How tāngata whai i te ora | service users experience their occupations during COVID-19 restrictions in a forensic mental health setting: An interpretive description study

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Abstract

Background: Within forensic mental health settings, tāngata whai i te ora | service users are at risk of occupational deprivation that can detrimentally impact their rehabilitation, recovery, and well-being. The COVID-19 pandemic exacerbated these concerns with the implementation of Public Health and Safety Measures such as social distancing; isolation requirements; and closure of workplaces, learning centres, and community businesses, such as gyms and cafes.

Methods: A qualitative interpretative descriptive study was undertaken to explore tāngata whai i te ora | service users' experiences of their occupations during COVID-19 restrictions, while living in a forensic mental health service. Once ethics approval was obtained, seven tāngata whai i te ora | service users, residing in three minimum-secure units, were recruited via purposive sampling. Data were collected through individual, semi-structured interviews. Transcribed data were then analysed using reflexive thematic analysis.

Findings: I interpreted four themes from the data. These were: 1) *'COVID Came Along and Pulled the Carpet'*, which described the sudden, unexpected disruption experienced by tāngata whai i te ora | service users to their everyday occupations, and the way this disruption led to experiences of loss and frustration; 2) *'The Layers Upon Layers of Restrictions'*, described the multiple layers of restrictions experienced by tāngata whai i te ora | service users that created barriers to everyday activities; 3) *'Keeping the Vibes Going on the Unit'*, included the intuitive attempts of tāngata whai i te ora | service users to create connections that improved occupational participation and well-being, and; 4) *'A Learning Experience'*, illustrated how tāngata whai i te ora | service users used previous experiences and new learnings to provide them with coping strategies to guide them through the restrictions.

Implications: The findings demonstrate the opportunities for co-production of policies, education, and communication strategies during emergency events. These processes can strengthen roles, and the sense of belonging and connectedness that

contributes to secure recovery for tāngata whai i te ora | service users. The results also highlight the inequalities forensic tāngata whai i te ora | service users face, and the need for services to implement holistic, culturally responsive support. Equally significant were the range of supportive and enabling factors that occurred to enhance occupational participation and well-being during unprecedented times. Information from the study will be used to identify areas for improvement in forensic mental health services responses to COVID-19 (and to other pandemics or emergency events), and to enable occupational participation and prevent experiences of occupational injustice.

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signature:

Date: 07.12.2024

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Chapter One: Introduction

Rationale and Significance of this Research

Since late 2019, the world has faced a global outbreak of Coronavirus disease (COVID-19), a contagious illness caused by the SARS-CoV-2 virus affecting people's lungs, airways, and other organs (World Health Organisation [WHO], 2022a). The COVID-19 pandemic has been one of the most significant worldwide events this generation has encountered. It has had a profound social and economic impact, reaching far beyond the severe impact on human health. Life as we knew it was disrupted; the way we live, work, learn, travel, and socialise has been transformed; and millions of people have died worldwide.

The WHO (2020a, January 30) described the onset of COVID-19 as a "public health emergency of international concern". People who are infected with the SARS-CoV-2 virus experience mild to moderate respiratory symptoms; however, others may experience more severe symptoms resulting in serious illness, Long COVID, and death (WHO, 2022b). Early in the pandemic, governments and health providers reacted to contain and manage transmission, which resulted in drastic changes to people's ways of life.

The Aotearoa New Zealand Government followed expert advice, introducing Public Health and Safety Measures (PHSM) which included: lockdowns, isolation requirements, social distancing, hand hygiene, contact tracing, vaccination mandates, and mask wearing (WHO, 2023c). Initially, during lockdowns, all non-essential businesses were closed; learning and education providers operated virtually; gyms and cafes/restaurants were closed; regional borders within Aotearoa New Zealand were instated; the international border was closed; social gatherings, such as weddings, were unable to go ahead and funerals had strict limitations; household bubbles meant limited social interaction face-to-face; and vaccination mandates meant those who were unvaccinated were unable to leave the region, eat at restaurants, or go to the

hairdresser. The impact on people's day-to-day occupations was profound (Luck et al., 2021; Sangster Jokić & Jokić-Begić, 2022; Segev-Jacubovski, 2023).

Serious concerns were held for confined populations, including those in places of confinement such as prisons and secure forensic mental health services (Simpson et al., 2020). The responses required of forensic mental health services to manage COVID-19 were unique, given the nature of the physical environment and complexities associated with the populations residing in these facilities (Chaimowitz et al., 2021; Simpson et al., 2020; WHO, 2020b). Forensic mental health services specifically allow for "people who have been charged with or convicted of an offence, and who meet certain criteria in terms of their mental illness, to be treated for that condition in hospital" (Ministry of Health, 2022, p.iii). In secure mental health services, living spaces are often shared and tāngata whai i te ora engage in group therapies resulting in close contact with others. Often, tāngata whai i te ora | service users have significant comorbidities making them high risk if infected with COVID-19 (Simpson et al., 2020).

There is continuing debate about the best term to use when discussing people who have been living with mental distress. Individuals who are accessing, or have accessed, services for their mental health or addiction needs can be known as service users, patients, consumers, clients, or a person with lived experience. Within an Aotearoa New Zealand context, they can also be known as tāngata whai i te ora which, in te reo Māori[1], means a person seeking health (Te Whatu Ora, 2023). For the purposes of this thesis, I will use the term tāngata whai i te ora. However, within Chapter Two: Literature Review, I will use the term service users when referring to international participants, as the literature has come from a range of countries and this provides a more generic term. Throughout this thesis, other te reo Maori terms are used, where relevant, reflecting the Aotearoa New Zealand study context. The terms

[1] "Te reo Māori is the Indigenous language of Aotearoa New Zealand. It is one of three official languages of the nation. The language itself is central to Māori culture, identity, and forms part of the heritage of the country" Te reo Māori (tpk.govt.nz).

are defined in footnotes where they are first introduced, and a glossary of the terms is provided after the references towards the end of the thesis.

As an occupational therapist working in a forensic mental health service in Auckland, Aotearoa New Zealand during the COVID-19 PHSM, I had concerns for tāngata whai i te ora and the way the restrictions might deprive them of engagement in meaningful occupations. Research suggested that PHSM have a particular impact on the daily activities of vulnerable populations, with harmful effects on health and well-being (Luck et al., 2021; Sangster Jokić & Jokić-Begić, 2022; Vesnever et al., 2023). Within forensic mental health settings, tāngata whai i te ora are already at risk of occupational deprivation, due to the nature of their physical living environment, institutional complexities, and organisational practices (Farnworth & Muñoz, 2009; Whiteford et al., 2020). Inability to engage in a range of meaningful occupations is known to negatively impact tāngata whai i te ora health and rehabilitation (Farnworth & Muñoz, 2009; Whiteford et al., 2020). Therefore, COVID-19 PHSM risked exacerbating such concerns.

Early on in the pandemic, Simpson et al. (2020) suggested a need for urgent evaluation of COVID-19 management within forensic mental health services to evaluate and improve the approaches used. Despite the global occupational disruption observed throughout the pandemic (Luck et al., 2021; Sangster Jokić & Jokić-Begić, 2022; Segev-Jacubovski, 2023), and despite Simpson's recommendation, few studies have discussed the impact of COVID-19 and the associated PHSM on daily activities and meaningful occupations of tāngata whai i te ora in forensic mental health services.

Given the risk of repeated outbreaks of COVID-19 in the future, or the possibility of future global pandemics, natural disasters, or events that cause significant occupational disruption, it is important to understand how COVID-19 restrictions are experienced by tāngata whai i te ora (Scudelarri, 2020). Understanding how tāngata whai i te ora experienced their occupations during COVID-19 restrictions will inform forensic mental health service responses in future pandemics or emergency events, to better enable occupational participation and enhance well-being. Additionally, it is

hoped that undertaking qualitative research with forensic tāngata whai i te ora will ensure their voices are being heard and that services can use this information to appropriately meet their needs.

This thesis presents a study undertaken in at the Auckland Regional Forensic Psychiatry Service (ARFPS) to explore tāngata whai i te ora experiences of their occupations during COVID-19 restrictions. This chapter begins by providing an overview of the key terms referenced within this thesis: forensic mental health services, occupations, tāngata whai i te ora, and COVID-19 restrictions. Defining these key terms is important to enable understanding of their meaning in relation to the research question and their use throughout the thesis. Relevant contexts within this study are then outlined. Lastly, my positionality as the researcher will be discussed

Research Questions and Objectives

This study aimed to explore the following question: 'How did tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting?'. The research question addressed the following objectives:

1. To understand how tāngata whai i te ora experienced their occupations during the COVID-19 restrictions
2. To identify areas for potential improvement in forensic mental health services responses to COVID-19 or other emergency events to enable occupational participation

Defining Key Terms

Forensic Mental Health Services

Forensic mental health services specifically allow for "people who have been charged with or convicted of an offence, and who meet certain criteria in terms of their mental illness, to be treated for that condition in hospital" (Ministry of Health, 2022, p.iii). Forensic mental health services deliver assessment and treatment to these people, with an emphasis on recovery and rehabilitation, but also require a need to maintain

safety and security for tāngata whai i te ora and the public, requiring differing levels of security in secure environments (Ministry of Health, 2022).

Occupation

Defining the term ‘occupation’, as applied in this thesis in relation to the occupations of tāngata whai i te ora, is complex given the diversity and uniqueness of occupations as well as changes across time, cultures, and contexts. Concepts relating to occupation cannot easily be captured within one single definition (Lalibert Rudman et al., 2022). That said, two descriptions that resonate with me are outlined next. Lalibert Rudman et al. (2022) described occupation as

> Pursuits that: matter for human health and wellbeing from individual to collective levels; can spark individual and societal change; occur in time, space and place; are assigned meanings informed by individual and collective values; and are shaped in relation to contextual elements. (p.15)

Hammell (2009) suggested occupations can be categorised according to how people experience them: as restorative; as ways to contribute and achieve a sense of belonging and connection; engagement in doing; and as ways to connect to life and hope for the future. For the purposes of this thesis, Lalibert Rudman et al. (2022) will be the reference point for the definition of occupation. Further definitions of some key occupational concepts relating to this research are stated next.

- Occupational participation is defined as “having access to, initiating and sustaining valued occupations within meaningful relationships and contexts” (Egan & Restall, 2022, p. 76).
- Occupational disruption refers to an interruption in one’s typical patterns of participation and doing in daily activities because of major life events, illness, injury, or environmental changes (Whiteford, 2000). In the case of this research, occupational disruption is understood to result from a global pandemic (Hammell, 2022).

- Occupational deprivation is defined as “a state of preclusion from engagement in occupations of necessity and/or meaning due to factors that stand outside the immediate control of the individual” (Whiteford et al., 2020, p.53).
- Occupational adaptation is the process and/or outcome of participation in occupations, a reaction to change and life shifts, and an ongoing process of constructing positive identities (Gillen & Brown, 2024).

COVID-19

COVID-19 is an infectious disease caused by the SARS-CoV-2 virus affecting people’s lungs, airways, and other organs (WHO, 2022a). Those infected with the virus usually experience respiratory symptoms such as a cough, sore throat, fever, headaches, and body aches. Less common symptoms include muscle aches, changes in sense of taste and smells, shortness of breath, persistent cough, severe fatigue and more. Onset of symptoms usually start a few days after exposure and symptoms can last for up to 2-weeks. In most cases, these symptoms are mild to moderate; however, in some instances, people can become very unwell requiring hospitalisation, and some people may die. When a person infected with COVID-19 breathes, speaks, coughs, sneezes or sings, they may spread particles containing the virus to other people. Less commonly, people may become sick after contracting COVID-19 off a surface (WHO, 2022a).

COVID-19 Restrictions

COVID-19 restrictions are PHSM taken by countries, territories, national governments, communities, organisations, businesses, schools, and individuals to slow or stop the spread of COVID-19 (WHO, 2023a). PHSM have been implemented across the world to prevent transmission of COVID-19, prevent death and serious illness, and minimise impacts on health services and social functions. These measures have included: Infection Prevention and Control (IPC) measures (hand hygiene, wearing of masks and other personal protective equipment (PPE), cleaning and disinfection); respiratory etiquette (covering your mouth and nose when coughing and sneezing); surveillance

measures (contact tracing, testing regimes, isolation/quarantine requirements); physical and social distancing (creation of household bubbles, limiting the size of gatherings, and maintaining distances in public places); border restrictions and closures, and closures of non-essential services. In Aotearoa New Zealand, a National Alert Level System and a COVID-19 Protection Framework were introduced to scaffold and support the implementation of PHSM (Ministry of Health, 2024). These measures will be discussed in more detail later in this chapter.

For the purposes of the research question, I use the term '*COVID-19 restrictions'* to cover PHSM, the Government implemented frameworks mentioned above, as well as the '*COVID-19 restrictions'* that were applied by the forensic mental health service where this research took place. These service-based restrictions included, but were not limited to, changes to ground and community access and leaves, changes to therapeutic programmes, restricted whānau[2] visits, and any other changes to business-as-usual practices implemented due to COVID-19 (refer to Appendix A). These restrictions were implemented in the service in response to COVID-19 and were not in relation to usual service risk procedures.

The next section briefly describes the aspects of the research context related to the research topic. Forensic mental health services and their service provision in Aotearoa New Zealand is discussed including the role occupation plays in a person's well-being and recovery from mental distress. Then, an overview of COVID-19 internationally and within Aotearoa New Zealand, and explanations of the associated PHSM and their impact on occupation, are provided.

Forensic Mental Health Services in Aotearoa New Zealand

Forensic mental health services are responsible for the assessment and treatment of individuals whose mental health needs intersect with the criminal justice system

[2] "(Noun) extended family, family group, a familiar term of address to a number of people – the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members" (www.maoridictionary.co.nz).

(Ministry of Health, 2022). People living within forensic mental health services are among the most disadvantaged groups receiving mental health care (McKenna & Sweetman, 2020). Typically, they have high and complex social needs such as alcohol addictions and substance dependence issues, experiences of poverty and trauma, and physical health diagnoses (McKenna & Sweetman, 2020).

In 1988, following a cluster of deaths in Aotearoa New Zealand correctional facilities, a Government Commission of Inquiry was undertaken, referred to as the Mason Report (1988). This report led to a complete overhaul of psychiatric care and created an opportunity for transformational change, contributing to a more integrated and supportive approach. Subsequently, five regional medium and minimum secure inpatient services were established in Auckland, Hamilton, Wellington, Christchurch, and Dunedin.

Aotearoa New Zealand legislation allows for individuals who have been charged with a serious criminal offence against people, and who meet criteria in terms of their mental health, to be cared for in hospital. Tāngata whai i te ora are generally referred to a forensic mental health service via prisons, courts, or within the legislative framework of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Criminal Procedure (Mentally Impaired Persons) Act 2003 (McKenna & Sweetman, 2020).

The forensic mental health services established in Aotearoa New Zealand were recommended to be comprised of court in-reach services, prison in-reach services, community outreach services, and inpatient units (McKenna & Sweetman, 2020). Levels of security within the inpatient units are typically medium (acute) and minimum (rehabilitative/ hostel/pre-discharge) in relation to criteria set by the service and/or broader health legislation. Additionally, there was a requirement for community based, step-down units capable of managing the needs of those who have experienced long admissions and who, thus, may have enduring effects of institutionalisation and need support to reintegrate back into community life.

According to data from the Ministry of Health (2007), 71% of tāngata whai i te ora in forensic mental health settings have been given a diagnosis of schizophrenia, making it the most common primary condition of people accessing mental health services in Aotearoa New Zealand. Common symptoms of schizophrenia may include delusions; hallucinations; thought-disordered thinking; behaviour that impacts on daily functioning, including lack of motivation to do everyday tasks such as self-cares, cooking, and laundry; social withdrawal; and changes in usual emotions (Healthify He Puna Waiora, 2022). Difficulties with cognitive function is a central feature of schizophrenia and is present in over 80% of those who have been given a diagnosis of schizophrenia. Limitations to cognitive function may present as difficulties in memory, attention, information processing, and executive functioning (Harvey et al., 2022). From an occupational perspective, cognitive difficulties create challenges in a person's ability to plan and perform everyday activities such as remembering to attend appointments, planning and cooking a meal, sustaining and follow conversations, and carrying out tasks at work or university (Harvey et al., 2022; Healthify He Puna Waiora, 2022).

Furthermore, tāngata whai i te ora in forensic mental health settings may have been given other diagnoses which present further challenges, such as alcohol and other drug dependencies, and/or personality disorder diagnoses (Indig et al., 2016). Adding to these complexities, 10% of the prison population have had a moderate to severe brain injury, and there is an overrepresentation of people with foetal alcohol spectrum disorder, intellectual disability, communication disorders, attention-deficit/hyperactivity disorder, dyslexia, and autism spectrum disorder (Lambie, 2020).

Service Provision in Forensic Mental Health Services in Aotearoa New Zealand

A shift in focus over recent decades has seen a move from a custodial model to a recovery and rehabilitative orientated approach in Aotearoa New Zealand (McKenna & Sweetman, 2020). Rehabilitation models focus on easing mental distress and reducing (re)offending behaviours with the goal of community reintegration. Deegan (1988)

defined rehabilitation as the services and technologies that are made available to support those experiencing mental distress to adapt to their world. From Deegan's perspective, the lived experience of the person is central to recovery as they accept and overcome the challenges of their distress. Secure recovery approaches enable person-centred, collaborative care, promoting individuals' "connectedness, hope, identity, meaning, empowerment, and security" (CHIME-S) (Senneseth et al., 2022, p1). The CHIME-S model provides a framework for understanding recovery in a forensic setting.

Forensic mental health inpatient services are equipped with multi-disciplinary teams (MDT) to enable tāngata whai i te ora to prepare for life in the 'real world' after discharge. Tāngata whai i te ora are offered a range of therapies that manage some of their mental distress symptoms and address the contributing factors to their offending; and, in doing so, decrease the chances of future offending. The rehabilitative needs of tāngata whai i te ora are addressed through medical and psychosocial therapies (McKenna & Sweetman, 2020). For instance, psychiatric medications are prescribed to alleviate some of the symptoms of mental distress; whereas psychosocial approaches include the use of psychotherapies or psychological intervention groups such as risk reduction and violence prevention programmes.

Within Aotearoa New Zealand, MDTs typically include, but are not limited to, psychiatrists, nurses, psychologists, social workers, psychiatric assistants, and occupational therapists. These roles all contribute to the ongoing care and treatment of tāngata whai i te ora from their discipline perspectives and areas of expertise. In conjunction with clinical teams, chaplains, consumer advisors, and Taurawhiri (cultural advisors) the MDT advises on and provides recovery-informed, culturally responsive, and holistic care.

Forensic mental health services in Aotearoa New Zealand are recommended to implement models of care that achieve equity in service delivery for Māori and other minority populations (McKenna & Sweetman, 2020; Wharewera-Mika et al., 2003). Te

Tiriti o Waitangi[3] is Aotearoa New Zealand's founding document. The principles of tino rangatiratanga[4], partnership, equity, active protection, and options provide a framework for articulating how the health and disability sector is committed to meeting the obligations under Te Tiriti o Waitangi (Ministry of Health, 2020). Equity recognises that:

> In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage may require different approaches and resources to get equitable outcomes. (Ministry of Health, 2018, p. 5)

Cultural responsiveness has taken time to be embedded into practice (Wharewera-Mika et al., 2003). Since the Kaupapa Māori [5] minimum-secure unit opened in 2006 at the ARFPS, practice has endeavoured to respond to this need by providing a model of care that intertwines a cultural paradigm, te ao Māori (the Māori worldview), with a clinical paradigm based on a rehabilitative approach (Boston rehabilitation model), which promotes the vision of a meaningful life by aiming for outcomes related to role functioning in 'real world' environments selected by the person (Farkas & Anthony, 2010).

Taurawhiri roles are Māori cultural advisor positions at the ARFPS. Staff in these roles understand te ao Māori through their own experience of being Māori. They are there to ensure that tāngata whai i te ora who are Māori receive equity of treatment, and culturally safe and culturally competent care (McKenna & Sweetman, 2020). Best practice in forensic mental health services recommends lived experience input (McKenna & Sweetman, 2020). Lived experience refers to groups of people who have their own firsthand experience of distress, psychiatric diagnosis, addiction, or use of mental health and addiction services (Te Hiringa Mahara Mental Health and Wellbeing

[3] "Te Tiriti o Waitangi is the founding document of Aoteaora New Zealand signed in 1840 between representatives of the British Crown and Māori iwi (Te Rua Mahara o te Kāwanatanga Archives New Zealand, 2024).

[4] "(Noun) self-determination, sovereignty, autonomy, self-government, domination, rule, control, power" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

[5] "Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology – a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

Commission, 2024). To ensure tāngata whai i te ora experiences and voices are influential in the design and delivery of care, consumer advisors are employed to help in providing services that are recovery-informed and consumer responsive. The consumer advisor role provides support to tāngata whai i te ora receiving mental health care throughout the service, and draws specifically from the lived experience perspective. Consumer advisors fulfil advocacy and education roles, facilitate groups, and contribute to policy development. The relationship between a consumer advisor and tāngata whai i te ora is a non-clinical relationship, it is an advocating peer support role.

Whakaora ngangahau[6] | occupational therapy is a crucial part of forensic mental health services. Occupational therapy's field of concern is occupation, and the profession has skill in improving well-being through enabling occupational participation (Whiteford et al., 2020). The opportunity to engage in occupations that are meaningful and purposeful within forensic settings can be limited by an individual's mental health symptoms; their perceived risk to themselves or others; the physical environment; and institutional policies, procedures, and legal restrictions (Royal College of Occupational Therapists, 2017). Choice and agency over when, where, and how individuals participate in occupation can be severely constrained in forensic mental health services, leading to boredom, a sense of hopelessness, and negative impacts on a person's mental well-being. People in such settings experience occupational deprivation and occupational imbalance (Whiteford et al., 2020).

Whakaora ngangahau | occupational therapy is provided in forensic settings with the aim of supporting tāngata whai i te ora to engage in occupations that give their life meaning and value, and mitigate alienation and antisocial behaviours (Royal College of Occupational Therapists, 2017). These goals can be facilitated by providing services that support tāngata whai i te ora to have necessary skills and opportunities to participate in roles, routines, and occupations. Such services can enable tāngata whai i

[6] Whakaora Ngangahau | occupational therapy represents the idea of reawakening, or restoring to health one's activeness, spiritedness and zeal. (Hopkirk, 2013, p.6).

te ora to be productive, contributing members of society. Long periods of living in institutionalised settings, with limited opportunities for participation in activities of daily living, can result in skills being lost or never developed. Therefore, individual or group therapies, provided by occupational therapists, target skill development in areas of vocation, coping strategies, community reintegration, social interaction, and leisure activities. Occupational participation within forensic settings can be seen as both a means and an end within occupational therapy service delivery, with a broad aim of occupational enrichment to reduce the impacts of occupational deprivation (Royal College of Occupational Therapists, 2017).

Restrictions for Tāngata Whai i te Ora in Forensic Mental Health Services

Tāngata whai i te ora detained in forensic mental health services are there against their will under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Criminal Procedure (Mentally Impaired Persons) Act 2003. The care provided to forensic tāngata whai i te ora necessitates balancing therapeutic input, all the while managing potential risk and upholding safety and security (Markham, 2021). However, the emphasis is often placed on physical, procedural, and relational security, which can lead to tāngata whai i te ora being deprived of opportunities they need to advance their recovery. Furthermore, according to Tomlin (2018), these types of settings can be highly restrictive, coercive, and risk averse. Tāngata whai i te ora experience punitiveness daily via the implementation of procedures, blanket restrictions, and other rules and policies. The restrictiveness of forensic mental health settings can be felt far beyond the bricks and mortar of the buildings to encompass limitations on the variety and meaningfulness of activities available to tāngata whai i te ora; the service wide or unit culture and its resources; how therapy is provided; and the range of implemented security methods.

Tomlin (2018) provided a detailed description of the restrictions typically imposed on tāngata whai i te ora, particularly living in forensic mental health settings. These included restrictions relating to available activities and personal belongings,

access to consumable goods food/tea/coffee, pornography, use of social media and phones for communication, and limited community leaves. Relationships can be restricted through limitations on visits (who, when, where). The physical environments are often described as oppressive and prison-like with perimeter security, double locked doors, windows that barely open, and use of staff panic alarms. Staff attitudes also seen as authoritarian and conservative. One of the most restrictive elements discussed were coercive measures such as seclusion, restraint, and forced medications. How restrictions are implemented differs across services and levels of security but is often the result of risk-averse security policy. Furthermore, the elements described above are identified to lead to individuals becoming institutionalised, bored, lonely, and hopeless (Tomlin et al., 2018).

The Global Context of COVID-19

SARS-CoV-2 virus (COVID-19) was first discovered in China, and it is believed to have originated in animals. However, it is still unknown how the virus came to infect humans (Saad, 2021; WHO, 2021b). The virus quickly spread to other countries, including Aotearoa New Zealand, with the WHO (2022a) declaring a pandemic on 11 March 2020. On August 9th, 2023, it was reported by the WHO (2023b) that there had been 760 million confirmed cases of COVID-19 and 6.9 million deaths globally, although the actual number is thought to be higher.

The onset of COVID-19 was a significant worry within the ARFSP, but raised alarm at an international level. Saad et al. (2021) stated COVID-19 was particularly concerning for several reasons. From the onset, very little was known about the virus or its projected long-term effects. There were reports of people infected with COVID-19 becoming very unwell and dying, with members of vulnerable populations, such as the elderly and immunocompromised, being particularly affected. The disease was highly transmissible, making it easy to spread from person to person (particularly in confined environments such as prisons, elderly residential homes, and secure mental health units), and it was reported to be rapidly spreading around the world including to places

not equipped to manage the virus. Furthermore, lockdowns, implemented to control the virus, had potential to cause psychological and economic impacts; and there did not appear to be a vaccination already developed that could bring the virus under control (Saad et al., 2021).

The WHO (2023b) stated implications of COVID-19 infection include death, respiratory failure, sepsis, thromboembolism (blood clots), and multi-organ failure, including injury of the heart, liver, or kidneys. Studies showed that 10-20% of those infected with COVID-19 went on to develop Long COVID (WHO, 2022b). Long COVID is explained as “the continuation or development of new symptoms 3-months after the initial SARS-CoV-2 infection, with these symptoms lasting for at least 2-months with no other explanation” (WHO, 2022a, December 7). There have been over 200 different symptoms reported for Long COVID, including fatigue and cognitive dysfunction, impacting on everyday functioning.

Since originating, the virus has evolved, producing multiple variants such as Delta and Omicron (WHO, 2023b). These different variants of COVID-19 may affect how quickly the virus transmits from person to person, or how unwell people get from the virus and the ongoing effects on people's daily functioning. With the virus rapidly spreading within communities around the world, causing major illness and death, there has been an urgent need to manage and slow the spread of COVID-19. Therefore, the world implemented a variety of PHSM resulting in some communities and countries requiring restrictions implemented on their everyday lives for months and, in some cases, years (WHO, 2023b). Differing levels of PHSM were implemented for a number of years within Aotearoa New Zealand, and specifically in the ARFPS. These measures are discussed in the sections below.

PHSM were implemented grounded on a risk verses benefit approach, taking into consideration the levels of transmission and health systems’ ability to manage (WHO, 2020c). Decisions to introduce or adjust PHSM were also balanced against the impact these measures may have on communities and individuals. The WHO (2020c) recommended the overall health and well-being of communities be at the centre when

deciding on and implementing PHSM. Considerations regarding the implementation of PHSM were complex, and included the need to factor in the economic impact, people's mental health and psychosocial well-being, human rights, social determinants of health, ability for health and public health programmes to continue, access to treatment and management of conditions other than COVID-19, and public commitment and adherence to the measures (WHO, 2020c).

There was also an urgent need for the development of vaccines to prevent and minimise the impacts of COVID-19. Typically, the vaccination approval process can take years. However, on December 11th, 2020, the Food and Drug Administration (2021) gave emergency authorisation to use two mRNA vaccinations, as data were showing these to be safe and effective. Vaccination played an important role in preventing serious illness, hospitalisations, and deaths from COVID-19 (WHO, 2023d). As of October 21st, 2023, a total of 13,533,465,652 vaccine doses had been administered globally (WHO, 2023d). Evidence suggests that both natural and vaccine-induced immunity diminish over time, which increases the risk of new variants emerging that have the potential to be more severe and lead to further restrictions. Thus, certain population groups may be at greater risk of severe disease.

COVID-19 Response in Aotearoa New Zealand

In Aotearoa New Zealand, from February 28th, 2020 to April 19th, 2023, there were 2,240,441 confirmed cases of COVID-19 and 2,716 deaths as a result of COVID-19, reported to the WHO (2023ed. Aotearoa New Zealand recorded its first case of COVID-19 on February 28th, 2020 and, from March 14th, 2020 the Government made it a requirement for anyone entering the country to self-isolate for 14-days (Te Kawanatanga o Aotearoa The New Zealand Government, 2023). A week later, the Prime Minister announced the closure of the border to all but Aotearoa New Zealand permanent residents and citizens, and enforced all gatherings of over 100 people to be cancelled. The Government quickly introduced a four-tiered Alert Level system (explained below) to help control the spread of COVID-19, and immediately placed

Aotearoa New Zealand into Alert Level 2. On March 23, 2020, Aotearoa New Zealand moved to a greater level of restriction, Alert Level 3 (Ministry of Health, 2024). The restrictions were applied nationally, including to those in forensic mental health services.

