot be gained through one-off participant conversation, and therefore, facilitate research that may be more effectively translated into practice.

It is well acknowledged that human experience and behaviour are embedded in the culture and social context we inhabit (Peters, McAllister & Rubinstein, 2001). Consequently, to fully understand an individual, there must be an understanding of the environment of which an individual exists (Cavallerio, Wadey & Wagstaff, 2016). Scholars have suggested that culture does not exist separately from social structure (Aronowitz, Deener, Keene, Schnittker & Tach, 2015). It can therefore be argued that environments with distinct organisational procedures, policies or restrictions may evoke a ‘culture’ within the structure of the environment. Secure hospitals offer a unique environment in which ‘culture’ differs to general society. As institutions, secure hospitals operate under distinct security procedures, rigid daily timetables and limited patient movement and autonomy due to both procedural and legal proceedings (Kinnafick, Papathomas & Regoczi, 2018), therefore, patient ‘reality’ exists within the institution in which they inhabit. To date, there is a distinct lack of knowledge surrounding secure settings as a potential research environment.

This procedure could provide a deeper insight than traditional processes offer to inform intervention design within an unexplored research environment, which may allow for the development of research embedded within the context. Knowledge of the setting is imperative for effective research translation into clinical practice (Hotopf, 2002), as disparity between research and practice has initiated the suggestion that clinical findings bare little relation to every day clinical practice (Savage, 2000). It has been suggested that for effective translation of research into practice, trial design informed by the setting is necessary to improve quality of delivery and overall efficacy of the trial (Webber, 2014). Consequently, an exploratory process involving continual exposure to this setting, with a view to underpin consequent intervention design, may offer a unique and invaluable contribution to knowledge in a relatively unexplored environment.

Recent work has recommended a methodological practice in which the researcher changes from an objective observer to a participant (Sparkes & Smith, 2014). Researchers utilising such participatory practises may conduct immersive fieldwork to facilitate a more in-depth understanding of the complexities within natural environments (Sanders, Wadey, Day & Winter, 2017).  Immersive methods are useful to enable investigators to acquire an understanding of the issues where research is either sparse or non-existent (Palinkas, 2014) and allows the researcher to learn what it is like to be differentially situated in an alternative environment or community (Wind, 2008). Immersive methods evoke the 'joining of two worlds', in which the perspectives of both the researcher and the researched are combined (Boyle, 1994). In an environment in which staff maintain consistent contact and have an intimate involvement within patients’ lives (Cavendish, 2013), the researcher and researched population are intertwined within the research process; consequently, the researcher is always ‘active’ and cannot be separated from the findings (Sparkes, 2002). The lack of reflexivity and absence of researcher voice in current realist tales may lead to dispassionate, objective portrayals of truth that do little to inform research design in unexplored settings; consequently, there are limited reflexive researcher accounts documenting their fieldwork experiences.

Although a rarity, Sanders and colleagues (2018) utilised immersive fieldwork and reflexive methodology to document experiences working in a hospital with amputee patients. This paper communicated important challenges and uncertainties researchers face in an unfamiliar environment and the feelings associated with these difficulties. There is no such account within a secure mental health hospital, yet mental health research has been widely critiqued for oversimplifying and decontextualizing the research process (Fitzpatrick & River, 2018). Further, institutional context is often implicated in mental health recovery success (Elkins, 2017), so understanding secure mental health settings is likely an important step towards effective treatments. To this end, the broad aim of this research is to provide an immersive, researcher account of a secure mental health culture. Three research aims, pertaining to theory and method, are posed:

1. To document the experience of reflexive practice in action in a secure mental health service
2. To provide an insight to the challenges of becoming immersed in a secure mental health context.
3. To explore how cultural immersion can provide practical insights into data collection within a secure setting.

**Methodology**

***Philosophical standpoint***

This research is guided by the principles of interpretivism; ontological relativism and epistemological social constructionism. Within the interpretive paradigm, reality is mind-dependent, experientially mediated and therefore multiple and malleable (Scotland, 2012). These philosophical underpinnings align with a paradigm shift towards methodologies sensitive to complex social phenomena within mental health care (Elkins, 2017). We assume this position as there is a growing appreciation that developing understanding of the wider interpersonal and contextual factors relevant to the mental illness experience can help better meets the needs of SMI patients (Michel et al. 2002).

