**From Let It Be to It Must Be Love: the development of a choir for patients and staff at a high secure hospital.**

**Abstract**

Patients in high secure services are necessarily excluded from the rest of society, a situation which nevertheless risks them becoming further alienated and unwell. Recent policy developments aimed at making mental health services more recovery focused and socially inclusive challenged therapists to find ways to introduce them in a high secure setting. A joint project initiated by the music therapist and a clinical specialist occupational therapist at a high secure hospital attempted to put these principles into practice by involving patients and staff in a weekly choir, which the members decided would be called the Vocal Group. The group worked together to decide its direction and purpose. The patients and staff felt that the group was inclusive, enjoyable, levelling and recovery focused. The group performed at the first ever patient conference at the hospital in October 2010. Despite dissolving in 2011, the choir started afresh, performing again at the 150th anniversary of the hospital in 2013, and continues as a high profile therapeutic intervention within the hospital. The new choir has been developed using lessons learned from the earlier project to ensure that the therapeutic benefits continue to be felt by both the patients and the organisation as a whole.

**The Benefits of Singing as a Group**

The joys and benefits of singing with others are well known to those who take part in this activity, whether in church halls up and down the country or indeed in football grounds on a Saturday afternoon. The huge success of the recent (and ongoing) BBC series The Choir and its offshoots (Malone, 2014) has brought the idea of singing together back into modern culture.

There has recently been a surge of interest in the harnessing of these benefits for more specific purposes, for example the singing groups established in East Kent by the Sidney De Haan Research Centre for Arts and Health for people with COPD (Clift et al., 2012) and the work of Bailey (et al., 2003) and Rio (2005) with choirs for the homeless. Accompanying this, there has been an increase in academic research which has served to give group singing medical credibility: there is a considerable literature base for the therapeutic benefits of group singing for mental illness sufferers (e.g. Clift and Morrison, 2011 and Dingle et al., 2013) and the Music Therapy profession has, since its earliest days, pioneered the clinical use of the voice to great effect with a variety of client groups (Alvin, 1966, Bruscia, 1991, Bunt, 1994, Wigram and De Backer [eds.], 1999, Bunt and Hoskyns [eds.], 2002). More specifically, there is a growing interest in the use of the choir as a therapeutic instrument in the forensic setting (Mezey et al. 2015).

Research carried out in the high secure hospital has showed that music plays a huge part in the lives of patients (Sharpe, 2012). In addition to the varied benefits conferred by listening, many patients have a history of also playing music, rapping, singing or as music producers. This is often experienced as a way of “being someone”, of not only being accepted but also of gaining respect in a world from which they often feel alienated. In keeping with current trends, hip hop and rap music have been incorporated into therapeutic vocal groups and Short (2014) has highlighted the specific mechanisms and benefits of these styles in boosting an individual’s sense of self-knowledge and empowerment. These possibilities for treatment have been highlighted in the national press (Hooton, 2014) and incorporated into our own group by popular request.

**A History of Music and Singing in the Hospital**

The high secure hospital discussed here is the oldest in the United Kingdom, and much has been written about the historical therapeutic use of singing and other creative media. Ralph Partridge (1953) and ex-hospital psychologist Tony Black (2003) have written about the historical use of singing within the hospital, both as a means of involving patients in an annual concert but also to bring patients together with staff, their families and local villagers. In the 1950s, every concert started with a song called “Let the People Sing” (from a film based on a J.B. Priestley story). This song has since been rediscovered, and the choir performed it at the hospital’s 150th anniversary ceremony in 2013. It is clear that the early choirs in the hospital were not just about enjoyment and the experience of working together on a group project, but also had the function of starting the process of integrating patients back into society, reintroducing them first to the local community and staff members’ families, in preparation for a gradual rehabilitation into the wider world.

The authors had previously successfully facilitated one patient who wanted to start a band with them and another patient within the hospital (Maguire and Merrick, 2013), but whilst they acknowledged that it was the leadership of the band that perhaps provided the greatest benefits to that one instigating patient, it was also possibly significant that the band leader sang whilst the other patient did not.

**Models and approaches**

The authors, along with many clinicians in the hospital, found inspiration within recovery literature, such as that by Humphries et al., (2008), who describe recovery as a personal journey to work with a mental illness to develop individual potential and capacities. Writers such as Deegan (1988) and Reeves (1998) have made clear from their personal experience that recovery involves developing a new identity through acceptance of symptoms as part of oneself. For patients in high secure services, however, public protection requires that social isolation is an essential part of their existence, despite this meaning that the patients are potentially missing out on the benefits conferred by modern recovery-focused, socially inclusive services. The development of the Vocal Group aimed to incorporate the values of recovery and social inclusion within the hospital environment through involving patients and staff equally in deciding its name, aims and objectives, as well as, of course, the songs that everyone would sing. This approach to the project was justified by critical reports from NHS London (2009) and the Care Quality Commission (2009) which pointed to systemic failings in the hospital including a lack of proactive engagement by staff with patients.