The Alert Level system was introduced as a strategy to eliminate COVID-19 (Ministry of Health, 2024). This tiered level system implemented associated measures ranging from Level 1 to Level 4. During Level 1, 'Prepare', there were no restrictions on personal movement or gatherings and schools and businesses were able to open. Level 2, 'Reduce', meant some gatherings were able to happen with limited numbers of people, the use of masks, and social distancing. Level 3, 'Restrict', meant people were encouraged to stay home whenever possible, extensive limitations were placed on gathering, and PHSM were in place. Level 4 meant outbreaks of COVID-19 were widespread and people were required to stay home in their 'bubble' (members of a household who only have close contact with each other), except for essential travel (Long et al., 2020).

On March 25th, the country moved to Alert Level 4, requiring the entire nation to go into self-isolation and a State of National Emergency was declared (Te Kawanatanga o Aotearoa The New Zealand Government, 2023). Aotearoa New Zealand reported its first COVID-19 related death on March 29th, 2020. Aotearoa New Zealand remained at Alert Level 4 until April 27th, 2020, when it began its transition back down the Alert Levels. On June 8th, 2020, there were no longer any cases of COVID-19 in the community and the country moved to Alert Level 1 where it stayed until August 11th, 2020. For the remainder of 2020 through to early-to-mid-2021, pockets of COVID-19 were recorded in the community and were swiftly eliminated by regions stepping up Alert Levels. On August 17th, 2021, the country moved back to Alert Level 4. During the next 4-months, different parts of the country were placed on different Alert Levels depending on the prevalence of COVID-19 within their local areas. The way different levels of restrictions were applied in the ARFPS will be discussed in the next section.

Medsafe provisionally approved the first vaccination in Aotearoa New Zealand on February 21st, 2021 (Te Kawanatanga o Aotearoa The New Zealand Government, 2021). Medsafe provides independent advice to the Government and approves all medicines and vaccines available in Aotearoa New Zealand. All New Zealanders, including those in forensic mental health settings, were encouraged to receive the free vaccination. The Government worked on developing a fair and equitable vaccination programme to structure the roll out of vaccinations. Initially, priority groups such as border workers, frontline health staff, and managed isolation and quarantine (MIQ) workers received the vaccination. These groups were followed by those most at risk of getting seriously unwell from COVID-19, including some living in forensic mental health services and, lastly, the remainder of the population (Te Kawanatanga o Aotearoa The New Zealand Government, 2021).

On December 2nd, 2021, Aotearoa New Zealand marked the end of the Alert Level system and began its new journey on the COVID-19 Protection Framework (Te Kawanatanga o Aotearoa The New Zealand Government, 2023). The COVID-19 Protection Framework ran from December 2021 to September 2022, and outlined rules for different traffic light settings to manage life with Omicron, the latest variant of COVID-19 at that time (Ministry of Health, 2024). The Framework had three traffic light settings–Red, Orange, and Green. The Framework was intended to help protect people from the virus, not overwhelm the hospital system, and minimise the impact of large outbreaks, while giving people and businesses more flexibility and stability.

Alongside the traffic light system, key tools were used to minimise the spread of COVID-19. These were vaccinations, masks, and capacity limits (Te Kawanatanga o Aotearoa The New Zealand Government, 2022). Vaccination was initially required before people could eat inside restaurants, leave their regional areas, or work at certain government organisations such as schools and hospitals. During Red and Orange traffic lights, people were required to wear masks in public spaces such as supermarkets, public transport, and health care facilities. In some places, capacity limits were applied to indoor areas based on 1-metre distancing.

Isolation requirements meant that those confirmed positive with the virus had to isolate at home for 7 to 14 days (Ministry of Health, 2020). Early in the pandemic, all household contacts were also required to isolate for the 14-day isolation period, starting the time again if someone else tested positive. This was reduced to 7-days as the pandemic progressed. Alongside isolation requirements, COVID-19 testing systems were introduced for frontline workers, symptomatic people, household contacts, and others who had spent time near anyone who had COVID-19. Since the removal of the Traffic Light System in September 2022, Aotearoa New Zealand has reduced restrictions in place based on high vaccination rates and population-based immunity across the country (Ministry of Health, 2024).

COVID-19 Restrictions within Forensic Mental Health Services in Aotearoa New Zealand

The standard forensic mental health service restrictions discussed above were exacerbated by the implementation of COVID-19 restrictions. Within Waitematā health district, the ARFPS was classified as an 'Enhanced Protection Site'. This meant, there was a high risk to tāngata whai i te ora due to their comorbidities and restricted living space (limiting social distancing) if infections occurred. The risk to tāngata whai i te ora could be further complicated by operational factors needing management; that is, staffing with specific skill sets (forensic mental health staff). Therefore, a high level of restrictions was implemented and maintained for a prolonged period. The COVID-19 restrictions imposed within the ARFPS responded to the wider, Aotearoa New Zealand restrictions, but also considered risks specific to the setting (see Appendix A).

Social and Psycho-social Impacts and Risks of COVID-19 Restrictions

The COVID-19 restrictions were implemented to reduce the spread of COVID-19 and minimise its impacts on peoples' physical health and the health care system internationally. COVID-19 restrictions had adverse effects on mental well-being around the world. The outbreak of COVID-19 and the COVID-19 restrictions led to further health troubles globally such as stress, anxiety, depressive symptoms, insomnia,

denial, anger, and fear (Torales et al., 2020). Within Aotearoa New Zealand, it was surmised the likely immediate social and psychosocial impacts of the COVID-19 restrictions would be social disconnection; isolation and overcrowding; family and other domestic violence; negative impacts on mental health and mental well-being; and adverse effects on child well-being, child development, and child protection (Ministry of Social Development, 2020). It was identified that certain priority population groups may be at higher risk of adverse social and psychosocial impacts from COVID-19 restrictions, including Māori and Pacific peoples, health workers, people with disabilities, people with existing physical health conditions, and, notably, people with mental health conditions and those residing in secure, confined environments (Ministry of Social Development, 2020). The Ministry of Social Development (2020) particularly acknowledged those who might have fallen into more than one of the identified priority populations, with this latter point of particular relevance to tāngata whai i te ora who are known to have complex needs. The Ministry of Social Development went on to recommend that COVID-19 management and associated resources should focus on those population groups most at risk and address structural and systemic inequities. This recommendation helped inform the PHSM responses within forensic mental health settings.

Impact of COVID-19 Restrictions on the General Population from an Occupational Perspective

The impact that the COVID-19 restrictions has had on the daily lives of people around the world is significant (Hammell, 2021). Fear of infection and implementation of PHSM had consequences for the way in which people went about their usual lives (Luck et al., 2021; Sangster Jokić & Jokić-Begić, 2022; Segev-Jacubovski, 2023). As a result, for the first time in recent history, occupational disruption was experienced on a universal scale.

Occupational disruption can present in various ways such as a lack of access to education and employment opportunities, inability to access physical environments

such as public spaces, and the inability to move easily in one's own community (Hammell, 2020). It can also be experienced due to a change in frequency or quality of occupations (Nizzero et al., 2017). Occupational participation is known to have positive impacts on one's well-being; but, in turn, occupational disruption can have numerous negative effects. Nizzero et al. (2017) stated these negative effects as anxiety, uncertainty, isolation, exclusion, and a loss of sense of connection and belonging resulting in feelings of frustration and emotional distress.

Typically, occupational disruption has been an experience mainly researched and understood in connection to persons with disability or illness, marginalised communities, geographical displacement, and unemployment (Hammell, 2021; Sangster Jokić & Jokić-Begić, 2022). However, with the emergence of the COVID-19 pandemic, occupational disruption has been experienced far more widely.

Changes to Patterns of Occupation Due to COVID-19 Restrictions

Research is beginning to emerge surrounding occupational disruption, and the negative mental health consequences associated to COVID-19 and the PHSM that were implemented. People changed what they did and where they did it in response to the pandemic, in order to maintain their occupational participation (Luck et al., 2021). For example, women living in Croatia experienced changes to their daily routines during COVID-19 (Sangster Jokić & Jokić-Begić, 2022). Although they spent decreased time engaged in community occupations such as gyms, cultural activities, going to the hairdresser, and socialising with friends and family, they spent increased time participating in occupations around the home such as cleaning and watching TV (Sangster Jokić & Jokić-Begić, 2022).

Vulnerable Groups' Experiences of Occupational Disruption During COVID-19 Restrictions

Not all people experience occupational disruption the same way, and specific consideration should be given to vulnerable groups in the event of COVID-19 restrictions. Different living situations, access to resources, or demographic

characteristics influence the scale to which people feel the changes to the quantity and quality of their occupations (Luck et al., 2021; Sangster Jokić & Jokić-Begić, 2022; Segev-Jacubovski, 2023). For example, more women than men had significantly reduced time spent in work during lockdown compared to pre lockdown and more women lost their employment (Segev-Jacubovski, 2023). Similarly, those with chronic illness or physical limitations have been found to experience additional challenges when completing instrumental activities during the COVID-19 restrictions (Luck et al., 2021). For example, considering these people typically depended on others for support or assistance, food shopping was a challenge due to regulations such as physical distancing, no shopping trolleys, bag your own, and one person per family. These challenges could potentially be similar to those in forensic mental health services who require functional support from staff when out participating in activities in the community. While these changes to usual practice may have supported in implementing social distancing, they created practical challenges to participating in activities of daily living for those with a chronic illness and other health conditions.

The Greater the Occupational Disruption the Higher the Mental Health Impacts

It is of concern for those living in forensic mental health settings that disruptions to occupations through COVID-19 restrictions may result in negative impacts on mental health. Those who report higher levels of occupational disruption due to COVID-19 restrictions exhibit significantly higher levels of anxiety, depression, and stress compared to those who experienced lower levels of occupational disruption, suggesting a relationship between greater occupational disruption and poorer mental health (Sangster Jokić & Jokić-Begić, 2022). Luck et al. (2021) reported people experienced feelings of fear, stress, anxiety, and isolation during COVID-19 lockdowns. It could be argued the negative psychological health impacts discussed in Luck et al.'s research was, in fact, partly due to changes in everyday occupational routines, and fewer opportunities to participate in occupation.

Overview of the Study

This interpretive description (ID) study explores the experiences of seven tāngata whai i te ora residing in the ARFPS. The following research question was asked; “How did tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting?”. The study is situated within the context of the literature relating to experiences of COVID-19 restrictions and occupational participation in forensic mental health settings.

Research is beginning to emerge surrounding the impacts that COVID-19 restrictions had on people’s occupational participation and well-being. The objective of this study is to produce knowledge and understanding around the perceived experiences of tāngata whai i te ora while living in a minimum-secure forensic unit during the COVID-19 restrictions. It is hoped data collected from this study will contribute to informing future pandemic or emergency event responses within forensic mental health services to better facilitate occupational participation. At the time of writing, no similar studies carried out in Aotearoa New Zealand had been identified. The ID methodology used for this research provided an opportunity to gain an in-depth understanding of participants’ experiences, and situated the findings back within my professional discipline, so that they will ultimately be meaningful and applicable to the practice environment (Thorne, 2016).

As an occupational therapist, by discipline, I view knowledge about occupation as most important. I am writing this thesis with the understanding that occupation is central to human health and well-being. Human life comprises of complex and interconnected occupations that link to a person's personal and social identity, social inclusion, and well-being (Lalibert Rudman et al., 2022). It is through occupation that people can develop routines, structure, and skills; express their identity; develop relationships; and find meaning and purpose in life (Townsend & Polatajko, 2013).

My Positionality and Motivation for Undertaking the Study

This next section reflects on my professional values, beliefs, and experiences that impacted the research. Locating theoretical allegiances within a discipline ensures that the findings will contribute to larger project of concerns of that discipline (Thorne, 2016).

I was born and raised in Aotearoa New Zealand. I grew up in the lower North Island and have lived in Auckland most of my adult life. My meaningful occupations include running, cooking, and being in the kitchen; reading; being a family member, friend, dog mum going for long bush walks in the Waitākere Ranges; and being a post-graduate student and occupational therapist.

Since graduating with a Bachelor of Occupational Therapy in 2013 I have primarily worked in mental health services. In 2014, I started my career working in a step-down supported accommodation service with tāngata whai i te ora who were settling back into the community after leaving a forensic mental health service. I then moved to a supported employment service providing work opportunities for those who experience mental distress, either under community or forensic mental health services. It was during this time that I became passionate about working with people who have been under forensic mental health care to support them to rediscover and experience positive role development, and to create meaningful lives for themselves.

I have spent the past 6-years working in an inpatient forensic minimum-secure unit, supporting tāngata whai i te ora reintegrating back into the community. My background in occupational therapy and my belief that each of the tāngata whai i te ora I work with is unique, underscores the importance of occupational participation contributing to a person's well-being. Whakaora Ngangahau | occupational therapy is a health profession with a focus and interest on restoring occupation, health, well-being, and overall quality of life (Whalley Hammell, 2018). I see tāngata whai i te ora choice and opportunity to participate in meaningful occupations as fundamental. Therefore,

through this work, I endeavour to address institutional barriers that restrict these processes.

When the COVID-19 pandemic began spreading overseas, I was asked to join the ARFPS 'COVID-19 Response Group'; established to plan and respond to the nuances of a forensic mental health services position during periods of community lockdowns and internal service outbreaks. Throughout 2020 and 2021, the work was periodic, with shorter community outbreaks and transmission being contained and life returning to a more normal resemblance. From late 2021 to the end of 2022, I was seconded to a full-time position as the COVID-19 Response Lead. This role involved, but was not limited to, coordinating with key stakeholders such as Te Whatu Ora (Aotearoa New Zealand's public health agency) and local District Infectious Diseases and Infection Prevention and Control departments; setting agenda for priority work and keeping a record of work which had been completed; linking in, and reporting back to the local district's COVID-19 Incident Management Team; and regularly communicating relevant information with staff working in the service. Decisions regarding which COVID-19 restrictions were appropriate for the service and how they would be implemented came from a combination of Government mandates, the local district COVID-19 Incident Management Team direction, and expert opinion within the service. The service was also in discussions with other forensic mental health services around the world that were faced with similar challenges. I was aware tāngata whai i te ora voices were missing from this decision-making process.

During COVID-19, I became acutely aware of how the pandemic and associated PHSM impacted on people's occupations around the world, and particularly within forensic mental health services. This left me wanting to know more and led me to consider the topic for my master's thesis. The service did not formally collect feedback from tāngata whai i te ora on their experiences of the COVID-19 restrictions or conduct any formal monitoring of the effectiveness or impacts of the COVID-19 restrictions. Viewpoints from tāngata whai i te ora were needed to inform the service of a possible balance between COVID-19 outbreaks against promoting occupational participation. I

am passionate about wanting to conduct research that hears firsthand experiences from tāngata whai i te ora and research that could lead to positive change. This guided me towards qualitative research and ID, which aims to bring about clinical change (Thorne, 2016).

Thesis Structure

This thesis is presented in five chapters. Chapter One has provided an introductory overview of the research topic. Key terms have been defined, and COVID-19 and forensic mental health services discussed at an international and local level. Furthermore, the provision of occupational therapy within forensic mental health services has been described. The chapter also outlined the rationale behind the study and presented the research question and objectives. Insights into my positionality and motivation for undertaking the study were explained.

Chapter Two details the literature review strategy used to search, select, and extract data relevant to my research. Thereafter, the chapter provides a synthesis of the current literature surrounding the experiences of tāngata whai i te ora in inpatient COVID-19 restricted mental health services and forensic mental health services. A summary of the main results is presented in themes relating to the review question and objectives. Gaps in existing knowledge are identified.

Chapter Three outlines the research paradigm and methodology that underpin this study. An overview and justification of ID methodology is provided. Thereafter, the methods used within the research are outlined, detailing the sampling and recruitment methods, data collection, and data management strategies employed. The data analysis approach to construct themes from the data is explained. Finally, this chapter details the ethical considerations and methods implemented to ensure rigour was maintained throughout the study.

Chapter Four details the demographic characteristics of the participants and the findings of the research. By using reflexive thematic analysis, four themes were constructed from the data. These four themes represent the tāngata whai i te ora

experiences of their occupations during the COVID-19 restrictions while living in a forensic mental health service.

Chapter Five presents the discussion and conclusion. Findings are reviewed within the current body of knowledge and a critical discussion of findings is presented. Implications for practice and recommendations for future research, and the strengths and limitations of the current study, are discussed. Final closing remarks are made.

Chapter Two: Literature Review

This chapter offers a review of the literature relating to the current study; that is, tāngata whai i te ora experiences of occupations in forensic mental health settings during COVID-19 restrictions. First, it will outline the strategy used for searching and selecting literature to include in the review. Thereafter, a narrative synthesis of the literature reviewed will be presented and the chapter will conclude with an appraisal of the evidence base and a justification for the current study.

Literature reviews are employed to look at published material as a means to establish what literature already exists and whether there are any gaps in knowledge (Grant & Booth, 2009). According to Thorne (2016), the literature review is one of the critical elements involved when positioning oneself to carry out a research study. A literature review that supports an ID study is one that places the study within the existing knowledge, proposes critical reflection on what does and does not exist, and provides an interpretive summary on the strengths and weaknesses within the overall body of knowledge (Thorne, 2016).

I chose to carry out a narrative literature review due to the limited availability of articles specifically relating to the research topic. A narrative literature review is defined as an analysis of scientific information on a specific topic that provides a method of synthesising and appraising the existing evidence (Theile & Beall, 2024). This narrative review serves to thematically summarise findings from the broader area relating to COVID-19 and changes in day-to-day activities (occupations) in secure settings that are relevant to the focus of this inquiry; that is, how did service users experience their occupations during the COVID-19 restrictions within a forensic mental health setting?

Search strategy

Support was provided by a liaison librarian at Auckland University of Technology (AUT) to perform general searches on relevant electronic databases. Some traditional narrative literature reviews omit details about search methods and data analysis strategies. Critics argue that this can make narrative reviews subjective and potentially

biased (Ferrari, 2015). This review does not qualify as a systematic review as it does not aim to identify or critically assess empirical studies related to the research question (Booth et al., 2012); however, it still employs a framework to minimise bias and ensure a comprehensive synthesis of the reviewed literature.

The Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines for systematic reviews was used to guide the search approach and selection of articles (Page et al., 2021) (see Fig. 1). The search terms, as listed in Table 1, and databases were confirmed with the supervisors. Literature searches were carried out between February 2022 and July 2024. Databases including PsychINFO, Scopus, and CINAHL via EBSCO Host were searched. These databases provided the most relevant articles relating to forensic psychiatry and COVID-19. Search terms included, but were not limited to, COVID-19, coronavirus, pandemic, sars-cov-2, “patient”, “service user”, forensic*, secure, and “forensic psychiat*”. Keywords from articles retrieved through the initial searches were analysed and included in further searches.

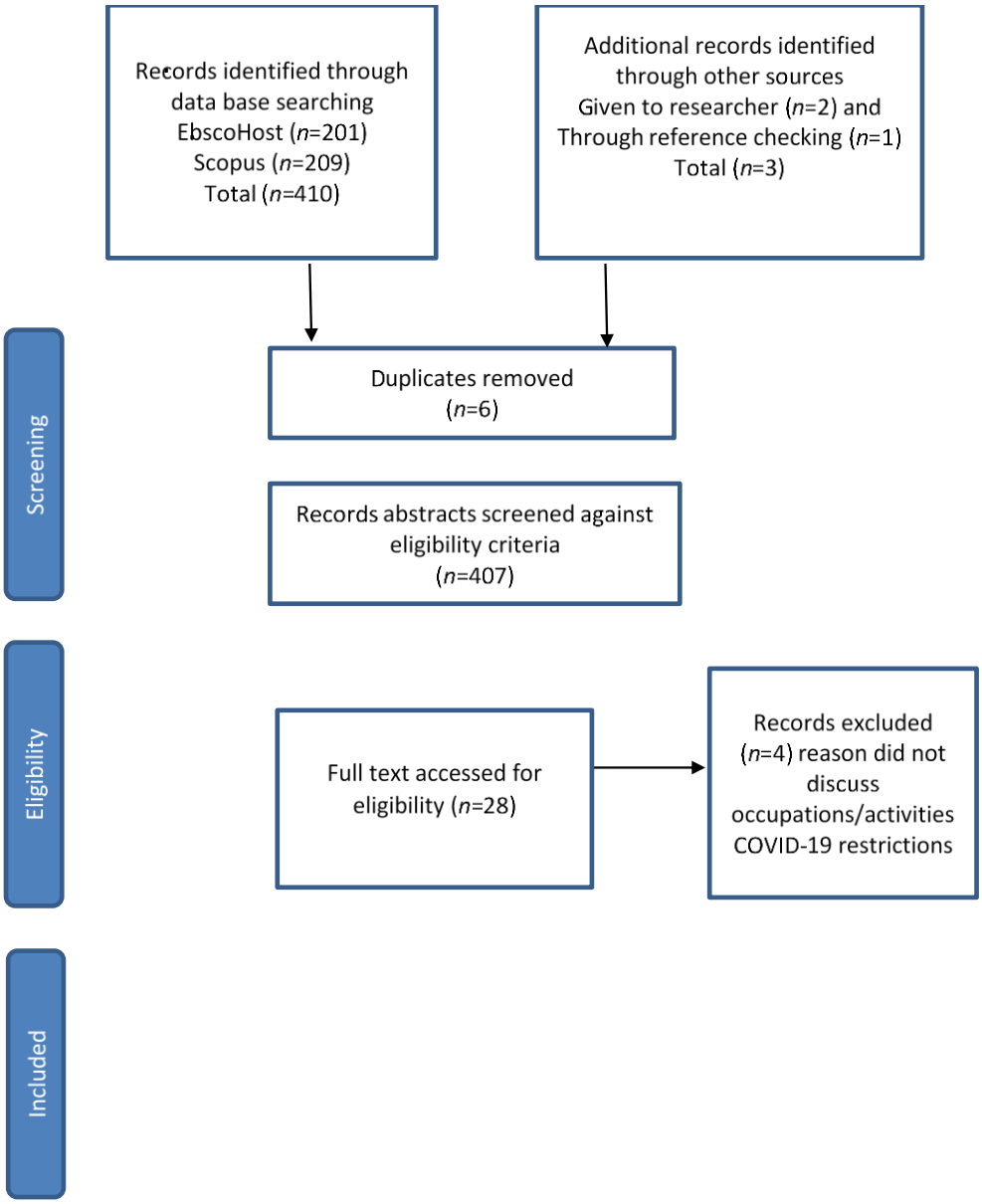
Table 1.

Literature Search Terms

Topic of Interest	Search Terms
COVID-19	(COVID-19 OR coronavirus OR sars-cov-2 OR pandemic) AND
Forensic	(forensic* OR “forensic psychiat*” OR “forensic mental health” OR “secure forensic” OR secure OR “inpatient forensic”) AND
Tāngata whai i te ora	(patient* OR “service user*” OR consumer)

Figure 1.

Search Results



Inclusion criteria discussed with the supervisors led to articles which were published in English and from the years 2020-2024, as the pandemic outbreak only came about in late 2019. Types of evidence sourced included research studies, literature reviews, guidelines, and expert opinion pieces to allow for breadth of information when there were limited peer-reviewed studies available at this time. Quantitative, qualitative, and mixed method studies were all included to consider various details relating to the research topic. Exclusion criteria included papers that did not discuss COVID-19 restrictions within a secure forensic mental health setting.

Reference lists from selected articles were also searched to identify additional relevant studies. Two articles were given to me by colleagues when I was working in the role of COVID-19 Lead for the forensic mental health service.

Article titles, abstracts, and findings sections were scanned to identify if the literature was discussed in a way that addressed the review question of how service users experienced their occupations during the COVID-19 restrictions. Articles were immediately excluded if they did not relate to the concepts or contexts of interest (i.e., COVID-19/pandemic; forensic/secure service or service users/patients; and day-to-day activities/occupations).

A sample of studies was screened by a supervisor to confirm decisions regarding the appropriateness of inclusion and exclusion criteria. A total of 24 articles were finally included in the review. Microsoft Excel was used to assist with article management and articles were filed using Endnote Library.

There were a larger number of articles that were not primary research. These ranged from opinion pieces (Farrell et al., 2022; Fovet et al., 2020; Gaudernack & Dudeck, 2020; Heitzman & Gosek, 2021; Kennedy et al., 2021; Scarpa, 2021; Tomlin, 2020; Wasser et al., 2020); literature reviews (Bodryzlova et al., 2022; Chaimowitz et al., 2021; Lemieux et al., 2020; Simpson et al., 2020); and a service report (Forensic Network, 2021). Reviewing these documents supported me in creating a picture of the experiences of service users during COVID-19 in forensic mental health settings internationally, that then situated the more relevant studies. The limited research available highlights that this topic it is a new and evolving phenomenon, and has the potential for research to be undertaken.

A selection of quantitative studies exploring various factors such as the impact of COVID-19 related restrictions on routine outcomes (Puzzo et al., 2022); the impact of the pandemic on the psychosocial rehabilitation in forensic psychiatry (Koch et al., 2023); the perceived mental health impact of the COVID-19 pandemic on people with schizophrenia in an inpatient forensic psychiatric unit (Dorner et al., 2022); trends in the frequency of self-harm over the course of the COVID-19 pandemic (Challinor et al.,

2021); a conceptual framework for the management of COVID-19 (Wilkie et al., 2021); and an investigation into the psychological impact of the COVID-29 pandemic on service users and staff within a high secure service (Levtova et al., 2024) were reviewed. Furthermore, I reviewed a mixed method study using surveys with service users to gain insights into their experiences of living in a forensic mental health service during the COVID-19 outbreak (Brennan et al., 2021).

The literature search found only three studies exploring service users' experiences and perspectives during COVID-19 in secure mental health services. These studies focussed on service user perspectives on COVID-19 prevention measures (Terkildsen et al., 2022); their overall concerns and needs during COVID-19 (Simjouw et al., 2022); and their lived experience during COVID-19 (Humphries et al., 2023). Further, a case study reporting on how service users and staff worked together during the COVID-19 outbreak as a "therapeutic community" in a forensic psychiatric ward in Japan (Kashiwagi et al., 2022) was reviewed. These qualitative studies were based on research undertaken in the Netherlands, Denmark, Japan, and the United Kingdom. As I read these studies, I noted congruence between the findings from these four qualitative studies that highlighted adverse emotions and disruptions experienced by forensic service users during COVID-19 that was worth exploring further.

The included articles mentioned above were from the United Kingdom, the United States of America, Denmark, Canada, France, Italy, Japan, Ireland, Netherlands, Germany, Poland, Austria, Scotland, and Switzerland. The diversity in which the literature originated highlights global interest in the research topic. Notably, there was no literature from Aotearoa New Zealand. A limitation for this literature review is the restricted amount of peer-reviewed research currently available. Therefore, this review largely consists of expert opinion pieces and literature reviews to describe the changes to service practice due to the COVID-19 restrictions that were impacting on service users' occupations. Of the 24 articles reviewed, seven were opinion pieces, four literature reviews, one Government report, one practice review, six quantitative studies, one mixed method, and four qualitative studies. The number of

results is relevant as it confirms that the research issue is an emerging topic. Table 2 outlines the details of the literature included in this review.

Table 2.