***Research background and context***

This paper is part of a wider project aiming to increase autonomous physical activity within a secure mental health service. The project arose through a partnership between Loughborough University and St Andrews Healthcare, a charity mental health service for patients with challenging mental health needs. The charity provides care across several services, including men’s and women’s mental health, child and adolescent mental health services (CAHMS), neuropsychiatry, autistic spectrum disorder and learning disability. Many of the patients have been through or are currently involved in the criminal justice system and are some of the most vulnerable individuals treated in the health service.

***Into the field***

During the first year at St Andrews, *the first author* (henceforth I) spent time with each member of the exercise team across all hospital departments; this provided me with a broad and holistic introduction to life within a secure psychiatric setting. I was able to gain an insight into procedures and practices, develop an understanding of activities conducted and their restrictions, whilst also recognising the structural, security and interpersonal differences between services. Alongside this, I spent time talking to clinical psychologists, ward staff and the wider disciplinary team, whilst also spending time on wards interacting with patients and staff and being involved in their daily routine. Before undertaking the initial fieldwork, my supervisors and I decided it would be beneficial to keep a journal documenting my experiences as a tool to inform the wider project. Diaries and journals are considered a useful tool for reflective practice (Chretien, Goldman & Faselis, 2008), with reflexive journaling shown to be valuable in healthcare settings (Epp, 2008).

***Distinguishing between reflection and reflexivity***

The terms “reflection” and “reflexivity” are frequently used interchangeably despite important distinctions. Reflection can be considered a process of in-depth consideration of events outside of oneself, and often involves mentally revisiting an experience (Bolton, 2014). Researchers who embrace critical self-reflection as central to knowledge construction, use it to assess their beliefs, values and approaches (Dugdill, Coffey, Coufopoulos, Byrne & Porcellato, 2009). Reflexivity moves beyond reflection as a process and involves a critical exploration of what we know, but more importantly, what we do not know, to attempt to understand our position in relation to others (Bolton, 2014). Researchers consider reflexivity to consist of two main types; prospective and retrospective (Edge, 2011). Prospective reflexivity seeks to help researchers grow their capacity to understand the significance of the knowledge, feelings and values that they brought into the field, the analytical lens they chose to use, and how this impacts findings (Attia & Edge, 2017). Retrospective reflexivity concerns the effect of the research on the researcher, and how experiences can shape the interpretation of phenomena. This concept is considered ‘the heart’ of a reflexive study; it is important for the researcher not just to document experience, but to attempt to analyse how these experiences may shape the findings, interpretations and conclusions drawn from the study (Attia & Edge, 2017). In this research, I seek to be both reflective and reflexive.

***Confessional Tale***

“In line with Sanders et al. 2017, this paper aims to use the genre of the confessional tale to explore the research process as experienced by the first author. Researcher experiences are sparse within health care settings, with the *reality* of fieldwork often left undocumented (Sparkes, 2002).” Confessional tales (Van Maanen, 1979) incorporate a highly personalised researcher voice to elucidate the authors point of view, making them highly visible within the research process and taking readers ‘behind the scenes’ (Sparkes, 2002). Such writings are being used more frequently to explore the research process as experienced by the author (see Wind, 2008) and allow a narrative of intimacy and development of personal character to reveal ‘truths’ within under-researched populations and settings (Sparkes, 2002). Confessional tales also expose the interpretive nature of fieldwork and may help reduce the shock to new researchers conducting similar projects by shedding light on challenges, dilemmas and surprises within the research process (Sparkes, 2002).

**Results**

Reflexive insights are organised into three broad sections; 1) becoming a reflexive researcher, 2) negotiating ‘the self’ in a mental health context, and 3) cultural means to logistical ends.

***Becoming a reflexive researcher***

Initially, I found my inexperience and lack of knowledge on reflective practice to be both daunting and frustrating. I felt awkward documenting my thoughts and emotions on paper, struggled to accurately articulate how I felt, and experienced continual self-doubt around whether I was conducting the process correctly. The notes I wrote in initial stages of the process merely offered a descriptive narrative of daily events and did little to acknowledge my position within the research or extend my understanding of data collection within the setting.