Writers such as Deegan (1988) and Reeves (1998) have made clear from their personal experience that recovery involves developing a new identity through acceptance of symptoms as part of oneself. Despite very real potential value in pursuing socially inclusive and recovery focused principles in a high secure environment, the lack of specific direction as to how to adapt these principles combined with the strength of the organisational culture in a high secure setting meant that implementing these principles was highly challenging (Gabriel, 1999). Placing the recovery and social inclusion agenda in this context sets up a powerful tension between a requirement to work with patients in a respectful and recovery-focused way, and the Knoll’s (2008) observations of a culture within a high secure environment of working as part of a team that serves to protect itself as well as the public by regarding its service users as inherently manipulative, cunning, and violent.

Whilst the development of the choir illustrated a severe tension between the demands of security and the need to provide a modern, recovery focused, socially inclusive approach, it also reflected an intersection of occupational therapy and music therapy, inasmuch as it provided a meaningful occupation to ameliorate severe symptoms of mental illness whilst generating emotional resonances within individuals in response to the creation of music.

From an occupational therapy perspective the choir was theoretically underpinned by the Model of Human Occupation (MOHO, Kielhofner, 2008), which is built on the notion of an innate human drive for mastery over the environment that requires functional capacities such as motor and cognitive skills, communication and interaction. If people are unable to fulfil this drive then they experience occupational deprivation (Pollard et al, 2009) It was felt the involvement of staff and patients in equal roles was seen as a means of enabling patients to access so many of the everyday activities that most of us take for granted. Most importantly of all, it was felt that the group would jointly experience an increase in volitional behaviours, key to Kielhofner’s (2008) model, and reflective of a sense of being creative (Wilcock, 1998).

**Ethical Considerations**

The creation of the choir and its evaluation formed part of the ongoing audit and service improvement process. However, as the outcomes were potentially reaching a wider audience, permission to develop the project and disseminate outcomes was obtained from the clinical director.

**Establishing the choir**

The choir met weekly in the beautiful, airy hospital chapel in the old hospital main building. The initial group session involved seven patients and eleven staff who were asked the following questions:

* What should the group be called?
* What ground rules should there be?
* What do you want to get from the group?
* What should we sing?

The questions reflected the importance of involving the group in its planning and development right from the beginning. Members of the group wrote on sticky notes and put their answers up on boards.

The group chose the name “Vocal Group” and identified the following ground rules, quoted verbatim.

1. Don’t take the Mickey
2. Give it everything you’ve got
3. Some might think they can do better
4. Listen to each other, enjoy, tolerate
5. Work hard for the goal, work as a team
6. No swearing if possible.

Some weeks later, the group added “Be compassionate”.

As Smith et al. (2007) explain, ground rules for a group are essential, as they help the members to feel safe; and it was stressed that the group was about enjoyment and social inclusion through a normative activity. Cvetkovitch and Baumgardner (1973) explained that group norms are illustrated in the way that members standardise their behaviours to create customary ways of acting and interacting.

The goals of the group were reviewed by the authors and later divided into tangible outcomes, spiritual benefits and social interaction/inclusion. These are shown in Table 1, again reproduced verbatim from the members’ written contributions.

The suggested repertoire encompassed a huge range, esoteric, traditional, musicals, and pop and rock from the 1950s to 2000s. We ended up focusing on a range of pop and rock from the 1970s and 1980s to 2000s.

|  |  |  |
| --- | --- | --- |
| **Tangible Outcomes** | Learn new musicMake enough material for an albumSome Experience Singing different things Sense of achievement andcollaboration | Some Vocal ExerciseA CDTo work towards a performance/concertImprove my singingLearn new songs/techniquesBobby Vee music |
| **Spiritual** | In front of the “Pope” maybe? Sing my Health and Soul “thy” our Lord - thanks | Sing in the carol concert A joyful noise |
| **Social Inclusion/ Interaction** | Sharing ideas with other people Have a good time Working Together Fun! Meeting people and joining a vocal groupGet to know other patients I don’t know alreadyEnjoy singing old/new songs Sense of community by it being mixed staff/patients Enjoyment Sense of Belonging (to a group)  | Fun with coffee + biscuits + cakeHave fun, get to know other peopleMeet new peopleThe pleasure of singing with a group of people – not done it for ages A good timeInteraction with other peopleGetting to know new friendsCooperation and enjoyment of thatBe part of a group on equal terms |