Literature Included in this Review

Authors	Title	Aim	Methodology	Setting Context and Origin
Simjouw et al. (2022)	Forensic psychiatry in times of COVID-19: A qualitative study into the concerns and needs of patients	Gain better understanding of the concerns and needs of forensic psychiatric patients regarding the impact of the COVID-19 crisis on their mental health and treatment	Qualitative Semi structured interviews	Forensic inpatient mental health Netherlands
Terkilsen et al. (2022)	Forensic psychiatric patients' perspectives on COVID-19 prevention measures: A qualitative study	To investigate how patients in forensic psychiatric wards experienced changes made to their everyday lives caused by the COVID-19 pandemic	Qualitative Semi structured interviews	Forensic inpatient mental health Denmark
Humphries et al. (2023)	Exploring the lived experience of secure patients during COVID-19	Explore the phenomenon of COVID-19 from secure patients' perspectives	Qualitative Semi structured interviews	Forensic inpatient mental health United Kingdom
Brennan et al. (2021)	A cross-sectional survey of patients and staff on inpatient forensic psychiatric units in Canada during the COVID-19 outbreak	To gain insight into the experience of those living and working in these environments during COVID-19 and to develop responses to these experiences	Mixed Method Staff - focus groups Patients - surveys	Forensic inpatient mental health Canada
Kashiwagi et al. (2022)	Responding to the COVID-19 outbreak as a therapeutic community in a forensic psychiatric ward in Japan–A reconsideration of the role of therapeutic community in disasters	This study reports on how the staff and patients in a forensic psychiatric ward in Japan worked together during the COVID-19 outbreak as a "therapeutic community"	Case study	Forensic inpatient mental health Japan

Authors	Title	Aim	Methodology	Setting Context and Origin
Puzzo et al. (2021)	The impact of the COVID-19 pandemic on forensic mental health services and clinical outcomes: A longitudinal study	To provide an analysis of the impact of COVID-19 related restrictions on routine outcomes within a large forensic mental health service	Quantitative	Forensic inpatient mental health United Kingdom
Koch et al. (2023)	The impact of the COVID-19 pandemic on the psychosocial rehabilitation of forensic psychiatric patients in Austria	To evaluate the impact of the pandemic on the psychosocial rehabilitation in forensic psychiatry	Quantitative	Forensic inpatient mental health Austria
Dorner et al. (2022)	Inpatient forensic psychiatry in the time of COVID-19: A survey study of perceived mental health implications on people with schizophrenia spectrum disorder	To assess the perceived mental health impact of the COVID-19 pandemic on people with schizophrenia in an inpatient forensic psychiatric unit and to identify personal networks most important for the person during the pandemic	Quantitative	Forensic inpatient mental health Switzerland
Wilkie et al. (2020)	A conceptual framework for the management of a COVID-19 outbreak on a secure forensic inpatient unit	To develop a conceptual framework to identify interventions to effectively respond to and manage COVID-19 outbreak in a secure forensic mental health setting	Quantitative	Forensic inpatient mental health Canada
Challinor et al. (2021)	The effects of COVID-19 on self-harm in a high secure hospital	To explore the trends in the frequency of self-harm over the course of the COVID-19 pandemic within a high-secure hospital	Quantitative	Forensic inpatient mental health United Kingdom
Levtova et al. (2024)	First insights into post-pandemic distress in a high secure hospital: Correlates among staff and patients	To examine the psychological impact of the COVID-19 pandemic on patients and staff within a high secure service	Quantitative	Forensic inpatient mental health United Kingdom

Authors	Title	Aim	Methodology	Setting Context and Origin
The Forensic Network, Scotland (2021)	Forensic mental health services' response to the COVID-19 pandemic	To set out an assessment of service responses to COVID-19 and outline any areas of learning or improvement that may be sustained over the longer term. Recommendations contained within seek to inform policy decisions in relation to the remobilisation, recovery and transition of services after the pandemic and the future delivery of care to forensic patients	Report	Forensic inpatient mental health Scotland
Heitzman & Gosek (2021)	Polish experiences of safety measures involving forensic psychiatric inpatients implemented during the sars-cov-2 pandemic	Present Polish guidelines for forensic care during COVID-19	Policy and practice review article	Forensic inpatient mental health Poland
Chaimowitz et al. (2020)	Stigmatization of psychiatric and justice-involved populations during COVID-19 pandemic	Describe challenges that forensic populations have faced during COVID-19 and how a rise in stigmatisation could lead to adverse outcomes	Literature review	Prisons; Forensic inpatient mental health Canada
Lemieux et al. (2020)	Management of COVID-19 for persons with mental illness in secure units: A rapid international review to inform practice in Quebec	Identify strategies, challenges and recommendations for dealing with COVID-19 outbreak in secure settings for persons with mental illness	Systematic review	Forensic inpatient mental health Canada

Authors	Title	Aim	Methodology	Setting Context and Origin
Bodryzlova et al. (2022)	The first wave of COVID-19 in forensic psychiatry: A rapid review series	Summarise empirical data on changes in the number of acute psychoses, suicide attempts, and involuntary hospitalisations at the initial stage of the pandemic. To better understand the burden of the pandemic on forensic mental health services and better plan the immediate response to future epidemics of severe respiratory infection requiring large scale public health measures	Systematic review	Prisons; Forensic inpatient mental health Canada
Simpson et al. (2020)	Management of COVID-19 response in a secure forensic mental health setting	Review international guidance on approaches to assist in decreasing risk of COVID-19 outbreaks as well as manage outbreaks of infection should they occur in forensic settings. The purpose of this article is to describe the approach taken by a 182-bed forensic mental health hospital to plan for and manage the early phase of the COVID-10 outbreak. Published articles and grey literature reviewed	Literature review	Forensic inpatient mental health Canada
Farrell et al. (2021)	Perspectives on the COVID-19 pandemic response in a forensic psychiatric hospital: Informing future planning	Examine the case examples to help guide development of best practices and policy guidelines for responding to a pandemic in a forensic inpatient context	Opinion piece	Forensic inpatient mental health Canada
Gauernack & Dudeck (2020)	COVID-19 in forensic psychiatric hospitals in Bavaria: Finding a balance between infection prevention, collective security and patient rights	Provide recommendations for action that facilitated the implementation of pandemic guidelines and that can serve as an example for other forensic psychiatric hospitals	Opinion piece	Forensic inpatient mental health Germany

Authors	Title	Aim	Methodology	Setting Context and Origin
Wasser et al. (2020)	The management of COVID-19 in forensic psychiatric institutes	Outlines specific challenges which are likely to recur in subsequent pandemics and suggests potential strategies to address them	Opinion piece	Forensic inpatient mental health United States of America
Kennedy et al. (2020)	Forensic psychiatry and COVID-19: Accelerating transformation in forensic psychiatry	Outline how COVID-19 tested service preparedness	Opinion piece	Forensic inpatient mental health Ireland
Scarpa (2021)	COVID-19 and forensic mental health in Italy	Describe treatment during COVID-19 in forensic psychiatry service in Italy	Opinion piece	Forensic inpatient mental health Italy
Tomlin (2020)	What does social distancing mean for patients in forensic mental health settings?	To suggest how we can use past research exploring patient experiences of restrictive interventions to guide the implementation of social distancing measures in light of the pandemic	Opinion piece	Forensic inpatient mental health Germany
Fovet et al. (2020)	French forensic mental health system during the COVID-19 pandemic	Outline changes and challenges experienced in French forensic mental health system during COVID-19	Opinion piece	Forensic inpatient mental health France

Review Findings

There are a number of different ways by which material from a literature search is organised, depending on the nature and substance of the available literature (Thorne, 2016). As this literature review sought to find out more about service users experiences of their occupations in a forensic mental health setting during COVID-19, it is structured in the form of a thematic summary (Barnett-Page & Thomas, 2009; Thorne, 2016). The reviewed literature highlighted restrictions and changes to business-as-usual practices that occurred due to COVID-19 restrictions that impacted on occupational participation for tāngata whai i te ora, such as implementation of infection prevention control (IPC) measures, education and communication strategies of the pandemic, impacts on social connections, and changes to rehabilitation activities. Each theme presented begins with a broader discussion from expert opinion. Quantitative findings are highlighted before moving towards studies discussing service users' experiences and perspectives. The following discussion presents the narrative synthesis of the literature review findings (Harden & Thomas, 2005).

Implementation of IPC Measures

The reviewed literature highlighted a variety of IPC measures such as social distancing, hand hygiene, use of masks, increased cleaning, routine testing, symptom screening, and isolation requirements commonly implemented by services to aid management of COVID-19 (Farrell et al., 2022; Fovet et al., 2020; Kennedy et al., 2021; Lemieux et al., 2020; Simpson et al., 2020; Tomlin, 2020). This suggests service users were required to make changes to their daily activities or implement new activities that had implications for occupational participation. Tomlin (2020) surmised that service users might find these measures as restricting and punishing. Furthermore, some service users may need constant reminding of the IPC measures and rules due to illness related cognitive challenges and disorganised behaviour (Brennan et al., 2021; Lemieux et al., 2020).

The literature described how bedroom and designated COVID-19-unit isolation requirements were implemented across many of the services for people with suspected or confirmed COVID-19 to minimise the spread of infection (Brennan et al., 2021; Farrell et al., 2022; Lemieux et al., 2020; Scarpa, 2021; Simpson et al., 2020). These COVID-19 isolation experiences are thought to risk reflection back to previous experiences of seclusion pre COVID-19, where forensic mental health service users were made to feel like an object to be managed, voiceless, and denied agency in both hospital and wider social inclusion (Tomlin, 2020). This may be a cause for concern as social isolation is well known to have detrimental effects on the well-being of a person with mental illness; therefore, being required to socially isolate may have exacerbated these concerns (Chaimowitz et al., 2021; Tomlin, 2020).

Recommendations from the literature suggest that when isolation requirements are required, psychosocial services, such as counselling, should accompany them to aid in minimising concerns (Brennan et al., 2021; Lemieux et al., 2020). However, the wider COVID-19 IPC measures, accompanied with risk protocols associated with forensic mental health services, meant there were limited psychosocial intervention activities that could be facilitated in COVID-19 isolation areas (Forensic Network, 2021).

The literature found the requirement of isolation when infected with COVID-19 was seen as both a loss of freedom and loss of social connection that had the potential to worsen psychiatric health and well-being of service users (Brennan et al., 2021; Humphries et al., 2023; Terkildsen et al., 2022). Seventy-five percent of service user participants identified the COVID-19 restriction requirement to stay in their bedrooms as a key challenge (Brennan et al., 2021). Interestingly, for some service users, the fear of being isolated in a bedroom for 24-hours to a few weeks was greater than the fear of being infected with COVID-19 and the potential health implications infection might cause. This resulted in some service users attempting to conceal their COVID-19 symptoms to prevent having to isolate (Simjouw et al., 2022; Terkildsen et al., 2022). Such findings reveal the potential impact isolation and occupational deprivation has on

tāngata whai i te ora. In contrast, a positive aspect identified of being isolated in a bedroom was the ability to engage in personally meaningful activities, with more time to focus on self-care and more time to relax (Brennan et al., 2021).

Across the literature participants reported the implementation of IPC measures resulted in feelings of worry, uncertainty, loneliness, and intimidation (Brennan et al., 2021; Puzzo et al., 2022; Simjouw et al., 2022). Brennan et al. (2021) found that as time progressed, service users became more 'frustrated' and 'aggressive' when asked to comply with mask requirements. Furthermore, the introduction of mandatory face masks for staff created additional challenges to the already limited face-to-face interactions. Masks created feelings of intimidation, as well as making it challenging to hear and read non-verbal cues, making it difficult to establish and maintain relationships (Brennan et al., 2021; Forensic Network, 2021; Terkildsen et al., 2022). Dorner et al. (2022) found that service users were more emotionally vulnerable during the pandemic than they had been prior to COVID-19, with participants reporting feeling less relaxed and more stressed. Puzzo et al. (2022) predicted the increase in self-harm during lockdowns may be in response to these feelings. However, in contrasting findings, the highly controlled daily routines and IPC measures were found to ease anxiety in some service users as they were visible measures which felt like the required preventative action was being taken (Brennan et al., 2021; Dorner et al., 2022; Forensic Network, 2021).

The literature identified service users' express powerlessness to oppose the IPC rules because the consequence of doing so risks sabotaging progress they have previously made (Humphries et al., 2023). Exploration of these factors is needed to understand how IPC measures may have impacted occupational participation, and exacerbated feelings of occupational deprivation and loneliness.

Changes to Rehabilitation Activities

Several of the articles discussed ways in which community leaves were adapted or cancelled due to COVID-19 (Brennan et al., 2021; Farrell et al., 2022; Forensic

Network, 2021; Heitzman & Gosek, 2021; Humphries et al., 2023; Kennedy et al., 2021; Koch et al., 2023; Puzzo et al., 2022; Scarpa, 2021; Simjouw et al., 2022; Simpson et al., 2020; Terkildsen et al., 2022; Tomlin, 2020). Furthermore, articles highlighted how therapy programmes and activity groups were reduced in quality, quantity, and scope, due to room capacity, social distancing requirements, and reduction in staffing that was impacting on clinical capacity to provide group programmes (Brennan et al., 2021; Forensic Network, 2021; Fovet et al., 2020; Humphries et al., 2023; Koch et al., 2023; Lemieux et al., 2020; Puzzo et al., 2022; Scarpa, 2021; Simpson et al., 2020; Tomlin, 2020). Despite the reduction in community leaves and group programmes, there was an increase in staff effort to facilitate ward-based activities, which was appreciated by service users (Forensic Network, 2021; Simjouw et al., 2022). Loss of these liberties, and the associated stress, was surmised to contribute to an exacerbation of symptoms, behaviour instability, and increase in the illness burden experienced by service users (Chaimowitz et al., 2021).

Discussed across the literature was the move to virtual group programmes that were facilitated via iPads and laptops due to the limitations of room capacity and restriction on mixing of unit 'bubbles' (Brennan et al., 2021; Farrell et al., 2022; Forensic Network, 2021; Kennedy et al., 2021; Lemieux et al., 2020). The aim of virtual programmes was to maintain activities and provision of therapy groups. While this may have problem-solved some IPC and social distancing concerns, it brought with it other challenges. For example, lack of resources, loss of privacy, and being unable to see the faces of the professionals were some disadvantages (Chaimowitz et al., 2021; Forensic Network, 2021; Simjouw et al., 2022).

The importance of community access to support recovery was clearly communicated by service users to the Forensic Psychiatric Hospital Emergency Operations Centre in a forensic mental health hospital in Canada, responsible for coordinating the COVID-19 response (Farrell et al., 2022). This resulted in several innovations to support community access to continue; for example, a focus on recreation and leisure activities in outdoor green spaces was facilitated. The cessation

of group activities, leaves, and discharges led to delays in accessing psychological treatment and caused frustration, anxiety, and distress in service users (Forensic Network, 2021; Koch et al., 2023). The change in activity was highlighted by Koch et al. (2023), who reported substantial decrease by over 90% in both individual and group excursion day-leaves while COVID-19 restrictions were in place. Consequently, Koch et al. attributed the decrease in discharges in the year 2022 compared to those that occurred between 2019-2020 due to the decline in rehabilitation activities occurring after the outbreak of the pandemic. It is, therefore, not surprising that 50% of participants reportedly found the lack of available leisure activities a hard aspect of the COVID-19 precautions (Brennan et al., 2021). Furthermore, Challinor et al. (2021) reported that the increase in self-harm incidents on the unit could be attributed to the reduction in off-ward activities and cancellation of rehabilitation activities.

Farrell et al. (2022) challenged services to consider how group activities could be modified and continued to the greatest extent possible, considering they are an essential aspect of service users well-being, recovery, and rehabilitation. The identified decrease in programming, activities, and leaves being offered was one of the biggest factors service users described as affecting their overall well-being during COVID-19. This created feelings of loss, disappointment, isolation, and boredom (Brennan et al., 2021; Forensic Network, 2021; Humphries et al., 2023). Participants experienced time as slowing down during the pandemic, as many meaningful activities were cancelled or minimised (Terkildsen et al., 2022). However, some participants reported to enjoy the increase in free time as this meant they could engage in meaningful, independent hobbies in their bedroom (Brennan et al., 2021; Forensic Network, 2021; Simjouw et al., 2022). Furthermore, the literature reportedly found engagement in meaningful activity improved service users' experiences of lockdown as it filled time and provided a sense of purpose, accomplishment, and distraction (Humphries et al., 2023; Simjouw et al., 2022; Terkildsen et al., 2022).

Throughout the literature a recurring theme was the impact COVID-19 restrictions had on service users' experiences of autonomy and freedom due to the

changes in activities and leaves (Brennan et al., 2021; Humphries et al., 2023; Simjouw et al., 2022; Terkildsen et al., 2022). The cancellation of leaves prevented skill development opportunities, progression with discharge, and employment opportunities, impacting important psychiatric rehabilitation processes (Brennan et al., 2021; Humphries et al., 2023; Koch et al., 2023; Simjouw et al., 2022). Hard work had occurred by service users to gain these privileges, typically over a number of months and years. These changes left service users feeling frustrated and with a sense of being punished (Brennan et al., 2021; Humphries et al., 2023; Simjouw et al., 2022). Participants experienced an increase in reliance on staff to do tasks such as accessing previously independent activities or making themselves a cup of tea or coffee, which resulted in feelings of loss of autonomy (Brennan et al., 2021; Forensic Network, 2021; Humphries et al., 2023; Simjouw et al., 2022; Terkildsen et al., 2022).

Participants reported several ways to cope with the effects of the pandemic. Some service users were able to self-initiate activities such as painting a picture for family. One participant purchased a sewing machine and made face masks. Some reportedly smoked cannabis in their bedrooms. In these ways, service users demonstrated resilience and actively managed changes in ward routine and atmosphere. (Humphries et al., 2023; Simjouw et al., 2022).

The Ways COVID-19 Restrictions Influenced Social Connections

The reviewed literature found many hospitals, long-term care facilities, and prisons around the world implemented strict visiting protocols that restricted whānau from visiting their loved ones. The intent was to prevent infection and transmission of the virus from the visitors to the service users (Challinor et al., 2021; Farrell et al., 2022; Forensic Network, 2021; Heitzman & Gosek, 2021; Kennedy et al., 2021; Koch et al., 2023; Puzzo et al., 2022; Scarpa, 2021; Simjouw et al., 2022; Simpson et al., 2020; Terkildsen et al., 2022).

When face to face visits were cancelled during COVID-19, use of virtual technologies was one of the ways services promoted social connectedness with loved

ones and external providers (Brennan et al., 2021; Challinor et al., 2021; Farrell et al., 2022; Forensic Network, 2021; Gaudernack & Dudeck, 2020; Lemieux et al., 2020; Puzzo et al., 2022; Scarpa, 2021; Simjouw et al., 2022; Tomlin, 2020; Wasser et al., 2020). However, literature highlighted how the lack of technology and stringent policies in forensic mental health services may have worsened the lack of face-to-face contact, and created a further barrier to engaging in meaningful occupation such as connecting with loved ones and fulfilling meaningful occupational roles such as mothers, fathers, students, and friends (Forensic Network, 2021; Scarpa, 2021; Tomlin, 2020). While there are clear benefits to virtual technology to keep whānau connected, some difficulties also arose. These challenges included inappropriate use of the technology to access unapproved sites, lack of familiarity with the technology, poor internet connections, and time use constraints (Chaimowitz et al., 2021; Forensic Network, 2021; Simjouw et al., 2022; Wasser et al., 2020). Additionally, access to social media platforms used by the general population was prohibited in some services, and was dependent on service users' levels of security and planned care (Tomlin, 2020). Therefore, not every service user had access to these options. However, some of the literature highlighted how making virtual technologies available increased social connectedness compared to in person visits pre pandemic (Farrell et al., 2022; Koch et al., 2023; Wilkie et al., 2021).

There was a reported substantial decrease of over 72% in the frequency of whānau face-to-face visits (Koch et al., 2023). Less contact with whānau was associated with a significant higher symptom severity and significantly more positive symptoms on the Positive and Negative Syndrome Scale (PANSS) (Dorner et al., 2022), and may have contributed to self-injurious behaviour due to loneliness and low social support (Challinor et al., 2021). With less time spent in rehabilitation activities, and more time spent in unstructured social time, there was also a reported increase in violence between service users and self-harm incidents that could be a result of spending more time on the unit mixing with one another, causing interpersonal difficulties and conflict (Challinor et al., 2021; Puzzo et al., 2022).

According to the literature, being unable to have face-to-face visits with supports was viewed as challenging, as most participants looked forward to seeing their friends and family each week (Brennan et al., 2021; Simjouw et al., 2022; Terkildsen et al., 2022). A shared sentiment among some service users was that due to restrictions of visits to the units, they experienced enhanced relationships with staff (Humphries et al., 2023; Simjouw et al., 2022; Terkildsen et al., 2022). This could be due to the fact that staff spent more time engaging with tāngata whai i te ora, asking them how they were feeling and organising activities (Humphries et al., 2023; Simjouw et al., 2022; Terkildsen et al., 2022). This finding was, to some extent, contradicted by Dorner et al. (2022), who reported family played the most significant role with tāngata whai i te ora, with friends, staff, and peers being significantly less important for the patients' well-being during COVID-19.

However, the COVID-19 restrictions also created feelings of inequality between the staff and tāngata whai i te ora, as staff could still leave and go home to their families, while service users could not (Simjouw et al., 2022). Furthermore, participants reported a sense of being connected to the general public whom they typically feel disconnected from, through shared experiences and adversity during the COVID-19 lockdowns (Humphries et al., 2023; Simjouw et al., 2022).

Education and Communication Strategies During COVID-19 Restrictions

The importance of effective, clear, and timely communication was discussed frequently within the reviewed literature and was considered one of the most vital aspects of the pandemic response (Brennan et al., 2021; Dorner et al., 2022; Farrell et al., 2022; Forensic Network, 2021; Fovet et al., 2020; Gaudernack & Dudeck, 2020; Kashiwagi et al., 2022; Lemieux et al., 2020; Simpson et al., 2020; Wasser et al., 2020; Wilkie et al., 2021). Continuously providing education and support to service users about possible COVID-19 risks and the IPC precautions was recommended to occur throughout the pandemic due to cognitive issues and disorganised behaviours, which may affect service users' compliance with the rules (Dorner et al., 2022; Gaudernack & Dudeck,

2020; Lemieux et al., 2020; Simpson et al., 2020). Poor communication strategies that are complex and confusing are known to add to stress in vulnerable populations. Therefore, it was recommended that messaging to service users used person-first language, was concise and consistent, and used language that could be easily understood (Farrell et al., 2022). Precautions were more readily accepted by service users when plans were explained to them regularly and in relation to their own health and safety; and when the rules were differentiated as 'COVID-19 related' and were not seen to result from forensic risk management or punishment (Simpson et al., 2020; Tomlin, 2020; Wasser et al., 2020; Wilkie et al., 2021).

Involving peer leaders in the sharing of information was a strategy to ensure appropriate language was being used and to support the acceptance of information (Farrell et al., 2022; Lemieux et al., 2020). Strategies discussed across the literature, included opportunities such as 'town halls', where service users were educated on the pandemic and provided with the opportunity to ask questions; and the creation of COVID-19 update boards to disseminate information (Farrell et al., 2022; Forensic Network, 2021; Kashiwagi et al., 2022; Tomlin, 2020). Information that flowed in both directions between staff and service users gave service users a sense of control and assisted with minimising the negative impact of the restrictions which increased compliance (Farrell et al., 2022; Kashiwagi et al., 2022; Lemieux et al., 2020; Simjouw et al., 2022; Tomlin, 2020).

Studies highlighted how maintaining communications and sharing information was a useful intervention, as service users were supported to gain a better understanding of the virus and to cope with stress associated with the pandemic (Kashiwagi et al., 2022; Wilkie et al., 2021). The Forensic Network (2021) reported positive attitudes and resilience amongst patients when efforts were made to engage with them and support their understanding of changes to ward activity. However, when rules were ambiguous, they left feelings of frustration, uncertainty, and doubt in tāngata whai i te ora, with study participants reporting that they did not always feel it was clear what they were and were not able to do, both inside and outside of the hospital, during

COVID-19 (Brennan et al., 2021; Simjouw et al., 2022). Furthermore, participants did not always feel information was timely. Service users suffering from psychosis reported more worry regarding the COVID-19 virus and may have had limited capacity to comprehend rules, or consider the well-being of others, and how to minimise infection risks to themselves (Simjouw et al., 2022).

Summary and Limitations of the Literature

This review has examined a range of international literature relating to COVID-19 in forensic mental health services. Research indicates there were multiple changes in daily activities for service users during COVID-19. The implementation of COVID-19 isolation requirements, mask wearing, and other IPC measures left service users feeling vulnerable and scared, and it increased their stress levels. Across the literature, the reduction or cancellation of most group programmes, community leaves, and social visits were highlighted. COVID-19 restrictions altered time use during the day where some felt bored and lonely. Additionally, the COVID-19 restrictions were found to impact on psychosocial rehabilitation processes. These changes caused feelings of disappointment and loss. While there was a strengthening of relationships with staff, the cancellation of face-to-face visits with whānau was a challenge.

Furthermore, this review identified some strategies that were identified as useful when it came to communication and education on the COVID-19 restrictions as a way of informing service users of the COVID-19 restrictions that were subsequently impacting on participation in daily activities. Ensuing communication is clear and timely was an important sentiment across the literature. The literature highlighted the way forensic mental health service users were impacted by COVID-19 restrictions due to limited resources, confined living environments, and existing service restrictions.

Overall, there was not a consistent methodological approach to the literature which made it difficult to compare studies. Furthermore, there was a paucity of literature providing deeper perspectives deriving from qualitative research with forensic service users on their experiences of COVID-19, with only four qualitative studies

sourced. This could be due to the novelty of COVID-19 only emerging in recent years, but also the ethos surrounding inclusion of forensic service users in research. Forensic service users' perspectives are understudied in general, as they are often viewed as vulnerable, requiring robust ethical considerations and methods to engage in research (Keogh & Daly, 2009). Despite this challenge, from the research reviewed, many authors suggested additional research to explore the experiences of service users' (Chaimowitz et al., 2021; Challinor et al., 2021; Dorner et al., 2022; Farrell et al., 2022; Koch et al., 2023; Puzzo et al., 2022; Simpson et al., 2020; Terkildsen et al., 2022; Wilkie et al., 2021).

The qualitative literature sourced focused on how service users perceived the IPC measures, their perceived concerns and needs during the pandemic, their overall lived experience of COVID-19, and their experiences of acting as a therapeutic community during COVID-19 (Humphries et al., 2023; Simjouw et al., 2022; Terkildsen et al., 2022; Kashiwagi et al.,2022). In the study by Terkildsen et al. (2022), only male participants were interviewed, and all were residing in medium secure units in Denmark. Thus, the views of other genders or the impacts on occupational participation from those living in minimum-secure units were unexplored. Typically, service users residing in minimum-secure units have greater access to community activities than someone residing in a medium secure unit. The COVID-19 restrictions may have had a greater impact on these liberties.

Simjouw et al. (2022) carried out semi-structured interviews with service users in a forensic mental health hospital in The Netherlands. This study provided insights into the rules and regulations imposed on forensic mental health patients in the country during the COVID-19 lockdown and the impact on their treatment and mental health. Clinical staff were involved in the recruitment of participants which could have led to bias when selecting participants with more positive or expressive participants being asked to participate. The study was also carried out early in the pandemic; therefore, changes in views and experiences of occupational disruption, occupational imbalance, and occupational deprivation as the pandemic progressed may have been missed.

Similarly, Humphries et al.'s (2023) study was carried out early in the pandemic, only providing a snapshot in time and experiences that may have evolved at a different point in time. None of these studies specifically discussed impacts on occupations and how this was experienced by the participants.

While there is literature describing the restrictions imposed on service users in forensic mental health settings internationally, there is limited research interpreting their experiences and perspectives; and no research exploring this from an occupational perspective or any literature within an Aotearoa New Zealand context. Forensic service users are already at risk of occupational concerns such as occupational deprivation. The COVID-19 pandemic had the potential to exacerbate these concerns further. The interruption to group programmes, community leaves, and other meaningful activities that service users needed to do or wished to participate in, but were unable to due to the COVID-19 restrictions needs to be explored further. This will assist in understanding the impacts on well-being and support in addressing barriers to occupational participation during emergency events.

Exploring tāngata whai i te ora experiences of their occupations during COVID-19 restrictions in a forensic mental health service in Aotearoa New Zealand is needed to highlight contrasting opinions, differences in context, and the unique cultural and social meanings tāngata whai i te ora in this country ascribed to occupations (i.e., what they wanted to do; needed to do; how they wished to do it; with whom, when, where; and to what end). This will support understandings about differences across countries and forensic mental health services' application of restrictions that may have impacted on occupations (duration of restrictions, specific implemented measures, risk focus etc.) before suggesting any potential improvements in a COVID-19 service delivery response or other future emergency events.

There is very little literature focused on service users' experiences in forensic mental health settings, and even less focusing on service users' experiences of their occupations. Therefore, this qualitative ID study aims to address the gaps in the

literature by addressing the question, How did tāngata whai i te ora experience their occupations during COVID-19 within in a forensic mental health service?

This literature review chapter has provided a narrative review of the literature relating to service users' experiences of their occupations in forensic mental health settings. A critical summary of the literature has been provided followed by justification for exploring the experiences of forensic tāngata whai i te ora in Aotearoa New Zealand. The next chapter will detail the methods, and ethical and academic rigour employed during the study.

Chapter Three: Methodology

All research requires a foundation for its investigation. This foundation is built on the researcher's worldviews and the paradigms that guide the study (Gelo et al., 2008). These worldviews and paradigms are reflected in the different formulations about the nature of reality (ontology), the theory of knowledge, how it is constructed and how the world is understood (epistemology), and the values and beliefs researchers hold (axiology) (Nayar & Stanley, 2024). Giddings and Grant (2002) suggested the value of a particular paradigm lies within its ability to address the research question more successfully than another. While the research question itself informs the research design and strategy, methodologies also ground and guide research and provide a systematic and structured approach to grow knowledge of a phenomenon (Gelo et al., 2008; Giddings & Grant, 2002). In this chapter, I expand on my worldviews that have been touched on in Chapter One, and describe the research paradigm and methodology used in the study. Additionally, this chapter outlines the methods used for recruitment, data collection and analysis; and discusses aspects of ethical considerations and academic rigour.

Research Paradigm: Interpretivism

All research needs to be located within a theoretical paradigm. It is this organised framework of beliefs and assumptions that guides how a researcher might frame a research question, and the procedures and methods used to investigate the research question (Hooper & Wood, 2019). There are three major paradigms in health research: positivist, interpretivist, and critical (Nayar & Stanley, 2024). These paradigms each bring a unique way of viewing reality, knowledge, and what is valued, and guide the way research should be conducted.

Positivism remains the dominant paradigm in health research. Quantitative research embedded in the positivist paradigm is grounded in the idea of a single reality that can be measured in some objective way (Nayar & Stanley, 2024). Nicholls (2009) discussed the problematic approach some health researchers have when treating the

perceptions of the social world as objective with subsequent neglect of the everyday social interpretations and people's lived experience that play a significant role in their well-being. Reflecting such concerns, qualitative research and its paradigms, including interpretivism, are becoming increasingly popular among allied health professions, including occupational therapy (Nayar & Stanley, 2024).

The research paradigm that guided this study was interpretivism. Interpretivist research is based on the relativist belief that multiple views of reality can and do exist (Nayar & Stanley, 2024; Thorne, 2016). Contrary to the reductionist approach to the human experience that occurs within positivism, interpretivism seeks knowledge about what it is to be human, and the meanings people attach to the events as experienced in their natural contexts (Giddings & Grant, 2002; Thorne, 2016). To obtain understanding of the human experience, and the meaning ascribed to experiences, the researcher relates and interacts with participants and focuses on an individual's descriptions and explanations of their experiences (Giddings & Grant, 2002).

Interpretivists come to their own understandings by talking to their participants, generating texts from interviews, and interpreting the data (Nayar & Stanley, 2024). The relationship is intersubjective, whereby a researcher acts as a listener to the data given by the participant and then interprets it (Nayar & Stanley, 2024). The research in this thesis was situated in the interpretivist paradigm, as I sought to understand participants' experiences of their occupations in a forensic mental health service during COVID-19 restrictions, holding the axiology position that each experience is unique and important to understand (Hooper & Woods, 2019; Thorne, 2016). With the interpretivist approach becoming more popular over the past 100 years, it has allowed the full extent of occupational practice to be embraced as scientific knowledge (Nayar & Stanley, 2024).