I feel like I don’t really know what I’m doing at the moment. Everything I write seems to be pretty obvious, or when I feel like I am managing to dig a little deeper, I just feel self-indulgent and that these feelings are completely irrelevant to the process. I just feel like I’m getting nowhere

Reflexivity has been described as ‘messy’ (Valandra, 2012), whereby issues of self-doubt and uncertainty are common, particularly among less experienced researchers (Sanders et al. 2017). Access to personal biases, values and emotions is not always simple and often the most useful reflections are hidden more deeply (Gemignani, 2011). Supervision from a more experienced researcher can be helpful to aid this process to give adequate training and prompt where necessary (Probst, 2015). Discussions with my supervisors helped to organise my thoughts and provide insight into where I should focus my efforts:

After a meeting with my supervisor I feel more confident when reflecting upon my day. I was encouraged to engage with my feelings during and after the conversation to explore their origins. For example, I had met a particularly interesting male patient on the ward earlier in the week and spent a few hours talking to him. Afterwards, I didn’t feel much different but had little enthusiasm to engage in any lengthy conversation with anyone else for the rest of the day.

Reflection can be challenging, as we only reflect on what strikes us as requiring reflection (Probst, 2015). After identifying an important event or experience, I often began to excessively self-analyse, often at the expense of a lessened focus on the research setting and participant (Finlay, 2002b). Antithetically, as the above quote evidences, there were times in which opportunities for reflection would have been missed without prompts from my supervisor. In this instance, I became withdrawn throughout the day following a conversation with the patient. Staff had previously warned of his manipulative tendencies and upon reflection I noticed I became more emotionally guarded in an attempt to reduce my vulnerability. As a consequence, I found the interaction tiring, which perhaps lessened my enthusiasm for intimate conversations with others. Supervisory discussions allowed me to recognise the importance of analysing seemingly insignificant experience whilst acknowledging the contribution or influence these experiences made to knowledge production.

Balancing actively attending to my thoughts and actions, while also attempting to integrate into hospital culture was exhausting. I began to note prompts or add rhetorical questions to my journal as a reminder to further explore these experiences at the end of the day:

One of the staff members told me today that I appear very calm when meeting patients, which normally differs to new or inexperienced students or staff. Why am I more comfortable in these situations than other people may be? Is it due to having an academic knowledge of psychology and mental illness, or perhaps a curiosity into secure settings in general? How did him saying this make me feel?

I also utilised rhetorical questions to explore logistics to future data collection:

I’m finding it difficult to find my way around medium secure and can never seem to find the correct key for the door I need. Will this level of security make data collection difficult? Where will I be able to collect data, will I need supervision?

Rhetorical questions acted as a prompt to revisit and explore experiences or further construct thoughts and perceptions beyond what I had considered at the time. Researchers have stated that analytic ideas may emerge while re-reading notes as the analytic process can become ‘non-linear’, and significant connections and synthesis can be made from seemingly unrelated material (Peters et al., 2001). Consequently, I wrote a considerable amount of my journal retrospectively at the end of my hospital day – a process termed reflection on action that requires critical self-appraisal of our own past work to acknowledge the uniqueness of the self within meaning making (Stynes et al. 2018). Detailing retrospective feelings was useful to fully engage in the process of reflection when I had more time to expand thoroughly on the event, rather than dismissing or glossing over seemingly unimportant events. Scholars have acknowledged reflection can often be time consuming, tedious and emotionally challenging (Probst, 2015; Sanders et al. 2017) and there were times throughout the day in which the prospect of engaging in reflection was an unwelcome thought. Keeping a reflective journal, and adding prompts and questions allowed me to re-engage with my field notes to elaborate on thoughts and emotions when time was less restricted. Revisiting the event when I was not preoccupied with other tasks or interactions at the hospital allowed me to develop a system to review material collected through the day and analyse insights I had gained in more depth.

***Negotiating ‘the self’ in a mental health context***

This section focuses on issues of ‘the self’ when navigating an unfamiliar context, how such issues manifest in behaviour, and how these challenges were managed.

*Understanding the influence of stigma*

Arriving at the hospital on my first day, my excitement was replaced by sudden feelings of nervousness and apprehension. Driving through the entrance gates, I was immediately reminded of stereotypical portrayals of ‘mental asylums’ within film and literature:

Driving through the gates today was surprising. The entrance is kind of shrouded by trees, but after turning the corner the main building of the hospital comes into full view. It’s a huge white building, spanning across a large grass area with great striped windows. I literally felt like I was driving into *Shutter Island*.

I felt embarrassed at making such a cliched association and began to worry about what other assumptions I might make and whether they may influence my position at the hospital. It was challenging to wrestle with a stigma that prior to arriving at the hospital I believed I did not possess. I began to recognise that although I possessed reasonable knowledge of mental health, my only previous exposure to secure settings was portrayed through popular culture. SMI is often negatively portrayed through the media as dangerous, unpredictable and violent leading to stigma and discrimination (Ma, 2016). In retrospect, I felt apprehensive at the prospect of entering a secure facility as I was uncertain of what I may encounter due to the views I had developed through media influence. This initial period of fieldwork was invaluable to gain a comprehensive understanding of the purpose and importance of secure services, whilst gaining an insight into the daily lives of both patients and staff which was fundamental in changing my views. I would encourage future researchers looking to undertake research in an unfamiliar environment to engage in an explorative familiarity process.

*Finding a role*

I struggled to situate myself within a particular role at the hospital and did not align within any specific department. As a research student, I partially ‘belonged’ to the research team, however, due to the practical focus of my thesis, I spent a lot of time on the ward and closely identified with the sports therapy team. I regularly felt out place and burdensome to the members of staff trying to organise their busy schedules:

Shadowing staff is useful to navigate the building, understand security and gain ward exposure, except, I feel like all I’m doing here is causing more problems for members of staff. Instead of being any use, I just feel like a visitor having to be escorted with patients between sessions, follow directions, and wait for staff members to open doors.

Researchers undergoing similar fieldwork have previously voiced comparable feelings of frustration, embarrassment and burden when entering a new role (Sanders et al. 2017) and have documented struggling to place themselves physically and emotionally alongside participants (Carless & Douglas, 2010). This process is particularly challenging in a secure mental health service, as becoming a ‘true’ participant is not an option; a noted struggle for researchers in clinical environments (Wind, 2008).

Participant observation assumes that it is possible to participate in the lives of the studied population and immerse yourself into daily regimes. Simultaneously, the researcher is expected to maintain enough distance to analyse and interpret the environment and interpersonal context. Sustaining this balance was difficult, and researchers have acknowledged the challenges associated with balancing both intimacy and distance (Wind, 2008). After several weeks of joining regular sessions, I began to feel less burdensome and developed relationships with patients and staff members. Cavallerio, Wadey and Wagstaff (2016) state that to fully understand an individual, there must be an understanding of the environment in which an individual exists. I discovered that an effective way to engage potential participants was to join in shared activity rather than act independent to their world. Sanders et al., (2017) highlighted that it is useful for researchers to negotiate a distinct role in which they may observe and interact with participants, however, I accepted my role within the hospital was novel. As a research student, I shadowed sport therapy sessions, but also had unrestricted time to attend psychology sessions and spend time on the ward. It was beneficial for my position to not align to a profession; I began to utilise this role to my advantage, using my role flexibility to interact with patients and staff members, without the rigidity of a permanent staff members obligations. There were differences across hospital personnel with regards to how I was received. Although most staff members were accommodating and supportive towards me, there were instances in which I felt burdensome, or when my role as a researcher was misunderstood or dismissed. The discrepancy in attitudes towards my work perhaps reflected varying views towards research within this setting.

*Overcoming stigma and building rapport*

Following a period of finding my feet, I began to spend time on the wards engaging in conversation with patients, and noticed the impact of preconceived stigma on behaviour;

Since I have spent time on ward talking to patients, the feelings of unease and apprehension I experienced seem to have disappeared and I really enjoy the time I spend there. A few months ago, I was nervous to enter a ward without shadowing a staff member, now I enter the ward alone and sit in the day area with the girls and chat.

Gaining daily exposure to severe mental illness was influential in reducing feelings of uncertainty and allowed me to shape my own views. Inaccurate exposure of SMI within the media does little to represent the positive influence mental health professionals have on patients, and prior to entering the service, I had limited knowledge of the purpose and value of secure settings, which may have resulted in inaccurate perceptions of both the setting and its patients.