Interpretive researchers recognise that we are all situated within a context and see and speak from that position (Terry & Hayfield, 2021). Despite both the researcher and participant being a part of the data collection process, it is the researcher's interpretation at the forefront of the analysis process. It is for this reason that the

researcher should make clear their position in relation to the phenomenon under investigation, which requires a level of reflexivity (Giddings & Grant, 2002). Reflexivity is concerned with documenting the nature and substance of the ideas a researcher holds about the phenomenon they are researching (Thorne, 2016). Thorne (2016) encouraged 'reflexivity' or reflections as an ongoing process throughout the study that is especially important during the data collection and analysis processes, to ensure the dominant aspects do not steer the interactions in anticipated directions. Reflexivity and reflections are discussed in further detail in the rigour section of this chapter.

Research Design: ID

ID is one among a handful of qualitative methodologies that align with the interpretivist paradigm. ID was developed as an approach that would enable health practitioners to come to an understanding of an aspect of a clinical phenomenon that would then evolve towards 'better ways of doing' their clinical practice (Thorne, 2016). Value is placed on similarities as well as individual expressions of the phenomenon (Thorne, 2016). Phenomenology and grounded theory are longstanding research approaches that also hold the idea that the most basic human truths are accessible through in depth understanding of people's subjective experience (Thorne, 2016). While these methodologies have their own purpose, it has been argued that these approaches are not particularly useful within a more applied practice focus, as they remain firmly based in theoretical rather than practical concerns (Teodoro et al., 2018 also Thorne, 2016).

ID methodology extends the research past a description of a phenomenon to associations, relationships, patterns, and meanings within the phenomenon that is being described (Teodoro et al., 2018; Thorne, 2016). Extending beyond description into 'so what', moves health practitioners closer to useful knowledge that is meaningful and relevant to the applied practice context (Thorne, 2016). An ID methodology was chosen for this study, due to its focus on generating meaningful knowledge that will be useful within a clinical context.

ID encourages the researcher to locate themselves within the epistemological positioning of the applied discipline for which the research is being undertaken (Thorne, 2016). From an occupational therapy standpoint, knowledge about occupation and the knowledge arising out of people's occupations within their world is most important (Gillen & Brown, 2024). I bring a worldview that sees humans as connected through their occupations with ever-changing environments that transform and are transformed by their actions, environments, and health (Gillen & Brown, 2024). I see collaboration with tāngata whai i te ora as essential to achieve their meaningful and satisfying participation in occupation that enhances their well-being. Consistent with ID methodology, this research aimed to explore how tāngata whai i te ora experienced their occupations during COVID-19 restrictions within a forensic mental health setting. The practical intention of the study was that this knowledge may be used to improve management of any further restrictions that may occur due to COVID-19, other pandemics, or service-in implemented restrictive practices, that impact on occupational participation.

Research Methods

Participants were purposively recruited through the ARFPS located in Aotearoa New Zealand. Semi-structured interviews were carried out to collect data, and analysis of data occurred through reflexive thematic analysis (TA) by familiarisation, coding, and developing themes that were then situated within the current literature. In accordance with ID, sample members are usually referred to as 'participants' due to its neutrality (Thorne, 2016).

Setting

The ARFPS primarily provide forensic mental health and intellectual disability services for people over the age of 18-years within the Te Whatu Ora, Northern district. The population of this region is about 2,000,000 people, or 40% of the country (Health New Zealand Te Whatu Ora, n.d). The Northern population is serviced by four regions: Te Tai Tokerau Northland, Waitematā, Te Toka Tūmai Auckland, and Counties Manukau.

The ARFPS service is delivered by Te Whatu Ora Waitematā on behalf of the whole region.

The ARFPS delivers forensic mental health services to the Northern region's courts, prisons, and general mental health services. The inpatient sub service is also known as the Mason Clinic. There are 121 inpatient beds across 9 inpatient units. These units consist of acute medium secure, sub-acute minimum-secure, two Kaupapa Māori units, an Intellectual Disability unit, and an open hostel.

Māori[7] are substantially overrepresented in the forensic population, comprising roughly half of the tāngata whai i te ora population at the ARFPS Mason Clinic, despite only making up 16.5% of the Aotearoa New Zealand population (Statistics New Zealand, 2013). Additionally, Pasifika peoples are another group overrepresented within the forensic population, making up 15% of the tāngata whai i te ora at the Mason Clinic (Mason Clinic, 2011). In line with the wider prison population, most tāngata whai i te ora are men, with data showing male tāngata whai i te ora significantly outnumber female tāngata whai i te ora, 73.9% compared with 16.1% in 2019 (McKenna & Sweetman, 2020). On average, the age of people accessing forensic mental health services in Aotearoa New Zealand is 35-years.

This research focused on participants living within one of the three minimum-secure units in the service. The minimum-secure units include one general rehabilitation male-only unit, one mixed-gender Kaupapa Māori unit, and a mixed-gender open (not locked) hostel.

Sample

Purposive sampling was used as it enables the researcher to obtain important data about the way an experience or event affects a particular population or phenomena of interest (Thorne, 2016). Participants were purposely sought who had in-depth

[7] ("Noun) Māori, Indigenous New Zealander, Indigenous person of Aotearoa/New Zealand – a new use of the word resulting from Pākehā contact in order to distinguish between people of Māori descent and the colonisers" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

experience of the phenomena; in this case, experience of COVID-19 restrictions in a forensic mental health setting.

Inclusion Criteria

Inclusion criteria required participants to have been living in one of the minimum-secure units at the ARFPS during the COVID-19 restrictions between 2020 and 2023. At the time of recruitment, participants could have been living in any one of the minimum-secure units or have moved into the community (under the Forensic Community Team care). At the proposal stage of the research, it was decided to contain the potential scope of participants to a particular area of the service. This was a multifaceted decision relating to the size and aim of the project. Different areas of the service have different levels of service-based restrictions due to risk. Higher levels of security impose greater service-based restrictions. Those residing in minimum-secure units typically have a higher level of liberty including access to the community, and other more independent activities. Therefore, there would have been different experiences across different security levels of how tāngata whai i te ora experienced their occupations during the COVID-19 restrictions. Comparing different security levels is not aligned with an ID study. Drawing from clinical experience, it was reasoned that the minimum-secure area of the service would have a different, but marked, impact on tāngata whai i te ora occupational participation, as they had increased levels of liberties such as community leaves and attending day programmes in the community. Additionally, advice from my supervisors was to contain this research to a master's level project; therefore, only focusing on one area of the service.

Exclusion Criteria

Participants were excluded from the study if they did not have a stable mental state. All potential participants were from the rehabilitation, minimum-secure stream of the service or had recently transitioned to the community. Potential participants would, therefore, have been mentally well for an extended period. However, it was recognised

that their presentation could be variable. It was unlikely, but still possible, that a potential participant could have been too unwell to participate in the study.

Exclusion criteria applied at the time of giving informed consent to participate in the interview. In operationalising this exclusion criteria, immediately prior to each interview, I verbally checked in with the participant's clinical team that a routine mental state check had occurred that day. If it was determined that the participant was mentally well enough at that time to participate, the interview was able to proceed. In addition to the participant providing informed consent, the Consent Forms (Appendix B) were then signed by the responsible clinician (RC) or primary nurse prior to the interview starting, confirming they were mentally well enough to participate. The RC is the person who develops and arranges treatment plans and ensures tāngata whai i te ora receive appropriate care while subject to the Mental Health Act (Ministry of Health, 2017).

Sample Size

Thorne (2016) suggested ID can be conducted with almost any sample size, with many studies within this approach involving from 5 to 30 participants. Enough participants are required to produce meaningful patterns across the data set that can then be developed into themes. Practical considerations relating to how many participants might meet the inclusion criteria and how many the researcher would be able to interview within the time frame also needed to be determined (Terry & Hayfield, 2021).

There are 39 beds within the minimum-secure units, creating a finite number of potential participants who may have been living there during the COVID-19 restrictions between 2020 and 2023. Considering a few may have been discharged, and the turnover of tāngata whai i te ora, there could have been 45-50 potential participants. This study aimed to recruit 6 to 10 participants.

Nine tāngata whai i te ora expressed interest following advertisements (Appendix C) within the units. Two withdrew their expression of interest following receiving the Participant Information Sheets (Appendix C); subsequently, seven were

recruited. According to Teodoro et al. (2018), it is through the immersed involvement with a small number of people familiar with the researcher and open to sharing their experiences, that it is viable to create something worthy of reporting.

In addition to meeting the inclusion and exclusion criteria, I sought to achieve varying perspectives among participants. Therefore, general demographic details were gathered during the data collection progress, such as residential units, gender, and ethnicity.

Participant Details

Of the seven participants recruited to the study, three were Māori residing in the Kaupapa Māori stream and four within the general rehabilitation stream or open hostel. Some of these participants transitioned to the community during recruitment. All participants were male. It would have been preferable if some participants were female; however, of the nine participants that expressed interest, the two who withdrew were female.

The unit where the potential participant was residing during COVID-19 restrictions gave insight into the how the different units may have approached implementation to the COVID-19 restrictions and the subsequent, variable impacts on occupational participation. Gender and ethnicity gave perspectives on choice of occupations and meanings ascribed to these occupations. Thorne (2016) acknowledged the samples researchers come up with will not in any meaningful way ‘be representative’; however, with some critical reflection findings can be produced in line with what researchers understand their sample to reflect.

Data Collection

Data were collected from semi-structured interviews with individual participants, allowing generation of rich and detailed data (Thorne, 2016). Interviews provide a way for researchers to discover people’s beliefs, perspectives, opinions, lived experiences, and meaning making (Flick, 2022). Consistent with ID principles, semi-structured interviews allow each participant to respond to questions and provide descriptions in

their own words (Thorne, 2016). The use of semi-structured interviews supported me to act as an instrument to collect data relating to participants' experiences of their occupations during COVID-19 restrictions, hearing firsthand accounts of participants, who are "experts by experience" (Nayar & Stanley, 2024).

I developed an interview guide (Appendix D) in line with my epistemological position in which I view knowledge about occupation as most important. I used questions aimed to invite participants to provide more detail and tell the story of their experiences of the research topic (Flick, 2022). Interview questions included*:* "*How did the COVID-19 restrictions personally impact on your day-to-day activities?*", "*What access to meaningful activities did you have during COVID-19?*", "*Were there any positive impacts COVID-19 had on your activities?*". Further probing questions included: "*Can you tell me more about that*" or "*How did you feel when that happened?*".

The draft interview schedule was trialled with an occupational therapist working in the service to ensure the questions were appropriate and that it provoked participant thinking into the impacts COVID-19 had on day-to-day activities. Subsequently, a change to the interview schedule involved opening with a question about participants' occupational participation pre COVID-19 to help establish existing occupations and routines that may have been impacted.

At the beginning of each interview, I verbally explained to the participants their right to withdraw or stop the interview at any time, reminded participants how they did not have to answer a particular question if they did not feel comfortable, and explained how their confidentiality would be maintained. Participants answered brief demographic questions which captured age, gender, ethnicity, and the unit the participant was residing in during COVID-19 restrictions. From there, participants were asked semi-structured interview questions regarding their experiences of how COVID-19 impacted their occupations while living in a forensic mental health setting. Interviews lasted between 17 and 75 minutes.

Procedure

Advertisements (Appendix C) were placed on the community notice boards in the minimum-secure units with contact details for potential participants to use should they be interested in taking part. Participants could self-initiate contact directly with me via details provided on the advertisements within the units. Additionally, the consumer advisor and taurawhiri verbally presented the research opportunity at tāngata whai i te ora community meetings and made flyers (Appendix C) available. The purpose of using intermediaries was to avoid coercion via power imbalance relationships that might have been present between the researcher and the participants (Keogh & Daly, 2009). At these meetings, contact details (names and units) of potential participants who expressed interest in taking part were collected by the consumer advisor and taurawhiri. Following an expression of interest, potential participants were provided with a Participant Information Sheet (Appendix D) and Consent Form (Appendix B) by the consumer advisor or taurawhiri. They were able to take this information to their clinical teams or a trusted member of staff to discuss and obtain further information if needed.

The recruitment process took longer than initially anticipated. Advertisements went up in the minimum-secure units in early December 2022; however, public holidays and staff leave postponed intermediaries being able to present the research at tāngata whai i te ora community meetings before the end of 2022. There was initial heightened interest with four tāngata whai i te ora expressing interest within the first few weeks of 2023. These participants were interviewed at this time. A second drive of recruitment occurred in May-June 2023 with the remaining three interviews being carried out in July and August 2023. I stopped recruitment attempts at this point as the target population had already been approached multiple times and recruitment attempts felt exhausted without putting undue pressure on tāngata whai i te ora.

I carried out interviews between January 2023 and August 2023. Interviews took place in a dedicated private interview room within the participant's home unit (refer to Appendix E for Safety Protocol). I informed the nurse in charge where the interview was taking place and carried a duress alarm, as per usual service protocol. The

taurawhiri supported in arranging the times and locations for the interviews with the three Māori participants. Furthermore, the taurawhiri sat in on the first interview with a Māori participant. Following this first interview, the taurawhiri offered to the other two Māori participants to be present during the interviews; however, neither felt this was necessary.

Five of the participants were known to me from years previously crossing paths in group programmes or walking around the service. I introduced myself to the other two participants whom I had not met before and shared some information about myself and my role in the service. No participant was on my case load as outlined in the ethics application (refer to Ethics Approval, Appendix G). All interviews began with small talk about what participants were planning to do with their day or what they got up to on their weekend, to build rapport and set the scene and tone of the interview.

I took brief handwritten notes throughout each interview as a reminder of aspects that could be further clarified or explored when a natural pause arose. This was to avoid interrupting the participant. All interviews were audio recorded (with the participant's consent) using two separate devices in case there were any issues with recording during the interview. Otter.ai (Otter.ai, n.d), a transcription application, was used to record and transcribe the interviews. Following each interview, the transcripts were checked against the audio recording for accuracy and all identifying information was removed. Data from these transcripts formed the basis of this study. In the findings chapter, some data were edited to remove repetitive words or irrelevant information. This was done by replacing words with '…'. Furthermore, the use of square brackets […] were used to provide contextual information and the use of {…} were used to replace words to protect confidentiality. After two interviews I discussed the interview transcripts with my supervisor. Guidance was given as to ways to pose the questions and use probes to support participants to provide depth of information.

Analysis

Reflexive TA

Thorne (2016) stated the generation of new ideas from the data constructed is one of the most difficult yet important elements in what creates a credible ID study. ID requires an analytical process that encourages the researcher to look beyond the obvious and deconstruct what they think they see, test theories, and take ownership over the potential meaning and impact of the outcomes that they will ultimately produce as findings (Thorne, 2016). In ID, the intent of data analysis is in the space of thematic patterns and recurring ideas (Thorne, 2016). This is an active process of familiarisation, coding, sorting, and shifting attention between individual cases and the whole data set (Thorne, 2016). A vital aspect of ID research is that data collection and analysis are inductive (Thorne, 2016). Unlike deductive reasoning that begins with a hypothesis, inductive reasoning begins by exploring then confirming, and theories are the outcome of the process. Inductive reasoning involves forming conclusions from a limited set of observations (Woodwell, 2014).

There is an immense body of literature on numerous qualitative approaches and actions providing a depth of valuable possibilities in working with data so that patterns and relationships become evident (Thorne, 2016). One possible method is Braun and Clarke's (2022) reflexive TA, described as a flexible analytical method used broadly across health sciences that allows the researcher to analyse and develop themes across a qualitative dataset. There are multiple different approaches to TA depending on the methodology (Braun & Clarke, 2022). Reflexive TA was chosen to interpret the data in this study. In line with ID, the 'reflexivity' in reflexive TA required me to critically reflect on my assumptions and actions throughout the research process (Braun & Clarke, 2022). To support this process a journal was kept to record my reflections. The flexibility of TA allowed analysis to take the form of an inductive approach that captured both semantic (participant-driven, descriptive) and latent (researcher-driven, interpretive) codes and provided a clear framework for analysis that

guided me as a novice researcher. A taurawhiri member participated in analysis of the data alongside me and my supervisors

Phase 1: Familiarisation with the Data

In keeping with Thorne (2016), concurrent data collection and analysis occurred as I started my familiarisation process while still collecting data. Braun and Clarke (2022) identified familiarisation as the initial step in becoming fully immersed in the data to lay the foundation for a quality analysis. As I carried out the interviews, this created an opportunity for early familiarisation to occur. Immediately following each interview, audio recordings were listened to while checking these against transcripts produced using the Otter Application (Otter.ai, n.d). Thorne urges researchers, specifically those who are new to research, to participate in the transcription process as a way of familiarising themselves with the data. Audio recordings were listened to, and transcripts were re-read multiple times. Words, sentences, and phrases were highlighted, and familiarisation notes were made in the transcript margins. The interview recordings were then deleted from the Otter app to ensure confidentiality. Familiarisation notes and observations were synthesised into ideas for each individual participant and across the entire dataset.

Phase 2: Coding Process

The coding process requires the researcher to sort and organise data into a manageable product (Thorne, 2016). An inductive approach was primarily taken, as codes were data driven (Terry & Hayfield, 2021). However, aspects of deductive orientation occurred as I noticed connections to theoretical ideas, early in the process, and used these to code around such concepts (e.g., occupational disruption). Codes reflected aspects of data that related to the research question, with a focus on experiences of occupations during COVID-19 restrictions. Coding was done on a semantic to latent level spectrum, with both types of codes being used, and others somewhere in between (Braun & Clarke, 2022), in line with the reflexive TA approach.

Firstly, coding was undertaken manually by using highlighters and coloured pens to make notes on printed transcripts. Using these scribbled on transcripts as a guide, the comment function on Microsoft Word was used to transfer the codes on hard copy transcripts to electronic versions. This offered an opportunity to review data and refine codes more than once to ensure rigour (Braun & Clarke, 2022). Codes were labelled with short phrases that enabled me to recall a key point without needing to return to the original transcript such as "*missed the routine and structure work rehab provided*" and "*change in occupational balance*" (Terry & Hayfield, 2021). As the coding process advanced, I began assigning existing labels to different extracts of data as relevant. I tried to stay open minded by coding all the data that was potentially related to the research question as I did not know what themes might be developed down the track. Initially coding felt challenging, as I wondered if there was a 'right' or 'wrong' code for each data extract. Coding was done by both myself and primary supervisor together for one of the transcripts to provoke critical thinking and support rigour (Thorne, 2016).

The Microsoft Word codes were then transferred to Miro (n.d), an online collaborative whiteboard, using 'Thematic analysis coding management macro' (Babbage & Terry, 2023). Once in Miro, codes were organised for each participant (Appendix H). These codes formed the building blocks for the next analysis phase (Braun & Clarke, 2022).

Phase 3: Generating Initial Themes

Initial theme generation involved combining codes to create meaningful patterns from across the data set and exploring initial meaning patterns (Braun & Clarke, 2022). Miro (n.d) was used to manage the coded data sets. Digital 'post it' notes on Miro were moved to create links between the different codes by clustering similar codes together. Multiple iterations of clusters were trialled. I tried to avoid 'bucket themes', which are everything participants say about a certain topic collected together into a 'bucket' (typically derived from an interview question). Rather, the aim was to create patterns of shared meaning or codes that told a story about the data (e.g., tāngata whai i te ora

utilising previous experience and coping strategies as a way to get through the COVID-19 restrictions). Hard copy visual maps were drawn to identify patterns of meaning, and possible connections, interconnections, and disconnections between themes and subthemes (Braun & Clarke, 2022). From this process four candidate themes were generated.

Phase 4: Developing and Reviewing Themes

The theme development stage sought to present the most meaningful set of findings to answer the research question. Each theme had its own central organising concept, which united shared meanings across the data (e.g., theme one being organised around the sudden, unexpected loss to meaningful occupations and routines that participants experienced (such as work)) (Braun & Clarke, 2022). Reviewing themes was carried out at two levels (Terry & Hayfield, 2021). Firstly, the prototype themes were reviewed against the coded data and overall data set to ensure the developed prototype themes had not drifted too far into interpretation beyond what could be evidenced in the data. Secondly, prototype themes were considered for their value in answering the research question. Thorne (2016) encourages researchers to keep in mind the purpose of their research; therefore, I kept a page with my research question close by and returned to this frequently. Interview transcripts were re-read for essence, reflecting on their relation to the research question. Input was provided from supervisors to support in refinement of each theme.

Phase 5: Refining, Defining and Naming Themes

Themes are the ultimate analytical purpose in reflexive TA (Braun & Clarke, 2022). In this phase, themes were defined. A theme definition clarifies and illustrates what a theme is about and links it to the research question (Braun & Clarke, 2022). Theme definition can foster further refinement of themes and confirm that the developed themes have sufficient depth to tell the desired story. Once the themes were defined, names were given to describe the identified themes, grounded in participants' words;

for example, '*COVID came along and pulled the carpet*' (Participant 4) (Terry & Hayfield, 2021).

Phase 6: Writing up the Report

The last phase, writing up the report, is captured in Chapters Four and Five. Reflexive TA allows for flexibility in how the reports can be written, where the 'findings' and 'discussion' sections could be combined or separated. Braun and Clarke (2022) recommended separating these sections when the purpose of the research is to produce clear implications or recommendations for clinical practice. In line with an ID approach, this study will keep the findings and discussion separate (Thorne, 2016).

The writing of a TA report should provide a concise, clear, non-repetitive, and compelling account of the data (Braun & Clarke, 2022). This was done by introducing each theme name and description, followed by supporting evidence using data extracts analytically (Braun & Clarke, 2022). Interpretations were made through connections and similarities between participants and keeping interpretations as close to participants' accounts as possible (Terry & Hayfield, 2021). A key mantra in reflexive TA is that "data do not speak for themselves*"* (Braun & Clarke, 2022, 75). Therefore, it requires the final write-up to move beyond describing the data to analysing what it means in relation to the research question and why that is interesting and important. Further, the write-up of the discussion in this thesis then situates the analysis within the current literature, highlighting what it contributes to the body of work and to practice.

Trustworthiness

Steps and procedures need to be carried out to ensure there is a proper degree of credibility to both the ID research process and the outcome. It is the researcher's obligation to ensure that all claims made, based on the findings, have been analysed within the disciplinary logic and practice context of the audience for whom they are intended (Thorne, 2016). Lincoln and Guba (1985), proposed that the value of a research study is reinforced by its trustworthiness. Trustworthiness involves establishing credibility, confirmability, transferability, and dependability. However,

Thorne (2016), argued that there are more effective ways to consider achieving credibility when undertaking an ID study. These are epistemological integrity, representative credibility, analytical logic, and interpretive authority (Thorne, 2016). These four criteria will be defined and discussed in relation to the research.

Epistemological Integrity

It is an expectation that all qualitative research has a clear line of reasoning from the assumptions made about the epistemological views through to the methodological procedures by which choices about the research process are justified (Thorne, 2016). Therefore, for findings to be credible, the research process is obligated to show a research question that is congruent with the identified epistemological position, data sources, and processes that follow logically from that question (Thorne, 2016). Within this chapter I have explained my epistemological standpoint and considered how this relates to an ID methodology. I have carefully considered and discussed how the research question, data collection, and data analysis were informed by the key principles of ID, enhancing the credibility of this research.

Representative Credibility

Thorne (2016) described representative credibility as showing the theoretical claims of the study are consistent with the sampling and data methods. Representative credibility was attained in numerous ways in this study. Firstly, a purposive sampling method was used to recruit participants to represent the group of interest, based on them living within a minimum-secure unit during the COVID-19 restrictions. Consideration was given to participant gender, ethnicity, and the unit where they were residing to support variation in perspectives. Subsequently, prolonged engagement occurred through my employment within the forensic mental health setting where the research took place in their role as an occupational therapist and COVID-19 Lead. I had the opportunity to build trust and rapport with research participants, and understood nuances in their descriptions relating to the setting.

Analytical Logic

Analytical logic requires evidence that an inductive reasoning process has been made adequately visible throughout the report (Thorne, 2016). To promote transparency, an auditable trail of transcripts, coded data, and my reflexive journal were maintained. Examples are provided that illustrate the analytic process. Furthermore, reports were constructed that embed data extracts, incorporating a level of contextual detail to help the reader understand the significance of the data and assess my interpretations of them (Braun & Clarke, 2022).

Interpretive Authority

Finally, an assurance is required that the researcher's interpretations are trustworthy, and that they disclose a truth external to their own personal bias or experiences (Thorne, 2016). This can be achieved by building in systems to check interpretations against those of the research participants. Coding and theme development were carried out between myself and primary supervisor over several sessions, and supervisor feedback and further development of themes occurred in the process of drafting my findings chapter. The interpretations were given back to participants for feedback, as a way of establishing the fit between their views and the way they have been represented in the report, also known as member checking (Lincoln & Guba, 1985).

Tracking Reflection

Consistent with ID, I acknowledged the assumptions, theoretical orientations, and preconceptions I was bringing to the interpretation of the data by engaging in regular reflective processes (Thorne, 2016). Braun and Clarke (2022) stated that who you are and what you bring to the research shapes and informs your research and engagement with data. I kept a journal to record all my thoughts, questions, and ideas throughout the research process.

Ethical Considerations

Thorne (2016) discussed the fundamental principle of obtaining ethical approval as part of a process to ensure the research participants' best interests and needs are respected. The research proposal received approval from the ARFPS taurawhiri group (Appendix I) and ARFPS Research Forum group. Locality sign off was obtained from the ARFPS Clinical Director and Group Manager (Appendix J), Te Whatu Ora Waitematā District Research and Knowledge Centre (Appendix K), as well as AUT (Appendix L).

An ethics proposal was developed for this research project considering and addressing relevant ethical considerations. Ethical approval for this study was granted through Auckland University of Technology Ethics Committee on October 3rd, 2022 (AUTEC reference number 22/259) (Appendix G).

Informed Consent

All tāngata whai i te ora participants involved in the study are under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and/or the Criminal Procedure (Mentally Impaired Persons) Act 2003. Tāngata whai i te ora are detained and treated involuntarily and represent a particularly vulnerable population; therefore, AUT ethics approval was important. However, not including 'vulnerable populations' in research would mean overlooking those whom occupational therapists most need to understand and serve (Sieber, 2013). Ensuring informed consent was, therefore, of particular importance (Keogh & Daly, 2009). Consideration was given to ways in which the research population could be considered vulnerable and how their vulnerability could be minimised.

Within the exclusion criteria, participants were required to have a stable mental state. Participants' RC or keyworker were required to sign the consent form to confirm the participant was well enough to participate in the research prior to the interview commencing (Appendix B). This was to ensure the participant was able to make an informed judgement regarding their decision to participate (Keogh & Daly, 2009).

Participation in the study was voluntary. Participants could self-initiate expressions of interest and there were no obligations for them to participate. Prior to engaging in the research, all participants were sent a participant information sheet (Appendix D) and a consent form (Appendix B). These documents outlined vital information regarding the study such as the purpose of the research, how the participants' interview data would be used, who they could contact if they had any further questions, and how their privacy and confidentiality would be maintained. Participants were encouraged to discuss involvement with a trusted member of staff. Participants were fully informed about the nature of the study and that their involvement or decisions to withdraw at any stage would not impact on clinical decisions, or care and treatment planning.

At the beginning of each interview the research aims were re-stated, the participants were reminded of their right to withdraw their consent to participate at any time, and verbal consent to have their interview audio recorded was obtained. Revisiting information and consent at multiple points ensured consent remained informed (Thorne, 2016), an important consideration given some participants may have needed support with understanding and remembering information (Keogh & Daly, 2009). All participants had the opportunity to ask questions and were required to sign and return the consent form prior to commencing their interview.

Participant Confidentiality

The identity of each research participant is only known to myself, the supervisors and the RC or keyworker who signed the consent form for individual participants. However, there is a chance a staff member reading the findings may be able to inadvertently identify a participant due to the nature of the service. Service protocols require staff on the unit to be notified of meetings taking place in the unit, as per usual safety protocols. Mitigating steps were taken to best protect the participants, such as participant identifiers used in place of names to protect participants' identities in the coding and

writing phase of the research. All identifiable information were removed in the transcript development stage of the process.

Privacy was maintained during the interviews by using a private meeting room within the unit where conversations could not be overheard. There are no audio or visual recordings placed by the service on site. The only recording devices were the ones used by me to audio record each interview. I transcribed the recordings myself with support from the Otter AI application and, once transcriptions were checked, recordings were deleted from devices and the app. All steps were taken to maintain confidentiality, but this could not be guaranteed. This was made explicit in the participant information sheet (Appendix D).

Te Tiriti o Waitangi

Hudson et al. (2010) stated that "All research in New Zealand is of interest to Māori, and research which includes Māori is of paramount importance to Māori" (p.1). While this research did not specifically target Māori participants, the purposive sampling method within the Kaupapa Māori minimum-secure unit recruited three Māori participants. The purpose of the study valued the voices of those who were currently using the service to inform and improve services. I worked with participants by engaging in a mutual sharing of information during the interview process. To keep true to the principles of te Tiriti o Waitangi[8], I used the Te Ara Tika Guidelines for Māori Research Ethics tikanga[9] based framework to guide how ethical issues were addressed (Hudson et al., 2010).

[8] Te Tiriti o Waitangi (in English, the Treaty of Waitangi), Aotearoa New Zealand's founding document (Te Rua Mahara o te Kāwanatanga Archives New Zealand, 2024).
[9] (Noun) correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention, protocol – the customary system of values and practices that have developed over time and are deeply embedded in the social context (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

Te Ara Tika Guidelines for Māori Research Ethics

Whakapapa (Relationships).

Within the context regarding decision making about ethics, whakapapa refers to the quality of relationships and the structures or processes that have been put in place to uphold these relationships (Hudson et al., 2010). During the development stages of the research proposal, I consulted with the taurawhiri group to present the proposed research concept. The development of these meaningful relationships and consultation processes with the services' taurawhiri helped to ensure there was opportunity for constructive critique of the study and its potential impact on Māori (Hudson et al., 2010). A letter of support was given from the taurawhiri group stating the research meets te Tiriti o Waitangi obligations (Appendix I). A 1-page written report on the research findings was presented back to the group at the end.