Throughout the fieldwork, I remained aware of the possibility of an unequal power dynamic between myself as a researcher and the patients and I endeavoured to guard against this disparity by integrating into the wider hospital community. I spent consistent time on the wards which I would utilise for data collection and engaged in patient exercise sessions to create bonds, whilst building feelings of comfort and familiarity. However, the power dynamic began to become apparent if my schedule became inconsistent:

I try to spend time on ward as often as possible, but I haven’t been able to attend the facility as often recently due to other commitments. After entering the ward again, I found some patients to be interested in where I had been, though some I felt I had begun to build a relationship with seemed disinterested and reluctant to engage in conversation.

Consistency and continuity (Laugharne, Proebe, McCabe, Garland & Clifford, 2011) and foundations of trust (Hall, Zheng & Dugan, 2002) are considered fundamental to build healthy professional relationships with individuals with SMI. Additionally, research suggests that shared activity can decrease the power differentiation between patients and staff by creating a feeling of likeness (Tetile et al. 2009). As a non-clinician, I was able to engage in conversational topics that evoked common interests, allowing for discussions beyond treatment; a process considered important when building therapeutic alliance (Kornhaber, Walsh, Duff & Walker, 2016). The more regularly I entered the ward and engaged in conversation, the more open to engagement patients became, and began to show interest in my research. Overcoming initial uncertainties and experiences of stigma was fundamental in developing the relationships I gained within the hospital. It was important to recognise the subconscious preconceptions I held and how they may manifest in my interactions.

In addition to struggling with the power dynamic, it was also important to understand the individual variability between wards and patients. Before entering the ward, I was informed I was to able to access all patient risk factors and current progress reports to ensure security procedures were adhered to. Mental health staff have often described psychiatric wards as hostile and aggressive (Barksy & West, 2007) and I was shocked by the nature and content of patient’s backgrounds and safety risks. I duly struggled with the dissonance in my values; I wanted to remain non-judgemental when interacting with patients, however, it was necessary to be vigilant to patient characteristics to safeguard against potential risks.

I spent 30 minutes talking to a guy about football today. We got on well, and I thought he would be a great person to ask to participate in an interview study because he was really chatty. I later found out he had just been released from seclusion for attacking a staff member, sometimes it’s so easy to forget where you are.

Managing these conflicting feelings proved difficult and led to feelings of guilt following interaction with service users. The negative effects of stigma on interactions within mental health services are often neglected (Verghaeghe & Bracke, 2011), and it has been shown that mental health professionals may hold similar negative beliefs and apprehensions to the public (Schulze, 2007). To begin with, I felt uneasy and almost insincere by engaging in pleasant conversation with patients, whilst also being preoccupied with thoughts of their past actions or risk behaviours. However, spending time at the hospital prior to data collection allowed me to grapple with this problem and learn how to handle my apprehensions; had I entered the setting to immediately collect data without recognising or dealing with my worries, the prospect of gaining quality data would have been unlikely. I accepted that the acknowledgement of risk behaviours was both a professional necessity and sensible for personal security.

*Power dynamics in secure settings*

During the initial months at the hospital, I focused on personal integration into the setting and gave little consideration to interpersonal dynamics. As I became more familiar with the setting and my place within it, I was able to attend to the patient-staff power imbalances that had hitherto gone unnoticed.

Since starting to feel more comfortable with hospital proceedings, I’ve started to spend a lot more time on ward engaging in conversation and activities with patients. It’s mostly enjoyable, though I feel uneasy sometimes when I talk to the guys about my life. Not because of the information I give, but I realise every time I mention something that I am in a position in which I uphold most of my free will, which makes me increasingly aware that theirs is minimal.

The nature of SMI is assumed to inhibit the option of choice, due to a perceived lack of judgement and an often-involuntary admission to a secure service (Laugharne et al., 2011); consequently, power is a central issue in mental healthcare (Warner, Mariathasan, Lawton-Smith & Samele, 2006). The flexible position I held at the hospital was helpful to guard against the power disparity as I held no clinical obligation. However, the power balance between researcher and mental health inpatient is perhaps at its most disparate; environmental restrictions impede patient capacity to act independently, whilst the context of their condition renders them vulnerable. Research into clinician power dynamics suggest power can be reduced when both clinician and patient contribute to decisions in patient care (Suchman, 2006); therefore, a collaborative approach to research that facilitates a patient ‘voice’ may be effective to reduce, or even just acknowledge this disparity. Although by no means perfect, this period of fieldwork aimed to reduce the power imbalance for the wider project by increasing researcher-participant familiarity, to avoid the dangers of ‘helicoptering’ into an institution with limited experience or understanding. Within qualitative research, the researcher arguably holds the power as they initiate, determine topics and decide when to terminate conversation (Brinkmann & Kvale, 2005). However, it is suggested that discussions of understanding and experience are useful to reduce the power disparity (O’Connor & O’Neill, 2002); therefore, an initial approach to data collection involving qualitative methodologies may be useful to allow patients to feel associated with the research.

Scholars have argued that engaging in reflection is good practice to guard against insufficiently addressing the power dynamic (Probst, 2015). In line with this approach, I utilised my journal to note instances where I felt power imbalances had surfaced and affected my work.

There is a levels system at the hospital – patients on level 3 are able to attend off ward activities, whilst those below are restricted to on-ward activities. Reaching level 3 rests on consistently showing no risk behaviours, such as self-harm or aggression. I spoke to level 2 patients and spent a while engaging in conversation with one woman. When some of the girls were getting ready for their swim session, I asked this woman why she wasn’t attending, to which she replied she wasn’t allowed due to her levels. When I asked why, she quickly became dismissive in conversation and moved seats away from me.

Reflecting on conversations provided an insight into the power I may hold as a researcher and how I could change my behaviour in future interactions. Williams (2017) suggests researchers grapple with competing demands whilst in the field; I struggled to align with staff expectations, whilst also creating a conversational style which allowed patients to feel comfortable disclosing honest feelings. Relationships can be affected by the institutional context (Karnieli-Miller et al. 2009) and I remained aware that patient’s may be reluctant to disclose information if they perceive it to portray them unfavourably. To attempt to reduce patient discomfort, I tried to build familiar rapport outside of a clinical capacity to encourage honest responses and reinforce the credibility of researcher-participant confidentiality.

***Cultural means to logistical ends***

This period of fieldwork provided valuable insight into the practicalities, feasibility and potential logistical challenges of data collection in a secure environment.Strict security regulations regarding the use of data collection devices such as voice recorders, presented a significant methodological issue. Consent to the use of devices is a lengthy procedure that involves confirmation of approval from multiple departments in addition to the responsible clinician for the ward. It is well acknowledged that the consent process in SMI is more challenging than in comparison to other medical illness or otherwise healthy individuals (Jain, Kuppili, Pattanayak & Sagar, 2017), and although only 20-30% of psychiatric inpatients lack decision making capacity (Candia & Barba, 2011), capacity to consent is dynamic and the process should be continuous (Jain et al., 2017). Research participants often fail to appreciate the distinction between research practice and ordinary treatment (Henderson et al. 2007) and often have misconceptions of research goals (Appelbaym & Lidz, 2008); therefore, it is essential when introducing technology into SMI populations to explicitly explain the use of the device and its independence from regular treatment.

This fieldwork was also vital to gain insights into the suitability of data collection measures and associated equipment. For example, when looking to introduce wrist worn accelerometers to the women’s ward, I was advised that over half of the ward would be unable to participate due to an increased risk of self-harm. Severe self-harm and institutional violence are common within women’s mental health wards (Uppal & McMurran, 2009), which can limit the use of technology within data collection. In addition, spending time on the ward afforded time to consider which measures would be appropriate for data collection prior to submitting my NHS ethics application. Utilising appropriate measures is important to this population and setting; however, research appropriate, clinically beneficial and feasible measures in SMI populations are short in number and many standardised physical activity measures are yet to be validated within SMI (Deenik et al., 2017). Service users have also reported difficulty responding to lengthy questions in interviews and questionnaires (Wynaden et al., 2012). From these interactions, I noted short measures of a small quantity may be effective to engage and not overload participants; an insight I would not have gained without spending consistent time on ward.

I have found many of my conversations with patients to be short in duration or involve multiple topic changes throughout the interaction. From this, I recognised that to engage patients in my research, data collection must be relatively short and simple to keep patient attention.