Tika (Research Design).

Tika refers to the validity of the research proposal (Hudson et al., 2010). I worked in partnership with one of the taurawhiri group members, who worked as a Māori advisor throughout the research project and supported the me in the design and delivery of the research. He offered support to participants of Māori whakapapa in their decision to participate or not, and offered to be present for their interviews. The taurawhiri participated in analysis of the data alongside myself and the supervisors. Furthermore, they were acknowledged and engaged in the dissemination of results, including the writing of a journal article.

Manaakitanga (Cultural and Social Responsibility).

Within the research context, manaakitanga is related with concept of cultural and social responsibility and respect for people (Hudson et al., 2010). Ensuring participants had access to appropriate advice (taurawhiri) and that their privacy and confidentiality would be respected was vital. Interviews were carried out in private meeting rooms and all identifiable information were removed from transcripts and data. The use of Māori protocols for data collection was done through face-to-face interviews, thereby

maintaining the Māori tikanga of 'kanohi ki te kanohi'[10]. Included as part of tikanga was the offer to start and close the interview with karakia[11] (Hudson et al., 2010).

Mana (Justice and Equity).

Taurawhiri were collaborated with in the design and delivery of the participant information sheet to ensure it was clear and culturally safe, and that any potential risks were highlighted. As a way of upholding mana, a koha[12] voucher was provided to participants to acknowledge their contribution and reciprocity of benefits as a result of the research. Hard copies of the finalised transcripts were offered to participants to keep. This recommendation was made by the taurawhiri to ensure that this information is available to future generations, and acknowledge the power of speech and stories of ancestors.

Summary

This chapter has provided the reasoning for choosing ID as the research methodology. It included a summary of the methodological and theoretical foundations of the research design and methods used for recruitment, data collection and analysis. The chapter described aspects of academic rigour that were employed to address my biases and establish trustworthiness during the research process. It concluded with ethical considerations. The outcomes of this completed research process are described in Chapters Four and Five which explore how tāngata whai i te ora experienced their occupations within a forensic mental health setting and situating data within the current body of knowledge.

[10] "(Stative) face to face, in person, in the flesh" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).
[11] "(Verb) (-tia) to recite ritual chants, say grace, pray, recite a prayer, chant Te Aka Māori Dictionary" (www.maoridictionary.co.nz).
[12] "(Noun) gift, present, offering, donation, contribution – especially one maintaining social relationships and has connotations of reciprocity" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

Chapter Four: Findings

This chapter presents the research findings. Initially, I outline the demographic characteristics of the seven participants and the results of the research. Next, I present and explain the four themes that were constructed from the data. The themes convey tāngata whai i te ora experiences of their occupations during COVID-19 restrictions in a forensic mental health setting.

Description of Participants

The three minimum-secure units across the ARFPS were approached for potential participants. Of the nine tāngata whai i te ora who originally expressed interest, two withdrew after reviewing the participant information sheet. Seven participants were successfully recruited and gave informed consent to participate in the research. There were participants from all three of the minimum-secure units. Some participants had progressed through to the open hostel or community by the time interviews took place. General demographic characteristics of the participants are summarised in Table 3. Details are limited in order to support confidentiality.

Table 3.

Demographic Details of Participants

Participant Demographic Details	**n = 7**
Participant Age	
18-29 years	0
30-39 years	2
40-49 years	4
50-59 years	1
60 years and over	0
Gender	
Female	0
Male	7
Another gender	0
Ethnicity	
Māori	3
New Zealand European	2
Pacific Islander	1
Asian	1
Other	0

Introduction

Four themes were constructed in this study portraying tāngata whai i te ora experiences of their occupations during the COVID-19 restrictions in a forensic mental health setting. The first, *COVID Came Along and Pulled the Carpet*, captures how tāngata whai i te ora experienced disruption in their daily occupations due to the suddenly imposed COVID-19 restrictions. The second, *The Layers Upon Layers of Restrictions*, illustrates how participants felt about the restrictive aspects of forensic mental health service operationalisation and how they contributed to the occupational participation challenges during COVID-19 restrictions. The third, *Keeping the Vibes Going on the Unit*, portrays the experience of kind gestures and support from others that enabled occupational participation to occur, and that kept spirits up during the COVID-19 restrictions. The fourth, *A Learning Experience*, illustrates the learning that facilitated understanding the rationale and impacts of the COVID-19 restrictions that subsequently supported coping during this time.

These themes are presented in an order that best reflects the unfolding experience of COVID-19 restrictions over time. Each theme is introduced and explained, outlining the central organising concept (Braun & Clarke, 2022). Subthemes are then presented, with explanations of their meaning and showing their relationship to the theme and variations. Data extracts from participants are provided to illustrate the essence of the themes, convey interpretations of the themes in the participants' own words, and support the findings. These quoted extracts are provided in italics, and are identified by the participant number, also in italics. The four themes and subthemes are summarised in Table 4. A summary of findings concludes the chapter.

Table 4.

Themes and Subthemes

Theme	Subtheme
COVID Came Along and Pulled the Carpet	One Step Forward, Two Steps Back Missing Out Torn Connections
The Layers Upon Layers of Restrictions	Blanket Rules Enforced Protection Layers Delay in Lifting Restrictions
Keeping the Vibes Going on the Unit	Laying Low – A Break from Usual Expectations The Staff Did a Really Good Job Bonding Over a Shared Experience
A Learning Experience	Understanding the Reasons Why Tāngata Whai i Te Ora as the Pros

Theme One: COVID Came Along and Pulled the Carpet

You weren't able to see your family; you weren't able to do other things. That's when you sort of got a little bit like, kind of upset, you know (Participant 7). Within the service, without warning, COVID-19 upended the foundations of people's lives. It suddenly, and completely, changed the way tāngata whai i te ora were going about their daily activities. It changed what, when, where, with whom occupations were participated in. This theme encompasses the setbacks, frustration, loss, disappointment, worry, and uncertainty tāngata whai i te ora felt when COVID-19 and the subsequent restrictions came along and unexpectedly pulled the carpet on everyday life. This theme is comprised of three subthemes: O*ne Step Forward, Two Steps Back*, *Missing Out*, and *Torn Connections.*

Subtheme One: One Step Forward, Two Steps Back

When the COVID-19 outbreak occurred and restrictions were implemented, everything that underpinned tāngata whai i te ora lives was abruptly thrown off balance. There were fewer freedoms and more organisational controls exerted over their lives than they had experienced previously. Moving forward in the service typically equated to more independent liberties; however, with the rapid onset of COVID-19 restrictions, they were compelled to take a step back from the typical independence that came with that move. Tāngata whai i te ora felt they were no longer progressing. They were

incrementally moving backwards rather than forwards. This was disheartening and disappointing, an emotion felt by all tāngata whai i te ora, as they were previously pushing forward with their recovery journey, only to be dragged back by the COVID-19 restrictions.

Tāngata whai i te ora shared how they had worked hard to get their leave privileges prior to COVID-19; "*it took me a while to get my leave status up*" *(Participant 6).* Working their way towards unescorted leave was perceived by tāngata whai i te ora as something they had earned. The privilege of having unescorted leaves was knocked over by the COVID-19 restrictions. The process of earning leave usually takes months or, in some cases, years, and resulted in feelings of disappointment and frustration when unescorted leaves were halted.

> *So, as it started progressing through the motion of things, through the motions of COVID, they* [staff] *kind of sort of started restricting us, so we they come to us and said, "hey look, because of what's going on now yous ain't allowed to go up into {community} at this time because of this". And so, so we did lose our leaves for a while there. (Participant 7)*

Having the freedom of community leave had provided an "*opportunity to get off the unit*" *(Participant 1)* and contributed to making living in a forensic mental health service "*easier*" *(Participant 1)*. The opportunity to step forward out of the units and out of the physical secure hospital environment, had meant tāngata whai i te ora were able to take part in valued activities and roles, and move forward in their journeys. Tāngata whai i te ora recounted their previously busy schedules and how they had been participating in lots of activities during their week prior to COVID-19. This was suddenly upended. Tāngata whai i te ora shared how things regressed. They were no longer able to go to the library, get takeaway meals, meet friends and family, go for a run, or attend education courses and work rehabilitation.

> *I had a lot of groups. I was going to yoga, I was going to work 2-days a week, maybe some craft time and then going up the road to {community}, going home for the day, taking the train, going to {community} to get something to eat with somebody, with a friend. And then just other groups... not being able to go out of the unit was quite a drawback. (Participant 2)*

Tāngata whai i te ora highlighted how they felt they were precluded from opportunities for meaningful participation once restrictions were implemented and felt it was a disadvantage to their progress when this stopped. It was a setback being confined to an enclosed space once again as "*there wasn't as much freedom to do what you want to do*" *(Participant 2).* Being unable to leave their physical environment in the same way they could pre COVID-19 suddenly jerked the tāngata whai i te ora backwards into a time when they did not have leaves and were in higher secure units with fewer liberties.

Tāngata whai i te ora recounted negative experiences when access to valued community-based activities was taken away, drawing them back within confines. They were left feeling agitated by being held back in the unit due to the removal of leaves, unable to freely access their typical activities that helped alleviate stress and boredom. "*I feel a bit stir crazy you know and without the kind of outlet... I couldn't leave the unit so was just stuck in there all day*". *(Participant 3)* This sentiment was shared by Participant 4, who expressed that without leaves their well-being might destabilise, jeopardising their mental state and meaning a move back to a higher secure unit. Progress in their mental well-being was at risk, thwarted by the COVID-19 restrictions. Their journey forwards were halted.

> *I was going out a lot more. When the first lockdown came, they* [staff] *were quite concerned about me because they saw over the last 2 or 3-years before in {service} that I basically needed my outings in the morning for a coffee hit and stuff and walking. (Participant 4)*

After the COVID-19 onset, tāngata whai i te ora described experiencing a lack of privacy from staff during escorted offsite family visits, which felt uncomfortable and impacted on meaningful, quality time with family. While escorted visits were a step forward towards a return of face-to-face family visits, they were a step backwards in independence and privacy for tāngata whai i te ora.

> *I think it was because they weren't allowed to come in… so the staff had to take me to I think it was a {community} park. But we were allowed to walk around the park they* [staff] *just had to keep an eye on us. But even that wasn't that great because there had to be someone there with me and we only have a certain*

amount of time. So, it just felt like we couldn't really enjoy it as much. (Participant 2)

A sense of being one step forward and two steps back also related to the feelings tāngata whai i te ora had when self-catering was stopped. The opportunity for self-catering was something tāngata whai i te ora had been excitedly anticipating as they progressed through the service as it signalled a move towards independent, community living. The return to hospital food felt disorientating. The experience of the more independent unit, that was a rite of passage in their rehabilitation journey, was taken away.

When I was in {unit}, we had to go back on to {service} meals. It made my experience at {unit} a little bit around the wrong way. I didn't fully learn what {unit} was about… And I just thought that I missed the meals [self-catering] *like I was, you know, looking forward to cooking my meals and then we went back to {service} meals, so that wasn't great. (Participant 4)*

The sudden removal of groups caused tāngata whai i te ora to feel "*isolated*" *(Participant 5)*, "*a little bit angry... just mainly sad, depressed*" *(Participant 6)*, and "*concerned*" *(Participant 7)*. When asked about group programmes Participant 6 stated: "*I like the groups because it gives me something to do, optimise my time and we learn a lot*". From these examples it is clear how tāngata whai i te ora felt aggrieved over stepping back from activities that they appreciated such as cooking, craft, and exercise groups.

I mean, any group that gets taken away is never nice if you know what I mean. Especially if it's a group you're enjoying. Two steps forward one step back, one step forward ya know. (Participant 4)

When living in a forensic mental health unit, time can feel slow, like you are not moving forward with your life after the sudden upheaval of being admitted to a forensic mental health service. Multiple tāngata whai i te ora discussed this notion, expressing their disappointment and worry with how the sudden disruption to groups might impact their progress through the service, potentially stalling their move into the community and their ability to participate in future meaningful roles and activities. Tāngata whai i te ora were upset that the work they had been putting in, advancing them towards future

employment opportunities, was suddenly halted. Working towards employment opportunities, tāngata whai i te ora had been envisioning their future where they would be contributing to and participating in their community in a meaningful way.

> *The coffee cart was suspended over COVID. That was a bit of a let-down… Just rubbing shoulders with people in a shopping situation, like a barista. It's good for our CV, it's good if I want to be a barista later on down the track. It's a good training experience to teach us the protocols of making coffee and serving customers... And then COVID came along and sort of, pulled the carpet. (Participant 4)*

Another person talked of being part of the kapa haka[13] group, takings steps forward to reconnect with their identity and culture on their pathway to their future self. Being unable to continue this journey, knocked them off course in their progress and caused worry and disappointment.

> *Because you want to keep on sort of learning. So, it was kinda like, you felt a little bit, you know, concerned that you weren't able to do your courses and stuff like that… Because it's like my pathway and that's where I want to be later on, like going back to my, back to my Māori Kaupapa side of things. So kapa haka means quite a lot to me. It's part of my culture, and it's a part of my makeup and a part of my recovery journey. Where I want to be later on in life, and that's what I'm going back to, so it's like just part of one part of my culture. (Participant 7)*

Subtheme Two: Missing Out

The unexpected removal of access and opportunity to participate in meaningful activities left a void. Tāngata whai i te ora were no longer able to go to visit family, go to work or the gym, or partake in other important activities. Time in the unit felt dull and tedious. No longer did they have the option for more interesting activities, resulting in deleterious impacts on their emotions, undermining their quality of life.

> *There wasn't much to look forward to which can be quite debilitating when you've got nothing to look forward to ...it can be quite boring. It's nice to have a little bit of something to look forward to each day… Sometimes in the COVID especially in {unit} could be quite bland. (Participant 4)*

[13] "Kapa haka group traditional Māori dance/action group" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

Being unable to continue attending work left a gap in tāngata whai i te ora time. Suddenly, an activity that provided the foundation to their week was taken away. The meaningful reason to get out of bed in the mornings, gone.

> *I think it just impacted the kind of structure that you have in the week. Going to work is good because it motivates you and helps you get up in the morning. Gets you a little pocket money. And it's good. It looks good on your CV and stuff like that. Yeah, I don't mind it, going to work… I kind of missed it a little bit… Having that structure in my week. (Participant 2)*

Tāngata whai i te ora felt upset they missed out on fulfilling other meaningful roles in their lives such as being a worker and a community member. They were missing out on opportunities to develop skills that support their rehabilitation and community reintegration journeys, unable to experience the step out from the stark, sterile hospital environment to a more naturalistic space that felt "*safe*" *(Participant 4)*.

Tāngata whai i te ora recounted a sense of nostalgia for important events and traditions that they were precluded from attending during the COVID-19 restrictions. Being separated from whānau during special events such as birthdays and Christmas was upsetting for tāngata whai i te ora. "*Like on my birthday, I couldn't meet up with my dad, it really sucked*" *(Participant 3).* Attending these events was a connection to home, to traditions and activities from life before they had been admitted to hospital. Unable to share in these festivities threw off balance the typical meaning and experiences of these important occasions.

> *It meant that I couldn't even go home for Christmas that year. My parents came to see me, but it was really brief. It was like 40 minutes, you know. I couldn't go home, you know. I couldn't celebrate with family. Other family as well, cousins and stuff like that… I just felt maybe a bit disappointed. (Participant 2)*

Further feelings of loss were experienced by tāngata whai i te ora when the unit-wide morning karakia and check in were cancelled. This disrupted tāngata whai i te ora usual morning routines and sense of equilibrium in their preparations for the day. Being unable to do this as a collective, and being separated from their peers, left feelings of disappointment and unhappiness. They were missing out on connecting with others over daily rituals and shared plans.

> *At around 8 o'clock in the morning, we kind of go into the whare[14] where we come together, and we have a karakia process. We do waiata[15], and then we do a round of ...what each and every individual's plan is for the day… that made me a little bit like, feel a bit sad …missing my karakia …that's kind of a part of the day where you are able to like, just get in the vibe for the day… But I was doing it by myself in my room. But, it's even better when you've got a group of people sort of vibing in that same channel and then sort of keeping on the same Kaupapa[16] for the day (Participant 7).*

Making choices about what, when, and where one eats is a novelty in a forensic mental health service, "*I love cooking... it's nice to be able to choose what you're going to eat that night rather than eating what's put in front of you*" *(Participant 4)*. Tāngata whai i te ora experienced a sense of sadness and dissatisfaction when this was taken away. The opportunity for choice, social connection, skill development and enjoyable meals was upended.

> *Oh, I missed it, because I loved doing devilled sausages and things like that, curries and things, learning how to cook, some guys teach me how to cook and all that, that's how I missed it. But I loved spending money, spending is kind of fun. ...I think it might have been the first time in history {unit} has ever had to have hospital food. (Participant 2)*

Subtheme Three: Torn Connections

Tāngata whai i te ora were left feeling saddened without their usual supports that held them up during their time in hospital. They described feeling "*pretty sad, sad I couldn't go visit*" *(Participant 5)*, "*I couldn't meet up with him [dad], it really sucked "(Participant 3).* This disappointment and struggle of being further separated from whānau was a focal point of importance for tāngata whai i te ora.

> *To be honest with you, quite difficult, because I'm very used to seeing Mum. Yeah, I'm quite attached to my mother as well. She has been a really good support for me. So, I did struggle a little bit in that area, I have to admit.... it's one of the things that I really look forward to. (Participant 1)*

[14] "(Noun) house, building, residence, dwelling, shed, hut, habitation" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).
[15] "(Verb) (-hia,-tia) to sing" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).
[16] "(Noun) topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

The experience of being disconnected from stabilising people in their lives took an emotional toll. Their usual, regular catch ups unexpectedly were pulled away. They were distanced from their connections, unable to keep up with events in whānau lives.

> *So, like, go out for lunch and stuff like that and catch up, depending if there was a doctor's meeting, a family meeting, or anything. But mainly it's just to catch up and catch up with where everyone's at. Like where my kids are at what they're doing and stuff like that and just like a good, just a good feedback time just to see how things are going on in the family. (Participant 7)*

An interesting perspective from all three of the Māori tāngata whai i te ora was the torn, internal feeling of missing their whānau and wanting to see them; however, also holding concern for their whānau well-being and wanting to protect them from illness they could potentially be exposed to by visiting the units in person. In response to their perspectives towards the cancellation of onsite face-to-face visits, tāngata whai i te ora said, "*I was worried about my whānau to see whether they were doing alright*" *(Participant 5)*, "*Not really, I thought they might catch it*" (*Participant 6).* The unexpected need to balance whānau connection against health was a dilemma. Suddenly, they felt anxious and worried about visits, rattled by the fear of COVID-19 infection.

> *But what concerned me at that time was because my mum being old now and she's got asthma and a medical condition, too. I thought oh man, I hope she's going to be okay. I sort of thought more about my family than myself when I was thinking. Just knowing family were okay around the time that, that was a biggie for me (Participant 7).*

Theme Two: The Layers Upon Layers of Restriction

When living in a forensic mental health service, tāngata whai i te ora experience restrictions in their everyday lives due to the policies and procedures imposed from an individual, legal, or institutional security perspective to manage risk. COVID-19 infection control added further layers of restrictions. Theme two conveys the burden of the multiple barriers to participation in their daily activities experienced by tāngata whai i te ora during COVID-19, which left them feeling frustrated, dependent, and unhappy. This theme contains three subthemes: *Blanket Rules Enforced*, *Protection Layers*, and *Delays in Lifting Layers of Restrictions*.

Subtheme One: Blanket Rules Enforced

Tāngata whai i te ora felt restricted and over-controlled when rules to regulate phone access to contact whānau were stringently followed while face-to-face visits were cancelled.

> *The problematic thing with the phone calls is you've got a maximum of 10 minutes. And just you know, by the time you pick the phone up and you feel you're talking, but you know, 10 minutes, it's pretty quick. So, by the time you have to hang up because obviously, you can't keep the, you know, the phone. Because other patients want to make calls. Yeah. So, staff are pretty strict around that. And they're monitoring that... yeah, there was a monitoring. (Participant 1)*

This level of micromanagement frustrated tāngata whai i te ora. There did not appear to be any flexibility with the schedule, "*we had a system ... where we had designated times for phones*" *(Participant 7).* Allocated time felt too short to be able to have a meaningful conversation with whānau. The cumulative rules and surveillance systems impacted the connection and support typically garnered from whānau at a time when they needed it the most; a time when they were unable to meet in person under COVID-19 restrictions.

In comparison, some tāngata whai i te ora felt empowered to make decisions about how and when they connected with whānau during COVID-19 restrictions when residing in a less secure unit that allowed personal cell phones to be held. They experienced the way cell phones enabled regular, uncomplicated contact with whānau. Not being constrained by unit resources or multiple blanket rules meant more freedom and autonomy.

> *I think I just talked to them via the unit phone because we weren't allowed to have phones on us while we're in that unit… So, it was only when I got to {ward} that we can keep the phone on us… You can video chat plus you can do it anytime you want, you know... you don't have to mess around a bit it just feels easier to access. (Participant 2)*

An upsetting experience of losing access to gaming and other electronic devices, when another tāngata whai i te ora reportedly broke some rules, felt unreasonable and disappointing. Tāngata whai i te ora felt they were being punished for someone else's actions. These additional restrictions and rules exacerbated

feelings of boredom during COVID-19 and highlighted the unfair way blanket rules were imposed.

> *I just remember that we lost our mp3 and our laptops and things like that. And it just didn't feel fair because it had nothing to do with you. But then you had to pay the price for someone else's mistakes... especially as there was nothing to do... That's the way it works, I guess. (Participant 2)*

Another experience of irritation was felt when it became a "*mission*" *(Participant 3)* for tāngata whai i te ora to continue participation in their studies. They became reliant on staff to support them with printing course content and accessing the internet within the units. This reliance was due to technology-based policies and COVID-19 restrictions, which prevented them from doing these tasks in the community. Having another step to follow and another layer of permission to gain in these usually independent activities created further barriers to navigate during COVID-19.

> *I had limited access to a computer and limited access to like printing out things. I didn't have my own Wi Fi so had to use the ward computer. It was really frustrating. (Participant 3)*

Tāngata whai i te ora felt confused when they were required to wear a mask while on their online Zoom class for university studies while in their 'home' unit. It signified the added layers of imposed protocols tāngata whai i te ora were required to adhere to in a new COVID-19 world, to be able to continue participation in their studies. This was yet another requirement expected of them.

> *Yeah… it was quite different because I still had to wear a mask and people weren't wearing masks. I was like, oh well. But... it was what it was aye. Yeah, it was a different experience. But now that I reflect back on it, you know it was what it was at the time. And those were the steps you had to take you know. (Participant 7).*

Tāngata whai i te ora were 'bothered' by having to wear a mask while at 'home' when other class members were not. The protective layers placed on tāngata whai i te ora would not typically be expected in the community. Although tāngata whai i te ora were resigned to the layers, they threw into focus the divide between them and the community.

Subtheme Two: COVID-19 Infection Protection Layers

An additional infection protection layer required tāngata whai i te ora to transfer to an isolation area after they had been diagnosed with COVID-19; "*I didn't really want to go there but it was for the safety of the other patients that didn't have COVID*" *(Participant 6).* Not only did they need to worry about themselves, but also their peers. It was an extra burden of responsibility and consideration for them to carry while they had COVID-19.

Tāngata whai i te ora described the COVID-19 isolation area as uncomfortable, lonely, and an unpleasant experience. It was a place that felt stark and sterile, that lacked consolation. Being in COVID-19 isolation was not unlike being in seclusion, where they were unable to leave, confined under the controlling restraints of the physical environment, and held there against their will. "*Well, it's a bit of a difference from seclusion to the open area... it felt very discomforting really. It just felt like we were locked in one place for a while. It made me feel sad*" *(Participant 6).*

COVID-19 isolation felt punishing. The rooms felt unhomely and were not an ideal space for recovery from COVID-19 illness. Like seclusion, tāngata whai i te ora did not have access to most of their personal belongings, limiting options of things to do or comforts at a time of need. They were alone and restricted in social interaction. COVID-19 isolation did not provide the holistic care they desired.

> *It was just completely deserted and there was no one there, which is quite poor. But I was the only patient there. I spent 13 and a half days there, and every night was incredibly cold, incredibly cold, and it was just not a very nice environment when you've got COVID, to just be isolated in a room and yeah, yeah, it wasn't, it wasn't very pleasant... it was like a lack of, lack of um, care.... {ward} was not equipped to treat COVID-19... There was just, there's just like being in a holding cell. (Participant 4)*

> *The beds were on the floor. So, I found that really uncomfortable... There is a DVD player there... There was a little Gameboy as well. But I didn't really play it. I'm not really into games (Participant 5)*

The effort tāngata whai i te ora had invested in escaping the burden of heavier restrictions, advancing through the service to a place where they enjoyed greater freedoms, left them feeling vulnerable. They perceived they were at risk of reverting to

a state with more limitations should they fail to comply with staff requests. This burden was revealed by in the following statement:

> *I was being pressurised for a COVID-19 vaccine, that I did not want to take, and I felt a little bit forced into it, and sort of saying "if you don't have a vaccination jab you may not be able to stay at {ward} for that time". So, I just bit my tongue and swallowed humble pie and went along with the nurse and got a vax. ...And that was the time that I thought to myself that I'm not going to ruin all this hard work that I put in … over something like that. I wasn't going to sabotage my hard work... yeah, it wasn't very pleasant to have to be forced when I didn't want to take that… I just felt a little bit offended that I was forced to take a jab that was my choice. I didn't want to take it. (Participant 4)*

Here, Participant 4 attempted to navigate a world where restrictive measures could be employed against them. It highlights the coercive actions and authority that staff can wield over tāngata whai i te ora. Such a level of constraint compromises medical autonomy. COVID-19 PHMS was used to impose greater control over tāngata whai i te ora.

Subtheme Three: Delay in Lifting Layers of Restrictions

Tāngata whai i te ora were left feeling disheartened and cheated when the service entered additional levels of restrictions longer than the community COVID-19 Frameworks and Alert Levels that were implemented by the Aotearoa New Zealand Government.

> *They [staff] were allowed to go out now. And we were still stuck to having these walks… I felt pretty bad about it really, felt like it was quite restricted, too restricted maybe…. And they're* [staff] *just was telling me you know, I couldn't do this. I couldn't do that. Or they will be like, "oh in the community we're allowed to do this and that"… I believed it, like you know, when they say things like that made me just feel a bit like, I was missing out a bit ...Maybe you felt like it was a bit unfair…. wasn't really much I could do about it. I think that they should have gave us less restrictions when it was orange light, I think when it turned orange {service} was holding on to the red lights a lot longer than they should have. (Participant 2)*

Tāngata whai i te ora felt envious of those living in the community being able to participate in different activities that they could not, due to the service clinging on to higher COVID-19 measures. There was a lack of balance between restrictions and freedoms. It was perceived as being unjust. Failure to move the restrictions away emphasised to tāngata whai i te ora the absence of choice and sense of control they

had over their lives, "*I would have liked to be able to go for a run, you know. There was no reason why I couldn't, it was just stupid rule*" *(Participant 3).* The service making decisions for them left tāngata whai i te ora feeling further separated from life in the community, distanced by compounding bureaucratic red tape.

Theme Three: Keeping the Vibes Going on the Unit

Despite the feelings of loss, frustration, and worry during the COVID-19 restrictions, there were positive outcomes as a result of an increase in free time. This free time enabled restoration and social connection to occur. In addition, supportive actions from staff created an upbeat mood amongst the tāngata whai i te ora.

> *The staff are quite understanding. They* [staff] *came they...did nice things for us. Like bake an apple pie, got some got some ice creams, little things like that. Keeps the vibes going. (Participant 2)*

Theme three conveys how these occurrences kept spirits up, fostered connection amongst the tāngata whai i te ora, and enabled occupational participation to occur. It was perceived as filling the void left behind by the loss of other meaningful activities. Theme three encompasses three subthemes: *Time to Kick Back and Relax*, *The Staff Did a Really Good Job*, and *Bonding Over a Shared Experience.*

Subtheme 1: Time to Kick Back and Relax

The atmosphere had changed on the unit with the onset of COVID-19 restrictions. No longer were psychoeducation groups or other rehabilitation activities the priority for the day. At times, these groups were perceived as 'work' or an expectation that needed to be faced. Tāngata whai i te ora felt appreciative of this shift in energy.

> *To be fair, it was it was quite nice sometimes to not have to do what I was doing before. It was quite nice to have free time. I know that sounds weird, but it was quite nice that I didn't have to, you know, front up sometimes, I could just lay low, and it felt quite easy and relaxing on me. I don't know if that sounds weird. But yeah, it was nice that I didn't have to, you know, as I said, front up… I could just go underneath the radar. (Participant 4)*

There was a more relaxed mood in the unit. A respite from usual responsibilities, "*it actually felt good that we were able to get a rest… the rest was*

good" *(Participant 7).* The down time felt positive, a much-needed break from the reality of usual day-to-day life in a mental health unit. It was an opportunity for restorative time to keep up energy, enthusiasm, and motivation, and ready oneself for other activities once COVID-19 restrictions were lifted.

> *It's just a good time just ... to relax and kick back because, you know, if your days are busy, you don't really get that opportunity just to lie back so I found like the first couple of days was just like real just kick back and relax and catch up on sleep. And you know, it was it was good sometimes you need that you know, just to relax. (Participant 7)*

Tāngata whai i te ora enjoyed utilising this change in pace to do the things they enjoyed. It was a meaningful time during which they could choose their activities freely, unlike the usual, enforced engagement in activities not of their choosing.

> *Reading a book or doing a puzzle or something like that. Talking with other people on the unit, just congregating and stuff like that. When I was in {ward} we had movie night, movie days and yeah. Maybe watch some guys play some XBox or something. (Participant 2)*

> *Crosswords and stuff... Oh, so, it's just relaxing for me. It's a good way to learn vocabulary and just listen to music on top of it, which is nice. Have my stereo on, doing crosswords, it's quite cool. (Participant 4)*

Subtheme 2: The Staff Did a Really Good Job

Tāngata whai i te ora described the staff as "*doing a really good job to engage the patients*" *(Participant 1)* and provide positive experiences and opportunities through a tough time; a time when usual routines and activities were halted. The staff were perceived as generous in providing enjoyable snacks. Staff were also generous in their time by participating in fun activities with the tāngata whai i te ora.

> *The staff were trying to engage all the patients so that, you know, they'd have more to do. It wasn't just sort of chess and scrabble; it was other things. Like they used to play card games and things like that with the patients… Because like, for example, there are patients that had work, {Work Rehab} & {Work Rehab}, and they weren't allowed to go there. So, they had to do something with the time. (Participant 1)*

The staff actively contributed to sustaining a positive mood on the unit. Tāngata whai i te ora felt the variety of activities that were offered provided a sense of choice when few other activities were available. "*I think they created a few more groups and*

made a few more things available" *(Participant 4),* They maintained a sense of busyness which kept morale up.

> *They organised a lot of classes for us during the day… just to keep us busy. So, our classes Alcohol or Other Drug programme, different other types of art stuff going,* [occupational therapist] *had a few programmes we were doing and so they sort of kept us occupied, you know what I mean? So, they gave us options, we had options. (Participant 7)*

Tāngata whai i te ora felt appreciative when these activities provided a sense of normality when the undertone in the units/community/world was anything but normal. In the fact of fear and uncertainty, it was reassuring to be able to maintain participation in some typical activities, when other routine activities had been taken away. Staff facilitating these familiar activities provided a sense of stability and provided opportunities for enjoyable activities to occur.

> *And going for walks around the {service} grounds. I think {ward} they took us out like once a day for half an hour. Yeah, it was. It was good. It was nice to be able to. I mean, it's nice when you got a little bit of normalcy in your life with COVID. (Participant 4)*

Tāngata whai i te ora also recalled staff doing a good job to keep spirits up when they were in isolation, which previously they described as a lonely, isolating, and discomforting experience. The kind acts and gestures by staff supported tāngata whai i te ora to get through this time, fostering an environment where they felt looked after.

> *So, our OTs* [occupational therapists] *at the time bought us in a box pack with different fidgety tools and different game options, deck of cards, all sorts of stuff, a few snacks and stuff like that, chocolate as they do, yeah, yeah, yeah. So, they made us a good little pack for the 7-day isolation. (Participant 7)*

When transitions into community living were reinstated in a later phase of COVID-19 restrictions, some tāngata whai i te ora felt their transition was celebrated by thoughtful gestures from staff. These acts during this time maintained positive experiences, and did not let the COVID-19 climate impact on significant milestones, such as moving back into the community. The work they had put in was acknowledged, keeping positive energy flowing.

> *I think they might have had a couple of farewell parties when I was in {ward}. Yeah. I think they might have had them during lockdown actually. So that kept*

going. And they just basically celebrate you leaving and just say 'don't come back'. (Participant 2)

Subtheme 3: All Going Through the Same Thing at the Same Time - Bonding Over a Shared Experience

Because all the services users and all the whaiora, all the staff were all going through the same thing at same time. So, you had something in common... it's sort of, it actually brought us together a lot more. (Participant 7)

Feelings of understanding, connection, and all being in the same boat appeared to be a reassuring and supportive aspect of the overall experience for tāngata whai i te ora. They often used the words "*we*" and "*us*" when talking about the COVID-19 lockdowns, demonstrating their view of it being a collective experience. Tāngata whai i te ora, staff, their local community, and the world were all facing similar challenges. Sharing this experience deepened relationships by providing a common ground for conversation and understanding. It created a bond that extended beyond mere acquaintance. It brought with it a sense of camaraderie that kept the energy up.

So, every time they came over to, to myself to have a conversation, and vice versa, I felt that we were acknowledging each other. Mutual respect, you respected me, ended up being a friend or mate. (Participant 6)

Despite being unable to see loved ones face-to-face, tāngata whai i te ora said, "*it wasn't lonely though, because there's always people around the unit …so that was a plus*" *(Participant 2).* The lockdowns positively impacted the socialisation and building of relationships within the units. The lockdowns strengthened connections and maintained spirits when tāngata whai i te ora they were separated from whānau, friends, and other social activities.

I noticed amongst, not just myself, but my peers, that we were sort of maybe communicating more, talking more, socialising more. Sometimes, some of the patients would put on movies after dinner in the main lounge, so we'd watch something... I thought it was nice because at the time, there were a lot of patients on the ward I would consider to be friends. And yes, it's always nice to engage with people. (Participant 1)

The increase in free time enabled more time to do activities with others. It was a novelty to be able to spend quality time with friends. It provided opportunities for connection and fostering of relationships on the units. There was a community milieu.

People provided support for each other, positively contributing to a sustaining ambiance.

> *Positive aspects? Just, just making things more congregated. Having people that are bored, and they want to do something together. Yeah, for example, movies or playing a game or something like that. Or just hanging out in each other's rooms or whatever. (Participant 2)*

Theme Four: A Learning Experience

This final theme, *A Learning Experience*, conveys the new learnings, and the old learnings that were relied on during the COVID-19 restrictions. Through education and staff sharing knowledge and information, tāngata whai i te ora were able to understand the reasons behind the COVID-19 restrictions that subsequently impacted on their daily activities.

> *I didn't feel angry or anything I just found it felt a little bit you know, just kind of annoyed you know, about the whole situation, but that was because you were in the unknowing about this virus you know. (Participant 7)*

Tāngata whai i te ora also drew on prior experiences from their time within mental health services which, together with new knowledge, provided them with strategies and deeper insights on how to navigate the COVID-19 restrictions and their impacts on occupational participation. This theme is divided into two subthemes: *Understanding the Reasons Why* and *Tāngata Whai i Te Ora as the Pros.*

Subtheme One: Understanding the Reasons Why

> *There was a virus out there and so staff had to notify us and get us as much information about the virus. So that was the first kind of line of call was giving us information and telling us this is what happened. 'This was what's going on…' they* [staff] *kept us informed and when it did turn up, there was a process they said they had to take regarding their response to COVID spreading inside {service}. (Participant 7)*

Very quickly, information regarding the COVID-19 restrictions and the subsequent changes to day-to-day life needed to be shared. Tāngata whai i te ora felt they were kept up to date with relevant information, "*we used to have meetings from time to time. So, the unit manager would give meetings… they gave us the right information*" *(Participant 1).* They could see the lines of information dissemination and

where they could go to ask questions. The information was flowing down from the Government to service management, to staff, and then down the tāngata whai i te ora.

> *By talking to staff, they sort of laid out all of the rules because they got the rules from up above and it just goes down. And they're just telling me you know; I couldn't do this. I couldn't do that. (Participant 2)*

Living through and experiencing COVID-19 and the rapid shifts it brought to day-to-day life was a whole new world for the tāngata whai i te ora. Initially, they were in a state of "*unknowing*" *(Participant 7)*. It introduced a new "*paradigm*" *(Participant 4)* that required them to navigate and "*move through the motions of COVID*" *(Participant 7),* all the while learning how to adapt to significant changes in their daily activities. Tāngata whai i te ora went through a roller-coaster of emotions, from confusion and worry to acceptance and understanding.

> *At the time you know, you get a little bit like, you're not, it's not upset. You're not upset. You're kinda like just sort of like, just to put like, curious you know, you sort of like "why is that, why is this?" Then, when you actually started to experience the experience of the COVID you kind of understand "wow, this is how fast this is moving. So, this is probably the appropriate thing to do right now". (Participant 7)*

COVID-19 was moving quickly; so too were the learning and changes taking place. Tāngata whai i te ora needed to learn about practical actions that could be taken to manage COVID-19. They demonstrated their knowledge and understanding of COVID-19 spreading in the community and the rationale for the implemented restrictions, "*I mean, I understand the reasons why {service} put all these restrictions into place*" *(Participant 1).* Having an awareness of why they were unable to do some of their usual activities made the restrictions easier to accept. They were able to weigh up the risks and benefits of the different approaches that could have been taken. "*I think what happened, with the lockdown, could have been a lot worse... if there was no lockdown... So, I think it was the lesser of the two evils*" *(Participant 4).*

Most tāngata whai i te ora displayed considered attitudes to restrictions that they may not have completely agreed with or wanted to do. "*It was kind of a little bit weird going shopping with the 2-metre social distancing, masks and stuff*" *(Participant 4)*. Tāngata whai i te ora discussed how, during times of surges of COVID-19 in the

community, or when there were outbreaks within their units, they were encouraged to wear masks when outside of their bedrooms. It was a requirement for community leaves, to catch the bus or when going supermarket shopping. Although these precautions felt unusual and took a while to get used to, tāngata whai i te ora also gained satisfaction from knowing the precautions were there to care for and protect others.

> *Yeah, it was different, but you get used to it after a while... I mean I said to myself that it's good to wear masks as a safety precaution, as it's no use him* [staff member] *getting COVID and then him getting sick and passing it on to us or not coming in to look after us... it made me feel good inside. (Participant 6)*

There was acknowledgement from tāngata whai i te ora that this was a learning curve for everyone, "*I just think it was a strange time for everyone. But we all did our best*" *(Participant 4).* They recognised and respected that the service and staff were also learning and gaining knowledge about a new virus and way of operating. "*They* [staff] *took everything into consideration*, *so yeah, I was happy with their* [staff] *response and how they handled things, with us and them*" *(Participant 6).*

> *I think {service} took a real good professional approach to it. You had to take it serious, because this thing was moving like very rapid, you know, and I liked the response they gave... it was good because it got it sorted. You know what I mean? And we could have been walking around infected all over the place. But without those steps, I think things could have been a lot different. (Participant 7)*

There was a sense of gratitude and appreciation for some of the implemented restrictions and the role they played in minimising COVID-19 infections. The staff were tasked with balancing COVID-19 restrictions against the need for personal freedoms and access to meaningful activities. At the same time, they were focused on preventing outbreaks within the units. Tāngata whai i te ora realised the staff tried their best with the knowledge they had in this endeavour.

> *I think the staff {service} did all they could to be fair, I think their hands were tied. Absolutely. And I think they did a quite a good job to be fair. I think it was a balancing act. You know, it's something that they weren't 100% used to. Yeah, COVID-19 lockdown. And to be fair, I think they handled it pretty well. Yeah. I mean, there were, there were occasions, but all in all, I think the staff at {service} did their best. (Participant 4)*

Tāngata whai i te ora showed insight into how staff may have experienced being constrained by COVID-19 restrictions. They saw that the staff, too, were unable to make many decisions or act on aspects of the COVID-19 restrictions, as they were equally bound by the Government and Service rules. The tāngata whai i te ora understood it was beyond their control.

Subtheme Two: Tāngata Whai i Te Ora as the Pros

> *I'm not saying it was nothing, but I am used to being locked away. So that was one advantage I had on people that weren't used to being locked up. (Participant 4)*

This was not the first-time tāngata whai i te ora had been through a life disrupting experience. The onset of mental illness and admission to a forensic mental health hospital had already altered life as they knew it. Tāngata whai i te ora shared stories of previous time spent constrained within their environments, with few opportunities to engage in activities.

> *Sometimes when you've got like, mental illness, you can't do anything because you're confined to just sitting there. It sounds a bit sad, but sometimes you just go to your room and twiddle your thumbs. (Participant 4)*

Having previously gone through such a disruption, tāngata whai i te ora felt they possessed the knowledge which gave them the upper hand in the COVID-19 restrictions situation.

> *So, when the lockdown was instated, the staff were a little bit concerned that I might get more disturbed with not having leave. But then I told myself "look, I've been in lots of situations before, I can handle this" …there was a time [pre COVID-19] that I was actually, from the moment I wake up to the time that I go to bed, sitting my room, like literally from 8 to 8, just sitting there and yeah, it was kind of weird. I wasn't doing much ...But I just remember sitting there for a couple of months just doing nothing. (Participant 4)*

When referring to being in "*lots of situations before*" *(Participant 4)*, tāngata whai i te ora were not referring to previous pandemic lockdowns and COVID-19 restrictions; but loss of liberties and access to meaningful activities that came with being admitted to mental health services or from impacts of mental illness symptoms. These previous experiences provided tāngata whai i te ora with an advantage in the

COVID-19 situation. Tāngata whai i te ora were insightful into the connection COVID-19 had with their previous experiences and used it as a way to reassure themselves they would be able to get through the current time.

Tāngata whai i te ora maintained hope that these restrictions would not be in place forever. This was a comforting thought. They knew they would eventually return to their meaningful activities.

> *I didn't get mad or anything, at anybody, because it wasn't really their* [staff] *fault, they were just doing what they were told. I just tried my best to be patient, optimistic, that eventually all these restrictions are going to end. (Participant 2)*

Tāngata whai i te ora utilised self-talk and reassurance strategies to get them through the pandemic. This internal dialogue influenced their behaviour and mind-set. Having this insight, tāngata whai i te ora recalled they had the tools to manage these challenges, "*I can, I can cope with it. I've just found ways, little ways to cope with it*" *(Participant 2).* They felt empowered to demonstrate how they could handle the challenge when presented with the new, unknown situation of COVID-19.

> *I mean, you had to sort of be resilient, because you knew it was gonna be over at one point in time or another, it was just sort of, when... and yeah, we got through it. (Participant 1)*

> *I coped pretty well with it, really. I didn't do anything silly. Or mess up or anything during the whole time... Keeping myself as busy as I can really. Try not to make myself bored. Just using my brain a lot… Just reading, puzzles and stuff like that. (Participant 2)*

Tāngata whai i te ora felt compelled to fill their new sense of free time in some way. They had existing knowledge and awareness of occupations they had available to them; they knew the need for and importance of these activities to fill the void left behind by the other activities they were no longer able to do due to the COVID-19 restrictions. They discussed how participating in enjoyable activities such as reading, crosswords, puzzles, music, socialising with peers, and watching TV were ways for them to keep busy and relaxed. The ability to use occupational strategies and tools independently gave participants an aspect of choice and control over the difficult situation.

> *So, we just filled up our time, from spending time in our room or going to watch TV and talking to each other... Just reading magazines, listening to music, do some push ups, sit ups. And then sometimes the other patients will come knocking at my door and we have a convo. (Participant 6)*

> *I basically filled out a crossword book yeah, yeah. So, I did my best to just keep busy. I think I did some colouring in in, some dot-to-dots and stuff but like, a Bible study programme going on, which kind of slowed down with COVID, but yeah, I think I was reading quite a bit. (Participant 4)*

There are power dynamics at play within health services. Usually, staff were seen as holding the 'experience' alongside academic and professional knowledge, providing programmes and overseeing care plans for tāngata whai i te ora pathways. However, during COVID-19 restrictions this situation was flipped, with tāngata whai i te ora having experienced and being the experts in handling a situation that was being faced worldwide. The source of knowledge was with the tāngata whai i te ora.

> *They* [staff] *seem to be a little bit more compassionate about our situation. Because I think they were experiencing a similar thing, like they would go home and go to bed and then come back to work and never see anyone and like the roads were deserted and all the rest of it. So, I think the staff understood us a little bit. I had a couple of staff say to me that you know, "now you guys are pros at handling this" and we were like "yeah". Just made the staff have a little bit more insight into what it is to be locked up. Which is quite a good thing... that was nice that felt like that you know, we had something in common. (Participant 4)*

Tāngata whai i te ora felt and appreciated a shift in attitudes from staff. They felt staff were more empathetic to their situations of living with restrictions. Staff were more aware of experiences of loss of access to meaningful occupations, social connections, and personal agency, like tāngata whai i te ora had experienced, which was seen as a positive outcome. The staff's personal experience and acknowledgment were validating for tāngata whai i te ora.

Summary

This chapter presented the study findings, comprising of four themes, *COVID Came Along and Pulled the Carpet*, *The Layers Upon Layers of Restrictions*, *Keeping the Vibes Going on the Unit*, and *A Learning Experience* and their related subthemes. The final chapter presents the discussion and conclusion. Findings from Chapter Four are reviewed within the current body of knowledge and a critical discussion of findings is

then presented. Implications for practice and recommendations for future research and the strengths and limitations of the current study are discussed and final closing remarks are made.

Chapter Five: Discussion

Within forensic mental health settings, tāngata whai i te ora are already at risk of occupational deprivation that can detrimentally impact their rehabilitation, recovery, and well-being (Barnao et al., 2015; Senneseth et al., 2022; Whiteford et al., 2020). COVID-19 had the potential to exacerbate these concerns. The aim of this ID study was to explore tāngata whai i te ora experiences of their occupations during COVID-19 restrictions, while living in a forensic mental health service. The objectives of this study were to: (1) understand how tāngata whai i te ora experienced their occupations during the COVID-19 restrictions, and (2) identify areas for potential improvement in forensic mental health services responses to COVID-19 (and other pandemics or emergency events) to enable occupational participation. Interviews were undertaken with seven tāngata whai i te ora residing in three minimum-secure units and data were analysed using reflexive TA.

International literature is beginning to explore the experiences of tāngata whai i te ora during COVID-19 in forensic mental health services. At the time of writing, however, no studies were found that had specifically explored this topic from an occupational perspective, and no research addressing this issue had been carried out in Aotearoa New Zealand. The findings of this study will contribute to the small body of literature on tāngata whai i te ora experiences of COVID-19 while residing in a secure forensic mental health service (Brennan et al., 2021; Humphries et al., 2023; Simjouw et al., 2022; Terkildsen et al., 2022). The findings demonstrated how tāngata whai i te ora held the skills and knowledge to contribute to the services pandemic response. The findings also illuminated how tāngata whai i te ora were subject to additional layers of restrictions compared to the community, impacting their occupational participation and creating further experiences of inequality during COVID-19. Lastly, the findings highlighted how proactive approaches from staff and tāngata whai i te ora promoted social connection and occupational participation to occur, acting as protective factors during COVID-19 restrictions.

The purpose of this discussion chapter is to provide an interpretation of the findings and highlight their significance in relation to existing literature. This chapter begins by presenting a brief summary of key findings, before situating these findings in the body of existing knowledge. The study's implications for practice and future research will then be discussed. Next, the strengths and limitations of the research are highlighted. A conclusion to the thesis will then be provided.

Summary of Key Findings

Three key findings were apparent within the study data. The first significant finding was that when 'COVID-19 came along and pulled the carpet', suddenly changing everyday life, tāngata whai i te ora perceived themselves to be the 'pros' in handling the situation. Tāngata whai i te ora reported that previous experiences of loss of liberties had restricted access to meaningful occupations and social connections. These previous experiences provided them with insights and coping strategies to get through the COVID-19 restrictions that had been implemented. This finding suggests tāngata whai i te ora had a valuable contribution to make in supporting staff understanding, and co-designing service policies and practice when responding to emergency events in forensic mental health services.

The second key finding was that the forensic mental health service implemented 'layers' of COVID-19 restrictions to a level above that of the Government within the local community, for a longer duration of time. This finding highlights how tāngata whai i te ora were treated differently to the general population in the circumstances. For tāngata whai i te ora, these additional 'layers' of restrictions exacerbated occupational disruption and their experiences of loss of self-determination and inequity.

The third noteworthy finding was that proactive approaches to engage in occupation with each other fostered a sense of solidarity and social connection that created positive experiences and 'kept vibes going' to get through the COVID-19

restrictions. These processes highlight the importance of relationships that can act as a protective factor in disaster events.

The key findings are explored in more depth in the next section, and strategies that draw from the findings are proposed to improve forensic mental health services responses to COVID-19 and other emergency events.

Evaluation of Key Findings

Tāngata Whai i te Ora Held Expertise in Coping with and Mitigating the Negative impacts of the COVID-19 Restrictions on Occupational Participation

The first key finding was that tāngata whai i te ora held knowledge and expertise that could have contributed to planning the services' response during the COVID-19 restrictions. Previous experiences of seclusion, occupational deprivation and disruption, and loss of liberties and social connection gave tāngata whai i te ora experiential knowledge that would have been useful information to aide in addressing occupational participation concerns and mitigating negative impacts on well-being during the COVID-19 restrictions.

Tāngata whai i te ora linked their experiences of seclusion and loss of liberties from living in a secure service to the loss of liberties and isolation requirements of COVID-19. They held some expertise and were perceived as the 'pros' in handling the COVID-19 restrictions. Furthermore, this study found that tāngata whai i te ora had an existing awareness of the need for, and importance of, occupation as a way to fill time. In this way, they used occupation as a coping strategy. This supports the view that tāngata whai i te ora demonstrated a remarkable level of resilience and adaptation throughout the pandemic (Humphries et al., 2023; Koch et al., 2023). In considering people's response to COVID-19, Brown (2021) proposed the notion of occupational resilience, which implies an individual's capacity to effectively and resourcefully cope with life stressors, confronting situations, and challenging events. This involves making adjustments and changes to daily tasks and occupational participation as needed. This ability is also seen in other studies that similarly noted tāngata whai i te ora

successfully, and independently, found activities that provided a sense of purpose and accomplishment; and which improved their experiences of lockdown (Brennan et al., 2021; Humphries et al., 2023; Simjouw et al., 2022). Within the CHIME-S secure recovery framework, Senneseth et al. (2022) cited that learning coping strategies was important for health maintenance and risk reduction.

This expertise gave them practical knowledge that could have been used to support staff understanding on addressing occupational needs and useful supports. Tāngata whai i te ora showed understanding that staff did the best 'job' they could with the information they had; however, staff understanding could have been enhanced by the inclusion of tāngata whai i te ora expertise. Conversely, the present study identified that education about the COVID-19 restrictions was a one-way approach, with management and staff providing the education to tāngata whai i te ora. There was no collaboration on ideas about meaningful occupations that could have been implemented as coping strategies during the restrictions. This association is significant, as tāngata whai i te ora insights could be valuable in the co-production of support plans and interventions. In turn, tāngata whai i te ora contributions to development of support plans and interventions has potential to enhance their occupational participation and well-being.

The findings of this study indicated there was potential for valuable, meaningful roles to be fulfilled by tāngata whai i te ora such as educators and advisors. Participating in meaningful roles, such as these, can contribute to a sense of belonging, self-discovery, and development (Hammell, 2014). Important aspects of 'belonging' are the opportunities to experience "a sense of being valued and socially included, and the ability and opportunity to contribute to others" (Hammell, 2014, p.41). Contributing would support recovery while reducing negative experiences during events such as COVID-19.

Literature identifies several benefits of occupational participation and collective action in disaster events including finding purpose and establishing a sense of control through working with others (Huppatz et al., 2024). Further research has highlighted

positive outcomes when forensic mental health units act as therapeutic communities during COVID-19 times (Kashiwagi et al., 2022). In addition, collaborative action to address occupational injustices has been found to build trust and reciprocity which, in turn, strengthened levels of social capital, building preparedness for future disaster events (Huppatz et al., 2024). These findings highlight how collaboration amongst staff and tāngata whai i te ora, and involvement of tāngata whai i te ora in educator or advisor roles on coping strategies during challenging times, had the potential to foster tāngata whai i te ora own sense of belonging and self-worth, integral to human health and well-being (Hammell, 2014).

The study supports the positions held by Te Pou (2020), Te Hiringa Mahara Mental Health and Wellbeing Commission (2024), The Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Schizophrenia and Related Disorders (Galletly et al., 2016), and He Ara Oranga: Report into the government inquiry into mental health and addiction (Paterson et al., 2018); namely, that lived experience experts are vital for the effective design and delivery of services. However, it was evident from the study's findings that a paternalistic approach is frequently employed in healthcare, where decisions may be made about tāngata whai i te ora without their complete participation in the decision-making process (Johansson & Holmes, 2022; Jørgensen et al.). This can be problematic as it impacts on power imbalances and restricts tāngata whai i te ora autonomy. It is apparent that mental health services struggle to uphold tāngata whai i te ora participation in the co-production of mental healthcare and service delivery, with 'lived experience' experts on the side-line of service design and delivery, rather than at its centre (Paterson et al., 2018; Stomski & Morrison, 2017).

The results of the current study suggest a disconnect between what is articulated as principle (i.e., 'nothing about us without us') and what services do in practice. The 'nothing about us without us' mantra is used to communicate the notion that no policy should be determined by any representative without the complete participation of representatives of the group affected by that policy (Charlton, 1998). In

this case, exclusion of tāngata whai i te ora from decision making processes could reflect the COVID-19 circumstances, with decision making and implementation of restrictions evolving at a rapid pace impacting consultation and collaboration opportunities. However, if faced with another emergency event that is unfolding quickly, services need to be ready to respond in a manner that upholds the 'nothing about us without us' concept.

The findings of this study suggest that tāngata whai i te ora held expertise in coping strategies and mitigating negative impacts of the COVID-19 restrictions on occupational participation. They could have educated staff and other tāngata whai i te ora and contributed positively to service policy design, communication, and delivery of the pandemic response. To be proactive, forensic mental health services could consider developing policies and processes aimed at implementing co-produced approaches for planning emergency events in order to better meet the needs of tāngata whai i te ora.

Addressing Inequitable Occupational Disruption Experiences for Forensic Tāngata Whai I Te Ora

The COVID-19 pandemic worsened social and health inequities and demonstrated how age, sex, gender, ethnicity, and other social determinants resulted in differential risks and outcomes of COVID-19 (WHO, 2021a). Secure populations have been among the most impacted by the stringent restrictions employed to control COVID-19, including prolonged lockdowns (Global Mental Health Peer Network and Human Rights in Mental Health FGIP, 2020; Harm Reduction International, 2023; WHO, 2021a). These extreme measures had the impact of making individuals who are already deprived of their autonomy and freedom, more vulnerable to health and human rights issues. The second key finding was that during COVID-19 the service employed 'layers of restrictions' beyond those that were implemented in the community, accompanied by a 'delay in lifting these layers of restrictions'. This study highlighted how these enhanced restrictions worsened experiences of occupational disruption and social exclusion

leaving tāngata whai i te ora feeling a loss of autonomy, and sense of inequality that required addressing.

Similar to findings from Humphries et al. (2023) and Simjouw et al. (2022), the participants in this study experienced a sense of connection to their community within the service, as they were all going through the same thing at the same time during COVID-19. Opportunities that provide a sense of connection to the community and that mirror significant, current events are shown to enhance feelings of inclusion and opportunities to feel like ‘mainstream’ citizens (Aga et al., 2021). However, marginalised communities typically report lower levels of social connectedness and feelings of belonging during natural disasters (Matthews et al., 2020). These findings are important, as feelings of connection to community are an important factor in secure recovery and well-being (Senneseth et al., 2022). Conversely, recovery and well-being can be threatened by a sense of disconnectedness and disempowerment (Aga et al., 2021; Senneseth et al., 2022). Furthermore, social connectedness and community belonging are important factors associated with reduced ongoing distress and positive mental well-being during disaster events (Matthews et al., 2020).

Findings from this study noted the extended restrictions tāngata whai i te ora experienced and, consequently, the limited accessible community occupations available, which led to feelings of inequality between staff, the wider community, and tāngata whai i te ora. This finding aligns to Simjouw et al.’s (2022) study, acknowledging disparities between rules in the forensic mental health hospital compared to those in the community. It was not only the delay in lifting restrictions that prevented tāngata whai i te ora from accessing important community resources, but also the enhanced COVID-19 restrictions within the service that were additional, institutional ‘layers’ of restrictions. Study participants reported feeling they had taken ‘steps forward’ in their rehabilitation process to enhance autonomy and access to a wider range of occupations, only to be pulled back by the COVID-19 restrictions. For example, tāngata whai i te ora ‘missed out’ on opportunities to go food shopping, to cook their own meals, or go for a run in their local community.

Previous research identified that secure tāngata whai i te ora being treated differently to the rest of society with longer duration of restrictions led to significant delays of psychosocial rehabilitation processes (Brennan et al., 2021; Forensic Network, 2021; Humphries et al., 2023; Koch et al., 2023; Simjouw et al., 2022). Participants in this study acknowledged these differences in treatment contributed to occupational disruption and deprivation and exacerbated feelings of being further separated from their local community, distanced by the layers of restrictions.

Literature from COVID-19 in forensic secure mental health services did not adequately address the inequitable impact on Indigenous populations in relation to their experiences, particularly their meaningful activities during the COVID-19 restrictions. This research provides some initial insights on the occupational experiences of Māori during this period. Māori account for 49% of the forensic tāngata whai i te ora population in Aotearoa New Zealand (McKenna & Sweetman, 2020). During the COVID-19 pandemic, the Aotearoa New Zealand Government utilised the Māori whakataukī[17], *he waka eke noa – we are all in this canoe together*, to encourage the nation to work collectively to survive the pandemic. However, reflecting on this study's findings raised the question of whether the occupational needs of Māori tāngata whai i te ora were considered during this time. Was it an equitable, collaborative approach to ensuring tikanga and Māori models of health were upheld?