Staffing demands in secure hospitals are high (Cleary, Hunt, Horsfall & Deacon, 2011) and staff are often required to balance multiple and conflicting priorities (Stanton, Happell & Reaburn, 2015). Patient movement is frequently restricted as it is dependent on available staff to escort (Kinnafick, Papathomas & Recogizi, 2018). Consequently, the constraints of data collection often limit flexibility, as staffing levels and patient behaviour are unpredictable and inconsistent. Planning data collection in advance is often not possible, with spontaneous data collection most effective to engage patients. From these insights, I found maintaining regular contact with the ward and creating a collaborative approach to data collection with staff was most effective.

*Collective value of physical activity and consequent issues*

Immersing myself into the policies and practices of hospital life allowed me to construct an interpretation of the value afforded to physical activity. My intimate involvement with the organisation’s everyday workings added a layer of complexity to the lip service that most healthcare providers pay regarding the importance of physical activity.

Physical activity promotion is so inconsistent across the hospital – some staff and wards are so encouraging, whereas on other wards it doesn’t seem important. There are so many different requirements and considerations for each patients wellbeing, I feel like exercise almost takes a back seat. Recently, cuts in organisational funding have led to redundancies in the exercise department, meaning that the opportunity for patient exercise rests much more heavily on ward staff, and the initial contacts I had made at the hospitals were no longer there, leaving me worried about the implementation of the future project

Collecting data in an environment in which physical activity is considered subordinate to mental health may prove challenging. Physical activity is rarely considered a priority in secure services (Stanton et al. 2015) due to the prioritisation of mental health outcomes (Rylance, Chapman & Harrison, 2012). Research has shown that ward staff hold conflicting views on whether exercise promotion was their responsibility, and those that did see exercise promotion as part of their job role, were uncertain on their capabilities to achieve this (Kinnafick, Papathomas & Regoczi, 2018). Staff scepticism may limit the extent to which patients are encouraged to be involved with physical activity and physical activity research. Organisational culture often acts as a mechanism that guides employee behaviour (Robbins, 2017); therefore making sport staff redundant may communicate a disregard for physical activity to the wider staff. The importance of integrating ward staff into the organisation and delivery of exercise sessions has been documented (Deenik et al., 2018), with a view to influence wider organisational change, as it is well recognised that values of an organisation manifest more frequently than those of an individual (Hofstede, 2010).

With routine an integral component of this environment, it may be appropriate to incorporate gradual change rather than implement new procedure (Vasudev, Thakkar & Mitcheson, 2012). Furthermore, when conducting research, it may be useful to highlight patient and organisational benefits from procedural change or intervention implementation. As improvement in mental health symptoms is often prioritised over physical health promotion (Rylance, Chapman & Harrison, 2012), offering insight into the benefits of exercise for the organisation, such as reduced patient aggression and improved medication compliance (Tetile et al., 2009) may be influential for organisational and staff engagement.

**Conclusions**

This confessional tale provides the first reflexive account of researcher fieldwork within the unique setting of a secure mental health service. Aligning with our original research aims, we have offered reflections on reflexivity in practice, illustrated a range of challenges to becoming culturally immersed in a secure mental health setting, and highlighted several practical insights to data collection gained through cultural immersion. In the following paragraphs, we consider how this process of cultural immersion might inform future applied research in unique settings.

First, this research highlights the limitations of traditional PPI methodologies in framing interventions on under-represented populations in complex settings. Immersive methodologies overcome well-cited criticisms of PPI. For example, by facilitating the researcher to construct a holistic understanding of a given culture or population, a superficial “snapshot” perspective is avoided. Striving for cultural immersion can lead to insights embedded within the research environment and operate under the structural constraints of the given setting. This nuance is more likely to be clinically relevant and should better inform research-design that meets population needs (McGinity and Salokangas, 2014). Time spent operating in the daily practices of hospital life also helped inform appropriate choice of measures and feasibility of data collection approaches in a way a simple staff/patient focus group could not. All this serves to reinforce the value of incorporating immersive methods into applied intervention research, particularly that conducted with unique or distinct organisational settings. Immersion into this distinct culture evolved my understanding of the ethical practice of researching an institutional setting. Ethics boards representing healthcare settings predominately cater for biomedical research and consider procedural ethics; research committee approval of an application form explaining methodology and strategies to address possible adverse events (Guillemin & Gillam, 2004). Procedural ethics however rarely acknowledge or prepare researchers for practical ethics within the field (Baker et al. 2016). Practical ethics refer to how a researcher responds to subtle, sensitive or unpredictable situations arising during research practice (Hammersley, 2015). As practical ethics concern unanticipated issues, deviation from planned procedures is common (Baker et al. 2016). Scholars have suggested that reflexivity is an effective tool to help researchers appreciate procedural ethics whilst also responding to practical ethics (Phelan & Kinsella, 2013). The immersive period detailed in this study, alongside building relationships with hospital staff, allowed me to navigate these ethical uncertainties within the research context. I was able to meet with clinicians and hold ‘if-then’ conversations, to ensure I was abiding by hospital policy, whilst also planning for unpredictability within the hospital. Future intervention work, in mental health settings and beyond, should consider the ethical imperative a period of cultural immersion holds.

The insights gained from this research demonstrate the dangers of ‘helicoptering in’ to distinct organisational cultures. Although findings from secure services literature were evident within the setting, the scale of which they impact hospital operations would not be recognised without cultural immersion. For example, a recent review highlighted limited staffing and competing priorities reduce the scope for exercise in secure services (Rogers, Kinnafick & Papathomas, 2018). However, spending time at the hospital highlighted that the inconsistency of patient well-being, stability of the ward, and patient safeguarding restrictions further exacerbate identified barriers. Consequently, helicoptering into institutions with purely academic knowledge and a limited understanding of the setting would be problematic, and the likelihood of implementing impactful change would be low. Furthermore, although some insights from this research will resonate with other institutions, due to the complexity of SMI, these insights may be specific to the wards and patients of whom I worked with. However, this does not weaken the value of fieldwork as an exercise and reinforces the importance of understanding the context of healthcare settings before commencing data collection. This further highlights the value of gaining a full understanding of the research environment as possible, in order to sensitise to the intricacies of the setting to develop intervention research that is both theoretically sound and practically feasible.

Thirdly, this immersive work demonstrates a tension between conducting robust applied research and contemporary academic culture. As a PhD student, I am privileged with the time I can dedicate to fieldwork due to the absence of competing activities that characterise a full faculty position. For academics burdened by a research culture that lauds a variety of output metrics, as well as continuous grant income pressures, opportunities to engage in prolonged fieldwork are likely to be limited (Mannay and Morgan, 2015). Similarly, in organisations that require ‘quick fixes’, the demand for easily implemented solutions on a short timescale limits the opportunity for immersive methods. However, gaining an understanding of how a culture operates can support better research insights and improve knowledge translation resulting in more long-term benefits. Ignoring more immersive approaches to PPI and subsequent data collection, for research that is fast and superficial may therefore represent something of a false economy. Short-termism of this kind may be particularly ill-advised when seeking to understand, as well as implement changes in, complex secure mental health settings.

To conclude, the process of becoming a reflexive researcher is challenging but can improve capacity to recognise, discuss and negotiate the interpersonal complexities associated with navigating an unfamiliar environment. The use of a reflexive journal provides an invaluable tool to note and revisit fieldwork experiences, highlight researcher vulnerabilities and identify logistical challenges associated with data collection. All this supports a deeply contextualised appreciation of an intervention site that goes beyond traditional PPI methods. When scholars seek to conduct applied research in distinct settings involving marginalised populations, immersive fieldwork should be considered as a means to achieve an authentic account of population needs and institutional barriers. The insights gleaned from this research have served to illustrate the intricacies of undertaking fieldwork in a complex and novel environment and demonstrate the usefulness of gaining a practical insight into the feasibility of undertaking research in secure mental health services. Similar to previous work by Sanders et al. (2017), this confessional tale offers one construction of fieldwork experience and may act as a loose template for other scholars considering immersion into a mental health setting or other unfamiliar environment. Given calls for more doctoral researchers to publish reflexive accounts of research challenges (Rimando et al. 2015), this article offers one example of how such a study might look. A further target of this article is interventionists who may not have considered how qualitative inquiry can inform their work beyond simple “process evaluation”.

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