The value of cultural approaches to disaster management is rarely acknowledged (Kenney & Phibbs, 2015), and the COVID-19 pandemic response was largely designed from a Western worldview (Bond & Whop, 2020; Junior et al., 2020; Waitoki & McLachlan, 2022). In this study, participants reported cancellation of group gatherings and face-to-face visits that meant tāngata whai i te ora missed out on unit and whānau karakia, kapa haka, and kanohi ki te kanohi visits with whānau. This cancellation prevented meaningful, culturally significant occupations from occurring,

[17] "(Noun) proverb, significant saying, formulaic saying, cryptic saying, aphorism." (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

and adds to others' findings, where investigations into the Aotearoa New Zealand's Crowns COVID-19 vaccination and shift to the COVID-19 Protection Framework (Traffic Light System) processes, reported breeches in Te Tiriti o Waitangi principles of tino rangatiratanga, options, partnership, active protection, and equity (Waitangi Tribunal, 2021). This finding is significant as Māori tāngata whai i te ora and other Indigenous populations are more likely to experience inequities across health care service provision (Wharewera-Mika et al., 2023), and in other emergency events exacerbating these experiences (Bond & Whop, 2020; Matthews et al., 2020; Waitoki & McLachlan, 2022; Waitangi Tribunal, 2021). By virtue of being an at-risk group with potentially inequitable outcomes, the findings and literature provide a rationale for the implementation of more culturally responsive targeted plans during emergency events for tāngata whai i te ora living in forensic mental health services. Findings of the present study also indicate such plans should include addressing occupational needs and preventing unjust outcomes.

Proactive Approaches That Boost Levels of Occupational Participation and Social Capital Could Act as Key Protective Factors During Emergency Events

The findings of this study highlighted the role occupation plays in disaster response and recovery to mitigate occupational injustice and promote connection and social inclusion (Huppatz et al., 2024). Study findings uncovered how tāngata whai i te ora perceived the staff as doing 'a really good job', and ways tāngata whai i te ora took the lead to create bonds with other peers. These approaches fostered a sense of camaraderie that facilitated and promoted occupational participation, which assisted with keeping a positive 'vibe' on the unit and enhanced COVID-19 experiences.

When COVID-19 came along and pulled the carpet, tāngata whai i te ora responded by adjusting the occupations they were participating in, where they participated, and with whom, in order to compensate for activities they were missing out on, due to the COVID-19 restrictions. One way this was achieved was through participating in activities with each other on the unit. Interestingly, it was the tāngata

whai i te ora taking the lead in initiating activities such as board games and watching movies with each other. This occupational adaptation process supported tāngata whai i te ora in maintaining participation in meaningful activities. Identifying this association is significant as occupational participation can positively impact health and well-being, identity, purpose, and occupational engagement during disaster recovery (Huppatz et al., 2024; Sima et al., 2017).

Tāngata whai i te ora sought social connection and opportunities to do activities with others to cope during the COVID-19 restrictions. This created a sense of solidarity that improved experiences during COVID-19 restrictions. These intuitive, collaborative, enabling processes to mitigate occupational injustices experienced during disaster events are known to have transformative potential (Huppatz et al., 2024); and social connection with peers is recognised as a vital aspect in the recovery of forensic mental health tāngata whai i te ora (Clarke et al., 2016; Senneseth et al., 2022). Findings of my study are consistent with previous literature on disaster preparedness and recovery, which has acknowledged social connection as a supportive factor in addressing occupation injustice during these times (Huppatz et al., 2024; Matthews et al., 2020).

Two studies highlighted how the level of care received from staff going above and beyond (to ensure there were opportunities for occupational participation to occur) was perceived as a positive factor that contributed to their overall COVID-19 experiences (Humphries et al., 2023; Simjouw et al., 2022). This present study added to those findings. ‘The staff did a good job’ through providing opportunities that supported participants in coping with COVID-19 related stress and boredom, while also ensuring recovery was positively supported by structures, routines, and the daily activities on the ward (Senneseth et al., 2022). My study has highlighted the importance of relationships between staff and tāngata whai i te ora. The quality of relationships with staff is viewed as essential in the recovery of forensic mental health tāngata whai i te ora, and it is contended that these relationships can either facilitate or hinder recovery (Clarke et al., 2016; Dreenan & Woolridge, 2014; Senneseth et al.,

2022). The present study findings identified that strategies such as making time to facilitate and participate alongside tāngata whai i te ora in activities made all the difference during challenging times, leaving tāngata whai i te ora with feelings of gratitude and appreciation that created a positive 'vibe' on the unit. This study contributes to understanding the significance of these relationships, promoting whakawhanaungatanga[18], aroha ki te tangata[19], manaakitanga[20], and kotahitanga[21] during COVID-19 (Waikaremoana & McLachlan, 2022). These Māori cultural values in disaster responses build social capital and social cohesion which act as a psychosocial asset that can alleviate the impact of trauma and loss (Kenney & Phibbs, 2015).

The connecting and novel occupations highlighted by participants in my study align to Zafran's (2020) notion that various types of occupations could act as 'occupational gifts' during the COVID-19 pandemic including: (a) connecting occupations in which people experience belonging and connection with others; (b) centering occupations that foster presence, mindfulness, and calm; (c) creative occupations which address the human desire to play and have fun (d) contemplative occupations which involve taking a worldview perspective and speaking about the big picture of what we are all experiencing; and (e) contributing occupations that involve giving back to the groups, communities, and organisations that uphold us.

Therefore, my present study adds to the existing body of knowledge by illuminating the significance of occupation, relationships, and engaging in occupations with others during disaster events. Thus, these factors should never be overlooked in planning responses and services should consider how they promote them as a potential means of supporting well-being and combating negative impacts.

[18] "(Noun) process of establishing relationships, relating well to others" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).
[19] "A love and compassion for all people" (Waikaremoana & McLachlan, 2022).
[20] "(Noun) hospitality, kindness, generosity, support – the process of showing respect, generosity and care for others" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).
[21] "(Noun) unity, togetherness, solidarity, collective action" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

Implications for Practice, and Recommendations for Future Research

The COVID-19 restrictions have, and continue to be, a hugely disruptive occupational experience. Interestingly, there has been a desire to return to 'normal' and forget the extraordinary experience that has just occurred. This phenomenon is being referred to as 'COVID amnesia' (Goggins, 2023; Murdoch & Bloomfield, 2024). It would be profoundly disappointing if the lessons learned from COVID-19 were overlooked, as failing to apply this knowledge could leave us unprepared for future public health crises. This section focuses on the implications for practice and research, based on the findings in this study.

Consistent with the aims of ID research (Thorne, 2016), there are important implications for practice that can be drawn from the research findings. The first is that there is an urgent need to re-conceptualise what a 'successful' pandemic preparedness and response entails, and to look beyond the physical health elements and infrastructure such as negative pressure rooms and vaccination rates. Secure service responses could be strengthened by considering how personal well-being, social connection, cultural responsivity, and occupational participation could be maintained. Indigenous people are disproportionately represented in forensic mental health services due to the traumatic effects of colonisation and health inequities (Mason Clinic, 2011; Wharewera-Mika et al., 2023). In Aotearoa New Zealand, obligations to Te Tiriti o Waitangi require that this inequity be addressed. Therefore, taking more of a holistic approach; for example, utilising Durie's (1998) Te Whare Tapa Whā model of Māori health[22] and involving Māori lived experience experts from the service would emphasise the importance of Indigenous perspectives, and uphold rights and values such as tino rangatiratanga, whānau, wairua[23], and tikanga. Such initiatives will possibly boost a sense of belonging for Indigenous people, a key driving factor affecting post-disaster distress (Matthews et al., 2020).

[22] Te Whare Tapa Whā is a Māori health model based on the concepts of whānau (family), tinana (physical), hinengaro (mental), and wairua (spiritual) health (Durie, 1998).
[23]("Noun) spirit, soul – spirit of a person which exists beyond death. It is the non-physical spirit, distinct from the body and the mauri" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

Additionally, those with lived experience should be included in governance, planning, policy and service development decisions when responding to emergency events. These findings support the opinion of multiple experts, that people need to be placed at the centre of such processes (Galletly et al., 2016; Paterson et al., 2018; Te Pou, 2020). Services need to consider how they hold the recovery paradigm paramount and embed the notion of 'nothing about us without us' in emergency events or other fast evolving situations (Te Hiringa Mahara Mental Health and Wellbeing Commission, 2024). Going forward, of practical value would be the development of guidelines and policies specific to the implementation of co-design approaches with tāngata whai i te ora and other lived experience experts in planning responses to emergency events to ensure service delivery is responsive to the needs of those it affects. Furthermore, a collaborative, enabling framework such as the Participatory Occupational Justice Framework (POJF)[24], could be used to tackle occupational injustice and promote social inclusion to enhance occupational participation and the wellbeing experiences of tāngata whai i te ora during emergency events (Whiteford et al., 2021).

The findings of this research highlighted the importance of occupation in tāngata whai i te ora lives; occupation is essential for their rehabilitation, recovery and social wellbeing. Tāngata whai i te ora were the experts in their own occupations, readily discussing the occupations that were meaningful to them such as wanting to connect with whānau, participate in kapa haka and collective morning karakia. Such occupations held cultural and spiritual meaning. Further to this, findings revealed how tāngata whai i te ora were also experts in experiences of occupational deprivation due to their prior experiences of seclusion and the physical and social environments of mental health settings thus providing them with vital coping strategies.

A key role of occupational therapists working in forensic mental health settings is the provision of meaningful occupation and occupational choice, which enable

[24] The purpose of the POJF is to facilitate social inclusion through raising awareness of and addressing scenarios of occupational injustice (Whiteford et al., 2021).

tāngata whai i te ora to engage in the constructive and structured use of time. This involves advocating for opportunities to participate in necessary and meaningful activities within the forensic mental health system to prevent occupational deprivation (Canadian Association of Occupational Therapists, 2024; Royal College of Occupational Therapists, 2017). These study findings endorse the importance of the role occupational therapists play in forensic mental health settings.

The findings of this study also suggest that in this setting, occupational therapists should organise workshops with tāngata whai i te ora, consumer advisors and taurawhiri (or other lived experience experts and cultural advisors) to co-design activities and plans for addressing occupational needs to enable occupational participation, that could reduce the negative impacts during emergency events. Occupational therapists are well placed to support emergency planning and emergency responses due to their expertise in working with communities and individuals in their everyday occupational challenges. It is recommended that occupational therapists work collaboratively with tāngata whai i te ora in identifying and planning their care. OTs possess knowledge of people's occupations and enablement skills such as consulting, collaborating and designing, to support this process (Townsend et al., 2013). These workshops could give a voice to tāngata whai i te ora to share their perspectives of meaningful occupations and previous experiences of coping strategies while also drawing on occupational therapists' knowledge of the environment, their knowledge in adapting tasks, and the occupational needs of individuals that could be used to mitigate the negative impacts of the emergency event.

The findings in this study highlighted scope for future research. Firstly, my research has indicated the importance of incorporating tāngata whai i te ora perspectives into research in forensic mental health settings. More research into understanding the experiences of tāngata whai i te ora across medium-secure mental health services and the voices of those living in the community, staff, and whānau, would be of value. Furthermore, mixed method approaches to enable triangulation of data to include other key stakeholders, such as staff, would be valuable. Another option

could be to collect quantitative data from standardised well-being measures, such as the EssenCES Survey[25], or tāngata whai i te ora hours spent in rehabilitation activities during and after emergency events. This triangulation of data would support understanding of the impacts on occupational participation from different angles.

Finally, but importantly, the findings of my study point to the use of a participatory action research methodology with researchers and tāngata whai i te ora sharing power, whereby tāngata whai i te ora are involved in decide on the research topic, data collection and analysis methods, and deciding on action to occur as an outcome of the research findings. This collaborative approach to research, with tāngata whai i te ora advising what their needs are and shaping services response from their experiential knowledge, could promote diverse knowledge generation and improve future emergency events within forensic mental health settings.

Strengths of this Research

To my knowledge this is the first study (within Aotearoa New Zealand and internationally) contributing tāngata whai i te ora perspectives with a specific focus on occupations during the COVID-19 restrictions within a forensic mental health setting. This is significant as forensic tāngata whai i te ora perspectives are understudied in general, and they are often viewed as vulnerable, requiring robust ethical considerations and methods to engage in research (Keogh & Daly, 2009). Furthermore, the findings of this study add to the sparse, qualitative research from tāngata whai i te ora in forensic mental health settings in Aotearoa New Zealand; while also responding to the need for occupational therapy research in forensic mental health settings (Chui et al., 2016). Therefore, this study has given a voice to those who have been under-researched, under-valued, and under-represented in the past. It also provided contextual insights into life in a forensic mental health setting, offering rich and

[25] The Essen Climate Evaluation Schema (EssenCES) is a short questionnaire, originally developed for assessing essential traits of the social and therapeutic atmosphere of forensic psychiatric wards, which is a crucial factor for the health and well-being of both staff and patients as well as the outcome of interventions (Schalast et al., 2008).

nuanced perceptions into the experiences during COVID-19 restrictions. Additionally, there were a variety of participants across age groups and minimum-secure inpatient units represented within the study, as well as Māori involvement that was close to their demographic representation across the service.

A methodological strength of this study is the use of semi-structured interviews, with questions which enabled the tāngata whai i te ora to respond in their own words. Open-ended questions provoked answers that were meaningful to participants. The flexibility within the interviews allowed tāngata whai i te ora to share points that were not considered in the original research design and interview schedule. Understanding precisely how people feel, and experience certain events can only be done through the sharing of their own stories which cannot be quantified. This makes qualitative research a valuable approach to exposing the feelings, experiences, values, and beliefs of tāngata whai i te ora.

The partnership with Taurawhiri throughout the research design, delivery, interpretation of data, and dissemination of findings was another strength of the study. Te Ara Tika guidelines emphasise the importance of fostering positive relationships and recognise the various roles, relationships, and responsibilities that each party holds in the engagement process (Hudson et al., 2010). As tauiwi[26], Te Ara Tika guidelines provided me a framework to engage with Māori and actively reflect on my Pākehā[27] way of thinking in order to do ethical and culturally safe research in Aotearoa.

Limitations of this Research

As with all research there are limitations that need to be considered. First, this was a small-scale study, limited to one forensic mental health service. Consequently, it is not indicative of experiences of all forensic tāngata whai i te ora across Aotearoa New

[26] "(Personal noun) foreigner, European, non-Māori, colonist" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).
[27] "(Noun) New Zealander of European descent – probably originally applied to English-speaking Europeans living in Aotearoa New Zealand" (Te Aka Māori Dictionary – www.maoridictionary.co.nz).

Zealand. It is specific to this setting and restrictions imposed specific to the service. It is, therefore, a snapshot into the experiences of tāngata whai i te ora in minimum-secure units at the ARFPS and a starting point to further expand on this research area. Second, the qualitative nature of this research means findings cannot be generalised to other settings; rather, it can be used to find similarities and differences of experiences that could inform clinical practice.

Third, this research was limited to tāngata whai i te ora living within three of the minimum-secure units. Therefore, various voices were not represented. For example, women, those with an intellectual disability, or those living in medium-secure units. Having additional Pasifika participants would have ensured the research reflected the diversity of the forensic tāngata whai i te ora population and accounted for the cultural differences in attitudes, behaviours and experiences. Thus, further research is needed to address the comprehensive context of forensic settings in Aotearoa New Zealand.

Important to note, as I carried out the interviews, there were power imbalances between myself (the interviewer) and the interviewees. This may have influenced participants' responses in the sense that they potentially shared what they thought I wanted to hear (Thorne, 2016). Additionally, my subjective view of interpreting what I heard also needs to be acknowledged. My professional and personal worldviews that hold the importance of occupational participation on human well-being, as well as my involvement in the ARFPS COVID-19 response, may have biased my views and interpretations of the data affecting objectivity (Thorne, 2016). My biases were addressed through methods such as reflection, research supervision, and member checking. Conversely, my positioning should still be considered when reading and interpreting the findings of this study.

Conclusion

The COVID-19 pandemic is ongoing, affecting many vulnerable populations. The risk of emergence of new variants and future surges or outbreaks of different pandemics that may result in further restrictions on participation in daily life remains real (Murdoch &

Bloomfield, 2024; WHO, 2024). The forensic tāngata whai i te ora population is rising within Aotearoa New Zealand (McKenna & Sweetman, 2020). Therefore, research and planning to prepare for emergency events in secure environments needs to be considered to ensure this population is not unequally impacted resulting in occupational injustice experiences.

This thesis began by providing a background and rationale for why an investigation into tāngata whai i te ora experience of their occupations during COVID-19 would make a valuable contribution to the literature. The research objectives were to (1) understand how tāngata whai i te ora experienced their occupations during the COVID-19 restrictions and (2) identify areas for potential improvement in forensic mental health services responses to COVID-19 (and other pandemics) to enable occupational participation. A literature review synthesised currently available research, focused on tāngata whai i te ora experiences of changes to day-to-day activities during COVID-19 in secure mental health services. The use of an ID study and important ethical rigour for engaging in research with tāngata whai ora residing in forensic mental health settings in Aotearoa New Zealand were also detailed. The findings chapter outlined key themes, the significance of which has been considered in this final discussion chapter.

In conclusion, this qualitative ID study offers a unique occupational perspective on tāngata whai i te ora experiences during the COVID-19 restrictions within an Aotearoa New Zealand forensic mental health setting. It has demonstrated the opportunities for co-production of policies, education, and communication strategies in emergency events. These processes can strengthen roles, and the sense of belonging and connectedness that contributes to secure recovery. It has highlighted the inequalities forensic tāngata whai i te ora face and the need for services to implement holistic, culturally responsive support. Equally significant were the range of supportive and enabling factors that occurred to enhance occupational participation and well-being during unprecedented times.

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Te Reo Māori Words[28] Glossary

Aroha ki te tangata	A love and compassion for all people (Waitoki & McLachlan, 2022)
Kapa haka	(noun) concert party, *haka* group, Māori cultural group, Māori performing group
Kanohi ki te kanohi	(stative) face to face, in person, in the flesh
Karakia	(verb) (-tia) to recite ritual chants, say grace, pray, recite a prayer, chant
Kaupapa	(noun) topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative
Kaupapa Māori	Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology – a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society
Koha	(noun) gift, present, offering, donation, contribution – especially one maintaining social relationships and has connotations of reciprocity
Kotahitanga	(noun) unity, togetherness, solidarity, collective action
Mana	(noun) prestige, authority, control, power, influence, status, spiritual power, charisma – *mana* is a supernatural force in a person, place, or object
Manaakitanga	(noun) hospitality, kindness, generosity, support – the process of showing respect, generosity, and care for others
Māori	(noun) Māori, Indigenous New Zealander, Indigenous person of Aotearoa New Zealand – a new use of the word resulting from Pākehā contact in order to distinguish between people of Māori descent and the colonisers
Pākehā	(noun) New Zealander of European descent – probably originally applied to English-speaking Europeans living in Aotearoa New Zealand
Tāngata whai i te ora/ tangata whai i te ora	Tangata whai ora (singular) / tāngata whai ora (plural) refers to a person/people who are the subject of care, assessment and treatment processes in mental health. 'Tangata whai ora' means "a person seeking health" (Ministry of Health, 2000). This term will be used throughout the thesis as it is considered more enriching

[28] Translations obtained from Te Aka Māori Dictionary (www.maoridictionary.co.nz) unless otherwise indicated.

	language than the terms client, patient, or service user (Opai, 2020)
Taurawhiri	Māori cultural advisors within the forensic mental health service (non-literal translation)
Tauiwi	(personal noun) foreigner, European, non-Māori, colonist
Te Ao Māori	Māori world view
Te Reo Māori	The language of the Indigenous people of Aotearoa New Zealand
Te Tiriti o Waitangi	The founding document of New Zealand signed in 1840 between representatives of the British Crown and Māori iwi (Te Rua Mahara o te Kāwanatanga Archives New Zealand, 2024)
Tika	(verb) to be correct, true, upright, right, just, fair, accurate, appropriate, lawful, proper, valid
Tikanga	(noun) correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention, protocol – the customary system of values and practices that have developed over time and are deeply embedded in the social context
Tino Rangatiratanga	(noun) self-determination, sovereignty, autonomy, self-government, domination, rule, control, power
Waiata	(verb) (-hia,-tia) to sing
Wairua	(noun) spirit, soul – spirit of a person which exists beyond death. It is the non-physical spirit, distinct from the body and the mauri
Whakaora Ngangahau	Whakaora meaning to restore health and ngangahau meaning active, spirited, zealous; therefore, whakaora ngangahau is restoring to health one's active self (Hopkirk, 2013)
Whakapapa	noun) genealogy, genealogical table, lineage, descent - reciting whakapapa was, and is, an important skill and reflected the importance of genealogies in Māori society in terms of leadership, land and fishing rights, kinship and status. It is central to all Māori institutions
Whakataukī	(noun) proverb, significant saying, formulaic saying, cryptic saying, aphorism.
Whakawhanaungatanga	(noun) process of establishing relationships, relating well to others
Whānau	(noun) extended family, family group, a familiar term of address to a number of people – the primary economic unit of traditional Māori society. In the modern context the

	term is sometimes used to include friends who may not have any kinship ties to other members
Whare	(noun) house, building, residence, dwelling, shed, hut, habitation

Appendices

Appendix A: ARFPS COVID-19 Restrictions

National Alert Level: **National Hospital Response Framework Alert Level:**	**Service delivery area inpatient:**	**Alert Level 1: "Disease is contained in NZ"**	**Alert Level 2: "Disease is contained but risk of community transmission remains"**	**Alert Level 3: "High risk the disease is not contained"**	**Alert Level 4: "The disease is not contained".**
GREEN **Trigger Status: No COVID-19 positive patients in your hospital; no cases in your community; managing service delivery as usual with only staffing and facility impact being for training and readiness purposes** **(If one or more COVID-19 positive cases at [redacted] regardless of the status of other hospitals follow**	Bubbles	BAU** = return to normal pre COVID-19 practice.	No bubble but risk remains - social distancing, IPC procedures and contact tracing.	*** Stream & proximal bubbles with minimised staff movement.	Unit bubbles with only emergency staff movement***.
			Cross bubble movements (on call, pharmacy, phlebotomy, duress responses, medical staff, deliveries) – contactless where ever possible. Where unavoidable, strict adherence to PPE, including use of fresh gloves disposed of and hands sanitised between bubbles, social distancing and NIC to ensure all surfaces etc wiped post contact.		
	Afterhours medical cover	BAU	Follow usual after hours process for medical emergencies. For all matters usually requiring a registrar, contact on call forensic SMO. On call medical staff may have a higher threshold for breaching bubbles and may use remote technologies to aid with assessment and advice		
	Leave	Ground access BAU**. Community Leave BAU**.	Re open trust office. All previously approved levels of leave reinstated subject to recent MDT documented individualised COVID-19	Trust office remain closed. Ground access relaxed to include stream/proximal 'bubbles' Exceptional circumstances leave	Trust office closed. Ground access limited to one bubble at a time as per schedule Exceptional circumstances leave (e.g. hospital/compassionate/cou

[redacted] COVID-19 POSITIVE section)			risk assessment (e.g. LEAVES tool) and safety plan.	approval on case by case basis – CD/DAMHS.	rt) approval on case by case basis – CD/DAMHS.
		Face covering to be worn as per MoH current direction.			
	Programmes	BAU** onsite Graded expansion of work and community group rehabilitation. In-reach facilitators resume if screen negative.	Cross service programmes BAU *** including residents of forensic step-down beds compliant with the visitor policy. In house programmes BAU. Religious service/chaplaincy led activities resume across site ***. External facilitators may now return***	Stream/proximal 'bubbles' shared programmes *** In house programmes BAU. No in-reach facilitators on site. Work Rehab closed. Religious services/chaplaincy led activities individualised support – not face to face. Virtual programme facilitation will be scheduled where possible.	Unit/team 'bubbles' programmes only. Limited in house programmes BAU. No in-reach facilitators on site. Work Rehab closed. Religious services individualised support – not face to face. Virtual programme facilitation will be scheduled where possible.
	Visits	All visitors to be security screened ***. Zoom visits also available for family/whanau and DI/legal counsel.	All visitors to be screened, if positive visit to be postponed. Masks to be worn by all visitors to site All visits to be supervised onsite***. Any visits in the community/ home leave previously approved - reinstated subject to recent MDT documented individualised COVID-19 risk assessment (e.g.	Compassionate visits only approved by Clinical Director and Operations Manager. Zoom visits available for family/whanau and DI/legal counsel.	Compassionate visits only approved by Clinical Director and Operations Manager. Zoom visits available for family/whanau and DI/legal counsel.

			LEAVES tool) and safety plan. Maximum of one visitor per service user as per allocated time slots. Zoom visits also available for family/whanau and DI/legal counsel.		
	Catering	Graded reintroduction to shopping including for food as leaves resume and shops reopen BAU***. Mulitskill BAU.	Rimu and Tane Whakapiripiri self-catering 'Canteen' and takeaways BAU- Note escorted shopping unless approved for unescorted COVID-19 leave. Cooking and meal preparation can return to BAU Mulitskill BAU.	Hospital catering only across site. Canteen provided. BBQ ordered from catering Baking within bubble using unit supplies. Unit to disinfect food trolley prior to entering the unit.	Hospital catering only across site. Canteen provided. Multiskill allocated to unit/team bubbles with minimal staff movement. Unit to disinfect food trolley prior to entering the unit.
	Admission transfer and discharge process	Admission: BAU*** Transfers and discharges BAU***	Admission: Pre-screen follow WDHB COVID Screening Tool process and pathway. Transfers only within same triage groups. Discharge if transition can be safely managed.	Admission: Pre-screen follow WDHB COVID Screening Tool process and pathway Transfers only within same triage groups Suspend transfer / discharge if lengthy transition required.	Admission: Pre-screen follow WDHB COVID Screening Tool process and pathway Internal and external transfers (by negotiation) allowed within same triage groups. Suspend transfer / discharge if transitional plan required.
	Training	Students and Study / CME as determined by DHB guidance.	Students and Study / CME as determined by DHB guidance.	No students on site C+R postponed. Study leave / CME cancelled.	No students on site C+R postponed. Resus, PPE, Infection control allowed.

		C+R and other mandatory training BAU***	C+R reinstated	AVL distance learning only.	Study leave / CME cancelled AVL distance learning only.
	HR processes	Recruitment BAU Orientation new staff BAU***	Recruitment BAU Site wide orientation with some limitations**	Contactless Recruitment e.g. Zoom on-going – temp contracts where references not possible Orientation within stream/proximal bubble Special leave- Occ Health review when to return	Contactless Recruitment e.g. Zoom on-going – temp contracts where references not possible Orientation only within strict bubble Special leave- Occ Health determined off site
	SPRP	BAU ***	BAU ***	Limit to max 10 in room. No outside panellists. Family/whanau via zoom.	No face to face panel. Reviews by documentation CD/DAMHS.
	Court	BAU unless advised differently by Judiciary.	AVL TBA by Judiciary	AVL TBA by Judiciary	Only AVL
	Court Reports	BAU ***	All assessees to be screened. If positive visit to be postponed. Reinstate usual site wide venues and processes**. Masks to be worn by all visitors to site Offsite community assessments to be confirmed (Courts, legal offices, residence etc.) where safe** and / or by AVL.	All assessees to be screened. If positive visit to be postponed, Limited identified venues on site only*. Offsite community assessments to be used (Courts, legal offices, residence etc.) where safe** and /or by AVL. In custody court reports as agreed with Corrections.	No on site court outpatient assessments. In custody court reports as agreed with Corrections.

			In custody court reports as agreed with Corrections.		
	Contact Register	Use of staff ID swipe cards at all swipe points to automatically track and trace movements through the facility.			
		Visitor register to be completed	Contact register to be completed		
	COVID-19 management	Follow Business Continuity Pandemic RFPS [redacted] [redacted] plan – weekly update	Pre-screening all admissions. Follow Business Continuity Pandemic RFPS [redacted] plan – weekly update		

Notes:
Green assumes no COVID-19 cases in [redacted]

*Note Kowhai is considered to be a community interface site and therefore not onsite.

**to ensure adherence to social distancing and safe hygiene practices

*** safe hygiene and COVID-19 National Guidance including use of governmental and COVID-19 Screening & Clinical Assessment Tool / recommended masks / face coverings / contact tracing etc.

BAU - return to normal pre COVID-19 practice.

National Alert Level: **National Hospital Response Framework Alert Level:**	**Service delivery area inpatient:**	**Alert Level 1: "Disease is contained in NZ"**	**Alert Level 2: "Disease is contained but risk of community transmission remains"**	**Alert Level 3: "High risk the disease is not contained"**	**Alert Level 4: "The disease is not contained".**
YELLOW **Trigger Status: One or more COVID-19 positive patients in your hospital; cases**	Bubbles	BAU = return to normal pre COVID-19 practice.	[redacted] Bubble (Includes Rimu, Excludes outpatients and step-down beds).	*** Stream & proximal bubbles with minimised staff movt.	Unit bubbles with only emergency staff movement ***
		BAU	Cross bubble movements (on call, pharmacy, phlebotomy, duress responses, medical staff, deliveries) – contactless where ever possible. Where unavoidable,		

quarantined in your community; isolation capacity and ICU capacity manageable; some staff absences and some staff redeployment to support response and manage key gaps **(If one or more COVID-19 positive cases at [redacted] regardless of the status of other hospitals follow [redacted] COVID-19 POSITIVE section)**			strict adherence to PPE, including use of fresh gloves disposed of and hands sanitised between bubbles, social distancing and NIC to ensure all surfaces etc wiped post contact.		
	Afterhours medical cover	BAU	Follow usual after hours process for medical emergencies. For all matters usually requiring a registrar, contact on call forensic SMO. On call medical staff may have a higher threshold for breaching bubbles and may use remote technologies to aid with assessment and advice		
	Leave	Ground access BAU. Graded reintroduction of normal leave processes to the community subject to recent MDT documented individualised COVID-19 risk assessment (e.g. LEAVES tool) and safety plan. ***	Re open trust office. Ground accessible by all units within usual times but escorted only min 1 staff to 2 service users. Access to cross-service programmes may drop off /pick up. Only escorted community leave for rehabilitative purposes ***.	Trust office remain closed Ground access relaxed to include stream/proximal 'bubbles'. Exceptional circumstances leave approval on case by case basis – CD/DAMHS	Trust office closed Ground access limited to one bubble at a time as per schedule Exceptional circumstances leave (e.g. hospital/compassionate/court) approval on case by case basis – CD/DAMHS
		Face covering to be worn as per MoH current direction.			
	Programmes	BAU on site Graded expansion of work and community group rehabilitation. In-reach facilitators resume if screen negative.	Cross service programmes BAU *** FCRS service users can attend programmes hosted in Kowhai compliant with the visitor policy. Limited work rehabilitation maintaining [redacted] Bubble. Religious service/chaplaincy led activities resume across site ***	Stream/proximal 'bubbles' shared programmes *** In house programmes BAU. No in-reach facilitators on site Work Rehab closed Religious services/chaplaincy led activities individualised support – not face to face.	Unit/team 'bubbles' programmes only. Limited in house programmes BAU. No in-reach facilitators on site Work Rehab closed Religious services individualised support – not face to face. Virtual programme facilitation will be scheduled where possible.

				Virtual programme facilitation will be scheduled where possible.	
	Visits	All visitors to be screened. If positive visit to be postponed, otherwise BAU. Any visits in the community to be approved on a case by case basis by the MDT. Zoom visits also available for family/whanau and DI/legal counsel	All visitors to be screened, if positive visit to be postponed. All visitors to [redacted] site to wear masks All visits to be supervised onsite and in community. Any visits in the community to be approved on a case by case basis by the MDT. Zoom visits also available for family/whanau and DI/legal counsel. Maximum of one visitor per service user as per allocated time slots.	Compassionate visits only approved by Clinical Director and Operations Manager. Zoom visits available for family/whanau and DI*/legal counsel	Compassionate visits only approved by Clinical Director and Operations Manager. Zoom visits available for family/whanau and DI/legal counsel
	Catering	Graded reintroduction to shopping including for food as leaves resume and shops reopen. Multiskill BAU.	Rimu and Tane Whakapiripiri self-catering. 'Canteen' and takeaways BAU (note escorted shopping). Multiskill BAU.	Hospital catering only across site. Canteen provided. BBQ ordered from catering Baking within bubble using unit supplies. Multiskill BAU. Unit to disinfect food trolley prior to entering the unit.	Hospital catering only across site. Canteen provided. Multiskill allocated to unit/team bubbles with minimal staff movement. Unit to disinfect food trolley prior to entering the unit.
	Admission transfer and discharge process	Admission: Pre-screen follow WDHB COVID Screening Tool process and pathway.	Admission: Pre-screen follow WDHB COVID Screening Tool process and pathway.	Admission: Pre-screen follow WDHB COVID Screening Tool process and pathway.	

		Admissions/readmissions/AWOL returnees triaged as lilac, blue or yellow to be admitted to Rata high care for further assessment. Transfers and discharges only within same triage groups	Admissions/readmissions/ AWOL returnees triaged as lilac, blue or yellow to be admitted to Rata high care for further assessment. Transfers only within same triage groups Discharge if transition can be safely managed	Admissions/readmissions/AWOL returnees triaged as lilac, blue or yellow to be admitted to Rata high care for further assessment. Transfers only within same triage groups Suspend transfer / discharge if lengthy transition required	
	Training	Students and Study / CME as determined by DHB guidance C+R and other mandatory training BAU	Students and Study / CME as determined by DHB guidance C+R BAU within [redacted] bubble	No students on site C+R postponed Study leave / CME cancelled AVL distance learning only	No students on site C+R postponed Resus, PPE, Infection control allowed Study leave / CME cancelled AVL distance learning only
	HR processes	Recruitment BAU Orientation new staff BAU Special leave- Occ Health review when to return Leave requests to be determined by HR	Contactless Recruitment i.e. Zoom Orientation within [redacted] Bubble only Special leave- Occ Health review when to return Leave requests to be determined by HR	Contactless Recruitment e.g. Zoom – temp contracts where references not possible Orientation within stream/proximal bundle Special leave- Occ Health review when to return Leave requests to be determined by HR	Contactless Recruitment e.g. Zoom – temp contracts where references not possible Orientation only within strict bubble Special leave- Occ Health determined off site Leave requests to be determined by HR
	SPRP	BAU ***	Limit to 1 family/whanau member ***	Limit to max 10 in room. No outside panellists.	No face to face panel. Reviews by documentation CD/DAMHS.

				Family/whanau via zoom.	
	Court	AVL TBA by Judiciary	AVL TBA by Judiciary	AVL TBA by Judiciary	Only AVL
	Court reports	All assessees to be screened. If positive visit to be postponed, otherwise BAU.	All assessees to be screened. If positive visit to be postponed, Limited identified venues on site only*. In custody court reports as agreed with Corrections.	Offsite community assessments to be confirmed (Courts, legal offices, residence etc.) where safe** and / or by AVL. No on site court reports as outpatients* . In custody court reports as agreed with Corrections.	On Bail assessments to be confirmed offsite. (Courts, legal offices, residence etc.) where safe and appropriate PPE is used** and / or by AVL. No on site court outpatient assessments*. In custody court reports as agreed with Corrections.
	Contact Register	Contact register completed every shift Use of staff ID swipe cards at all swipe points to automatically track and trace movements through the facility.			
	COVID-19 management	Pre-screening all admissions. Follow Pandemic RFPS [redacted] plan – weekly update			

Notes:
Yellow assumes no COVID-19 cases specifically in [redacted]
*Note Kowhai is considered to be a community interface site and therefore not onsite.
*** safe hygiene and COVID-19 National Guidance including use of governmental and WDHB COVID-19 Screening & Clinical Assessment Tool / recommended masks / face coverings / contact tracing etc.
*** Follow any National Guidance around social distancing, hygiene and contact tracing
BAU - return to normal pre COVID-19 practice.

National Alert Level: **National Hospital Response Framework Alert Level:**	**Service delivery area inpatient:**	**Alert Level 1: "Disease is contained in NZ"**	**Alert Level 2: "Disease is contained but risk of community transmission remains"**	**Alert Level 3: "High risk the disease is not contained"**	**Alert Level 4: "The disease is not contained".**

[redacted] **COVID-19 POSITIVE** **(If one or more COVID-19 positive cases at [redacted] regardless of the status of other hospitals – anticipates the possibility of a localised [redacted] outbreak asynchronous with National Hospital Framework Level)**	Bubbles	Unit bubbles with only emergency staff movt. Where possible consider alternatives to bubble breaches (contactless deliveries, telehealth, use of zoom, delegation to staff within bubble). Appropriate use of PPE for any unavoidable bubble intrusions.
		Cross bubble movements (on call, pharmacy, phlebotomy, duress responses, medical staff, deliveries) – contactless where ever possible. Where unavoidable, strict adherence to PPE, including use of fresh gloves disposed of and hands sanitised between bubbles, social distancing and NIC to ensure all surfaces etc wiped post contact.
	Afterhours medical cover	Follow usual after hours process for medical emergencies. For all matters usually requiring a registrar, contact on call forensic SMO. On call medical staff may have a higher threshold for breaching bubbles and may use remote technologies to aid with assessment and advice
	Leave	Trust office closed. Ground access limited to one 'white bubble' at a time as per schedule (Yellow and blue bubbles internal courtyard access only). Exceptional circumstances leave (e.g. hospital/compassionate/court) approval on case by case basis – CD/DAMHS. Face covering to be worn as per MoH current direction.
	Programmes	Unit/team 'bubbles' programmes only. Limited in house programmes. No in-reach facilitators on site. Work Rehab closed. Religious services individualised support – not face to face. Virtual programme facilitation will be scheduled where possible.
	Visits	Compassionate visits only approved by Clinical Director and Operations Manager. Use of appropriate level of PPE for all visitors
	Catering	Hospital catering only across site. Canteen provided. Multiskill no longer serve meals and concentrate on cleaning duties. Unit to disinfect food trolley prior to entering the unit.
	Admission transfer and discharge process	Admission: Pre-screen WDHB COVID Screening Tool process and pathway. Admissions/readmissions/AWOL returnees triaged as lilac, blue or yellow to be admitted to Rata high care for further assessment. Internal and external transfers (by negotiation) allowed within same triage groups. Suspend transfer / discharge if transitional plan required.
	Training	No students on site C+R postponed Resus, PPE, Infection control allowed

		Students and study / CME as determined by DHB guidance
	HR processes	Contactless Recruitment e.g. Zoom on-going – temp contracts where references not possible Orientation only within strict bubble Special leave Occ Health determined staff off site Leave requests to be determined by HR
	SPRP	No face to face panel. Reviews by documentation CD/DAMHS.
	Court	Only AVL
	On bail court reports	No on site court outpatient assessments including (community interface) Kowhai site. In custody court reports as agreed with Corrections.
	Contact Register	Contact register completed every shift Use of staff ID swipe cards at all swipe points to automatically track and trace movements through the facility.
	COVID-19 management	Pre-screening all admissions and discharges. Follow Pandemic RFPS [redacted] plan – weekly update.

Notes:
Blue assumes at least one COVID-19 case in [redacted]

*Note Kowhai is considered to be a community interface site and therefore not onsite.

*** Safe hygiene and COVID-19 National Guidance including use of governmental and WDHB COVID-19 Screening & Clinical Assessment Tool / recommended masks / face coverings / contact tracing / social distancing and hygiene etc.

National Alert Level: **National Hospital Response Framework Alert Level:**	**Service delivery area inpatient:**	**Alert Level 1: "Disease is contained in NZ"**	**Alert Level 2: "Disease is contained but risk of community transmission remains"**	**Alert Level 3: "High risk the disease is not contained"**	**Alert Level 4: "The disease is not contained".**
ORANGE **Trigger Status: One or more COVID-19 positive patients in your hospital; community**	Bubbles	Mason Bubble		Unit "bubbles" with minimised staff movement*. Bureau restricted to single "bubble".	Unit "bubbles" with only emergency staff movement.
		Cross bubble movements (on call, pharmacy, phlebotomy, duress responses, medical staff, deliveries) – contactless where ever possible. Where unavoidable, strict adherence to PPE, including use of fresh gloves			

transmission/multiple clusters in your community; isolation capacity and ICU capacity impacted; significant staff absences; extensive staff redeployment; gaps not being covered **(If one or more COVID-19 positive cases at [redacted] regardless of the status of other hospitals follow MASON COVID-19 POSITIVE section)**		disposed of and hands sanitised between bubbles, social distancing and NIC to ensure all surfaces etc wiped post contact.		
	Afterhours medical cover	Follow usual after hours process for medical emergencies. For all matters usually requiring a registrar, contact on call forensic SMO. On call medical staff may have a higher threshold for breaching bubbles and may use remote technologies to aid with assessment and advice		
	Leave	Re open trust office. Ground access relaxed to include stream/proximal 'bubbles' and access to cross-service programmes. Exceptional circumstances leave approval on case by case basis – CD/DAMHS	Trust office remain closed Ground access relaxed to include stream/proximal 'bubbles'. Exceptional circumstances leave approval on case by case basis – CD/DAMHS	Trust office closed Ground access limited to one bubble at a time as per schedule Exceptional circumstances leave (e.g. hospital/compassionate/court) approval on case by case basis – CD/DAMHS
	Programmes	Stream/proximal 'bubbles' shared programmes ** In house programmes BAU. No in-reach facilitators on site. Work Rehab closed. Religious services individualised support – not face to face. Virtual programme facilitation will be scheduled where possible.		Unit/team 'bubbles' programmes only. Limited in house programmes BAU. No in-reach facilitators on site. Work Rehab closed. Religious services individualised support – not face to face. Virtual programme facilitation will be scheduled where possible.
	Visits	Compassionate visits only approved by Clinical Director and Operations Manager. Appropriate provision for PPE to all visitors		
	Catering	Hospital catering only across site. Canteen provided. Multiskill no longer serve meals and concentrate on cleaning duties.		

		Unit to disinfect food trolley prior to entering the unit.
	Admission transfer and discharge process	Admission: WDHB COVID Screening Tool process and pathway limit admissions of non-infected service users where possible Respite support may be needed for NGO / FCT service users if placement breaking down Transfers only within same triage groups Suspend transfer / discharge unless certain not vectors of COVID-19
	Training	No students on site C+R postponed Resus, PPE, Infection control allowed Students and study / CME as determined by DHB guidance
	HR processes	Contactless Recruitment e.g. Zoom on-going – temp contracts where references not possible Orientation only within strict bubble Special leave Occ Health determined staff off site Leave requests to be determined by HR
	SPRP	No face to face panel. Reviews by documentation CD/DAMHS.
	Court	AVL TBA by Judiciary
	On bail court reports	Offsite community assessments to be confirmed (Courts, legal offices, residence etc.) where safe** and / or by AVL. No on site court outpatient assessments including (community interface) Kowhai site.
	Contact Register	Contact register completed every shift Use of staff ID swipe cards at all swipe points to automatically track and trace movements through the facility.
	COVID-19 Management	Pre-screening all admissions. Follow Pandemic RFPS [redacted] plan – weekly update.

Notes:
Orange assumes no COVID-19 cases in [redacted]

*Note Kowhai is considered to be a community interface site and therefore not onsite.
**to ensure adherence to social distancing and safe hygiene and COVID-19 National Guidance
including use of governmental recommended masks / face coverings / contact tracing / social distancing etc. .

National Alert Level:	**Service delivery**	**Alert Level 1: "Disease is contained in NZ"**	**Alert Level 2: "Disease is contained but risk of community transmission remains"**	**Alert Level 3: "High risk the disease is not contained"**	**Alert Level 4: "The disease is not contained".**

National Hospital Response Framework Alert Level:	area inpatient:				
RED **Trigger Status: One or more positive COVID-19 cases in your hospital; community transmission/widespread outbreaks in your community; isolation capacity, ICU capacity at capacity; all available staff redeployed to critical care** **(Assumes one or more COVID-19 positive cases at [redacted])**	Bubbles	Staff and SU move as required. Shielding of vulnerable patients not currently infected is prioritised. Where possible consider alternatives to bubble breaches (contactless deliveries, telehealth, use of zoom, delegation to staff within bubble). Appropriate use of PPE for any unavoidable bubble intrusions.			
		Cross bubble movements (on call, pharmacy, phlebotomy, duress responses, medical staff, deliveries) – contactless where ever possible. Where unavoidable, strict adherence to PPE, including use of fresh gloves disposed of and hands sanitised between bubbles, social distancing and NIC to ensure all surfaces etc wiped post contact.			
	Afterhours medical cover	Follow usual after hours process for medical emergencies. For all matters usually requiring registrar contact on call forensic SMO. On call medical staff may have a higher threshold for breaching bubbles and may use remote technologies to aid with assessment and advice.			
	Leave	Trust office closed. Ground access limited to one 'white bubble' at a time as per schedule (Yellow and blue bubbles internal courtyard access only). Exceptional circumstances leave (e.g. hospital/compassionate/court) approval on case by case basis – CD/DAMHS			
	Programmes	Unit/team 'bubbles' programmes only. Limited in house programmes. No in-reach facilitators on site. Work Rehab closed. Religious services individualised support – not face to face. Virtual programme facilitation will be scheduled where possible.			
	Visits	Compassionate visits only approved by Clinical Director and Operations Manager. Appropriate PPE to be provided to all approved visitors.			
	Catering	Hospital catering only across site. Canteen provided. Multiskill no longer serve meals and concentrate on cleaning duties. Unit to disinfect food trolley prior to entering the unit.			
	Admission transfer and discharge process	Admission: WDHB COVID Screening Tool process and pathway limit admissions of non-infected service users where possible – closed to all but legally required admissions or to support breakdown of community NGO / individual placements Transfers as needed to manage rapidly changing needs of service / service users			

		Suspend discharge
	Training	No students on site C+R postponed Resus, PPE, Infection control allowed Students and study / CME as determined by DHB guidance
	HR processes	Contactless Recruitment e.g. Zoom on-going – temp contracts where references not possible Limited safety related orientation Special leave Occ Health determined staff off site Leave requests to be determined by HR
	SPRP	No face to face panel. Reviews by documentation CD/DAMHS.
	Court	Only AVL
	On bail court reports	No on site court outpatient assessments including (community interface) Kowhai site.
	Contact Register	Contact register completed every shift Use of staff ID swipe cards at all swipe points to automatically track and trace movements through the facility.
	COVID-19 Management	Pre-screening all admissions and discharges. Follow Pandemic RFPS [redacted] plan – weekly update.
Notes: *Note Kowhai is considered to be a community interface site and therefore not onsite. Red assumes at least one COVID-19 cases in [redacted] **to ensure adherence to social distancing and safe hygiene and COVID-19 National Guidance including use of governmental recommended masks / face coverings / contact tracing etc.		

Appendix B: Consent Forms

Consent Form

Project title: ***How did service users'/tāngata whai i te ora experience their occupations during COVID-19 restrictions in forensic mental health setting.***

Project Supervisor: ***Dr Margaret Jones and Professor Brian McKenna***

Researcher: ***Sophie Simeti***

- I have read and understood the information provided about this research project in the Information Sheet dated 18 August 2022.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-recorded and transcribed.
- I understand the researcher will do everything in their power to ensure my confidentiality is maintained, however there may be situations where this is unavoidable.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and it will not affect my treatment or progress at the [redacted]
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please circle one): Yes No

Participants signature: .....

Participants name: .....

Responsible Clinician or Keyworker's signature: .....

Responsible Clinician or Keyworker's name: .....

Date: .....

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this

Appendix C: Advertisements

Would you like to share your experience of how COVID-19 impacted your day-to-day activities?

Participate in a 30-60 minute interview to have your voice heard. It will allow us to hear about the impact of COVID-19 directly from consumers. The service may consider finding from the research to improve future responses to COVID-19 restrictions.

Contact Sophie Simeti (OT) on ext. 47879 for more information.

AUT

Appendix D: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

18 August 2022

Project Title

How service users/tāngata whai i te ora experienced their occupations during COVID-19 restrictions in a forensic mental health setting.

An Invitation

Kia ora, my name is Sophie. I am an Occupational Therapist at the Mason Clinic. I would like to invite you to participate in my research project. It is your choice if you would like to participate or not and your decision to take part will not affect your treatment or progress at the Mason Clinic.

What is the purpose of this research?

The COVID-19 pandemic has changed our way of life. In Aotearoa New Zealand, restrictions were put in place to help manage the spread of infection. However, there is no research exploring how these restrictions impact on forensic mental health service users'/tāngata whai i te ora. I would like to find out about their experiences and the impact restrictions had on their day to day activities.

The information gathered from this research may provide a basis for improving outcomes for any potential future restrictions at the Mason Clinic. The findings of this research may be used for journal articles and presentations, and will support me in working towards writing a thesis for my Master's degree.

How was I identified and why am I being invited to participate in this research?

I am inviting you to participate in this research as you were living in one of the minimum secure units at the Mason Clinic during the COVID-19 restrictions. During this time the restrictions may have impacted on your day-to-day activities and I would like to hear more about how that experience was for you. It is important that you are well in order to participate in this research. I will need to check with your clinical team that they are comfortable you are well enough on the day to participate in the study. If your team decides you are unwell, then unfortunately you will not be able to participate, and I will discuss this reason with you and your keyworker.

How do I agree to participate in this research?

If you would like to participate you can contact me directly on extension 47879, or let a member of staff know who will get in contact with me. I will give you a Consent Form that you can take away and discuss with your keyworker / clinical team. A member of your clinical team will need to confirm that you can take part in the research and that your involvement won't cause you any additional distress. You can sign the consent form at the interview before we start.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

You will meet with me for an interview that will take about 30-60 minutes. You will need to meet with your keyworker before the interview to confirm that you are feeling ok for the interview. The interview will take place in a private meeting room at the Mason Clinic and it will be recorded. You will be asked questions about how your day-to-day activities were impacted during COVID-19 and how that experience was for you. You do not have to answer any questions you do not want to and can end the interview at any point.

The recording of the interview will be typed out, and a copy of the written transcript will be given to you. This is a record of what was said in the interview by both the interviewer and yourself. You will have the

Appendix E: Interview Guide

Indicative Questions

Gender:

Male Female Transgender Non-Binary Other Prefer not to say

Ethnicity:

Māori Pākeha Asian Pacifika Other

Age:

18-24 years 25-34 years 35-44 years 45-54 years 55 years or older

Unit:

[redacted] [redacted] [redacted] [redacted]

1. Can you tell me about your day to day activities and routines pre COVID-19?
2. How did the "COVID-19 restrictions" personally impact on your day to day activities?
3. How did you feel when that happened?
4. Can you tell me about any positive impacts on your day to day activities?
5. How was that for you?
6. What access to meaningful occupations/activities did you have during "COVID-19 restrictions"?
7. Was there anything that could have been done differently to make the "COVID-19 restrictions" easier for you?
8. Is there anything else you would like to share about your experience?

Prompting questions: Can you tell me more about that? Can you explain that a little more?

Prompts to day to day activities might include:

- Engagement with family/whānau/friends
- Cross Service Programmes
- Community reintegration
- Work rehab/education providers
- Self-catering (shopping, meal preparation)
- Meaningful/leisure activities
- Exercise outdoors/off grounds

Appendix F: Safety Protocol Extract

research.

Project title and brief description:

How service users/tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting.

Applicant

Margaret Jones

Primary Researcher

Sophie Simeti

Where is the research being undertaken?

The research will be undertaken in interview rooms on minimum secure units at the Te Whatu Ora Waitematā Regional Forensic Service. The primary researcher works within the services and holds all required access to the buildings (swipe cards, keys and finger prints).

Who will be collecting the data and interacting with participants?

The primary researcher, Consumer Advisor and Taurawhiri will be interacting with the participants. All of those mentioned hold employment positions in the service the research is taking place. All will follow usual safety protocols for being on one of the minimum secure units.

How familiar is the researcher with the social or cultural context of the research ?

The researcher has worked in forensic mental health for 9 years. This has given the researcher insight into the institutional culture that the participants live in. The researcher is mindful of culturally safe practice when interacting with service users/tāngata whai i te ora. The researcher has obtained Locality Sign Off from the Clinical Director and Operations Manager and Support from the Taurawhiri (Māori Cultural Advisor's) group.

How safe are the activities in which the researcher is taking part?

The researcher will be interviewing service users/tāngata whai i te ora in minimum secure units at the Te Whatu Ora Waitematā Regional Forensic Service. Potential participants will have been mentally well for an extended period of time however being on a mental health unit carries a small risk of physical/verbal harm. There is no perceived increase in risk as a direct result of interview.

What level of access to support is available?

The primary researcher will follow standard safety protocol for meeting with a tangata whai i te ora on a unit:

- Mental wellness checks for participant carried out prior to interview
- Informing unit staff of arranged meeting notifying where and when interview will take place
- Ending interview should participant appear in any way distressed
- Carrying a duress alarm
- Reporting any concerns back to unit staff

Should it be required there are nurses and mental health care assists who would be able to respond to a duress alarm. Staff responding to duress will support with any de-escalation if required.

These are all standard protocols and not implemented due to any perceived risk associated as a direct result of interview.

What emergency plans are in place? Who can help?

Should it be required there are nurses and mental health care assists who would be able to respond to a duress alarm. Staff responding to duress have attended required training and will support with any de-escalation if required.

Don't forget to update your safety protocol regularly:

Date for next review

January 2023

Appendix G: Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

11 October 2022

Margaret Jones
Faculty of Health and Environmental Sciences

Dear Margaret

Ethics Application: 22/259 **How service users/tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting**

We advise you that the Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application at its meeting of 3 October 2022.

This approval is for three years, expiring 3 October 2025.

Non-Standard Conditions of Approval

1. Please insert the AUT logo on the advertisement.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: sophie.simeti@waitematadhb.govt.nz; Brian McKenna

Appendix H: Coding Examples

Appendix I: Taurawhiri Approval

REGIONAL FORENSIC PSYCHIATRY SERVICES
Private Bag 19986, Avondale
Auckland, 1746, New Zealand

All Enquiries
Tel: 09 815 5168 Fax 09 845 7536

May 25th, 2022.

Auckland University of Technology Ethics Committee (AUTEC),
Auckland University of Technology.

Kia ora koutou,

Re: How service users/tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting.

At the Auckland Regional Forensic Psychiatry Service (ARFPS), we have a Māori Governance Group called the Taumata. The Taumata has appointed the Taurawhiri Group of cultural experts to review all research coming through the service, in terms of its cultural safety and Te Tiriti o Waitangi obligations. I am the tiamana (chairperson) of theTaurawhiri Group and authorised by our kaumatua at the ARFPS, Haahi Walker, to oversee all of the processes mentioned.

On the 3rd of May, Masters in Health Science candidate, Sophie Semeti and supervisor Professor Brian McKenna addressed the Taurāwhiri Group after sending us an overview of the above mentioned research. Taurāwhiri had the opportunity to review the proposal and seek clarification of the research process.

At the meeting, a number of points were highlighted by the Taurawhiri Group and Sophie was asked to discuss these with her supervisors and come back to a further meeting to discuss. These were:-

- The value of restricting the research to minimum secure settings.
- If whānau could also be interviewed.
- The need for Māori cultural support to be present during the interview of tāngata whai i te ora.
- Consideration of koha for tāngata whai i te ora being interviewed.
- The value of interviewing tāngata whai i te ora who were living in the community and had a readmission during COVID-19 restrictions (as a point of comparison).

Following discussion with her supervisors , Sophie returned to the Taurawhiri Group on 25th May. The Group acknowledged the need to constrain this research because it is a Masters study. A discussion was had that the success of this research could stimulate further research to address some of the points made (like the need to capture a whānau voice). An offer was made by me, as the chairperson of the Group, to act in a Māori advisory position as the research progresses.

After a thorough review, we feel that the research meets its Te Tiriti obligations and can be approved to proceed from a culturally safe perspective.

Hei kōnā,

Barry Pene-Gestro,
Tiamana, Taurawhiri Group.
Auckland Regional Forensic Psychiatry Services.

Appendix J: Service Approval

Application for Approval of Research

Te Whatu Ora
Health New Zealand
Waitematā

RM15369 **How service users/tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting**

WDHB Contact: Sophie Simeti

Department: Regional Forensic Psychiatry Services

Project Type: Observational research

Duration: 30/09/2022 - 30/11/2023

Description: The COVID-19 pandemic has caused changes to the way of life around the world. However, there is no research exploring how these changes impact on forensic mental health service users'/tāngata whai i te ora occupations. An Interpretive Description methodology will be used to describe service users'/tāngata whai i te ora perspectives and experiences of COVID-19 restrictions in a forensic mental health service, to explore how their occupations were affected. The information will provide a basis for improving outcomes for any potential future restrictions.
I am using the term `restrictions' to cover National Lockdowns, COVID-19 Protection Framework, COVID-19 related isolation (blue/yellow streams), changes to leaves, therapeutic programmes, whānau/family visits and any other changes to BAU relating to COVID-19.

Locality Review

The undersigned agree to the following:
- The study protocol and methodology has merit and aligns with departmental/service area interests.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Appropriate arrangements are in place to notify other relevant local health or social care staff about the study, and for making available any extra support that might be required by participants.
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that results will be disseminated & the findings translated into evidence-based care (where appropriate).

Before this study is granted approval to commence, the Research & Knowledge Centre on behalf of Te Whatu Ora - Waitematā will check:
- there has been the appropriate level of ethical review eg ethics committee approval if required.
- cultural consultations have occurred or will be undertaken, as appropriate.
- appropriate confidentiality provisions have been planned for.

Dept/Org	Role	Name (Print Clearly)	Signature	Date
Regional Forensic Psychiatry Services	*Clinical Director*	*Krishna Pillai*		5.9.22
Regional Forensic Psychiatry Services	*Manager*	*Mark Ashby*		5th September 2022

Return completed form to the Research & Knowledge Centre. Alternatively, emails from approvers are acceptable as electronic sign-off.

Appendix K: Waitematā Research and Knowledge Centre

Research & Knowledge Centre <research@waitematadhb.govt.nz> Sophie Simeti (WDHB)

RM15369 - How service users/tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting - Locality Authorisation

Dear Sophie

The Research & Knowledge Centre has now received the relevant approvals for the following study:

Title: How service users/tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting

Registration #: RM15369

This study now has Waitematā Locality Authorisation. Any substantial amendments to your study must be submitted to the Research & Knowledge Centre for review.

Note that all research, audit and related activity must meet ethical standards in relation to the safe storage, retention and disposal of research data.

At the conclusion of this study a copy of any outputs, reports or publications should be forwarded to research@waitematadhb.govt.nz

Good luck with your study.

Regards
Research & Knowledge Centre
Te Whatu Ora - Waitematā
research@waitematadhb.govt.nz

Appendix L: PGR1 AUT Approval

Auckland University of Technology
Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999
www.aut.ac.nz

15 July 2022

Sophia Simeti
64 Lynwood Road
New Lynn
Auckland 0600

Dear Sophia,

Thank you for submitting your PGR1 Research Proposal application for the Master of Health Science.

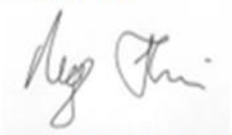
Your proposal has been reviewed and approved by the Faculty of Health and Environmental Sciences, at the Postgraduate Research Committee July 2022 meeting.

Your enrolment details are:

Current programme:	Master of Health Science
Enrolment:	HEAL999 Thesis (part-time)
Student ID:	1118776
Topic:	How service users/tāngata whai i te ora experience their occupations during COVID-19 restrictions within a forensic mental health setting
Primary supervisor:	Dr Margaret Jones
Mentor supervisor:	Prof Brian McKenna
Start date:	18 July 2022
Expected completion date:	12 July 2024

For more information about the programme of study, please refer to the *Postgraduate Handbook*.

Yours sincerely



Associate Professor Nigel Harris
Associate Dean Postgraduate Research · Hoa Mautaki Taura Rangahau
Faculty of Health and Environmental Sciences · Te Ara Hauora A Pūtaiao
Auckland University of Technology · Te Wānanga Aronui o Tāmaki Makau Rau
09 921 9666 extension 7301

Cc Primary supervisor Dr Margaret Jones