Table 1 Goals of the Vocal Group

**Outcomes**

Our repertoire started from common ground – Silent Night – and branched out to include the following songs:

* Bridge Over Troubled Water (Simon)
* Hey Jude (Lennon and McCartney)
* Wonderwall (Gallagher)
* Yesterday (Lennon and McCartney
* Hallelujah (Cohen)
* Nowhere Man (Lennon and McCartney
* Amazing Grace (Newton and Walker)
* Bohemian Rhapsody (Mercury)
* Jolene (Parton)
* All You Need Is Love (Lennon and McCartney
* No Woman No Cry (Ford)
* Folsom Prison Blues (Cash)
* Chasing Cars (Lightbody)
* Knocking On Heaven’s Door (Dylan)
* It Must Be Love (Siffre)
* Let It Be (Lennon and McCartney

The significance of certain tunes that affect all of us became our theme; that what may have been a happy experience associated with the music for one may have been its opposite for another. Tolerance of these differing, sometimes contradictory responses, meanings and memories and the common validity given to them gave the Vocal Group its flavour and whilst we were one group, it was impossible to forget that at the core of this homogenous whole was the uniqueness of the individuals involved.

The fact that we were together for the whole afternoon gave the activity a more “natural” feel where things could happen at their own pace. Organisational narratives (Browning, 1991) describe how the hospital used to work in this way. TLC – tea, largactyl and cigarettes are spoken about by older staff as the best way of relating to patients by sitting down with them and simply talking, taking time, being interested, sharing experiences and so on.

|  |  |
| --- | --- |
| **Question** | **Examples of Responses** |
| What are your impressions of the Vocal Group? | Meeting new people. If I meet people from around the hospital who have been in the group I say hello.It proves that you don’t have to have a particularly good voice – everybody can have a go and join in.I didn’t think I’d be able to do half of what I have been able to do – it has been self esteem buildingGeneral sense of peace, achievementI’ve challenged myself, doing something out of my comfort zoneI don’t feel so trodden down here |
| How have you found singing with patients/staff? | It was great! They show a lot of respect. I know it’s their job, but if I were them it’s something I wouldn’t mind doing in my spare time (patient)When I moved from rehab to high dependency I thought I wouldn’t be able to do the group anymore and I was quite upset (staff). |
| Have you encountered any problems with the group? | We are unable to get here – 2 o’clock is difficult because of congestion on the patients’ escort radio system.I got embarrassed. That’s why I don’t do it anymore. I’m a bit shy really!  |
| How should the group develop in the future? | It would be better if you could somehow get people from a choir or who just sing, they could coach us. There is a woman in patients’ education who would do it. If you don’t know anything about singing it’s difficult to know where to start. 2 or 3 part harmonies.Just keep doing what we are already doing. |

 Table 2 Outcomes from the initial audit of the Vocal Group

After four months there was an initial audit. Some of the outcomes are shown in Table 2, once again quoted from the members’ contributions. A range of questions was asked to mixed focus groups of staff and patients: Outcomes were incorporated into changes to the Vocal Group where possible, but there were contradictory responses. Some wanted more structure, more teaching, more direction, and some wanted things to stay as they were.

Staff feedback was unfailingly positive, with one occupational therapist commenting that

“It was an excellent example of staff and patients on a level playing field working in partnership with each other to achieve something rewarding and something to be proud of”.

A clinical psychologist added “I loved it; it was a great experience just to be doing something “normal” with others, to share in something enjoyable, a shared interest. To see patients and staff working together in the community of the hospital to produce something creative. The importance of thinking about all aspects of a patients’ life, not just “formal therapy” but doing things which we all need in our lives, to keep the balance and to promote mental wellbeing.”

Patients talked of “not feeling so trodden down here”, and used words such as “levelling” to describe the experience. Comments such as “We’ve done quite well considering none of us know each other” would seem to refer to the ability of individual patients to tolerate a group setting at all; singing in front of other patients and staff merely adding another level of challenge to a process that is already incredibly difficult.

**The Performance**

 The First Patient Recovery Conference was held at the hospital in October 2010, and the Vocal Group was involved. Staff and patients assembled at the front of the room and began singing, and then the audience joined in as well. A remarkable thing happened just before we started singing. Simon, a patient who had felt unable to continue after a few early sessions of rehearsal, when his sense of paranoia overwhelmed his wish to stay in the group, was in the audience, and the other patients en masse invited him back into the choir, saying that he was a necessary part of it, and welcoming him back into the fold. A lapsed member was welcomed back – the difference between lapse and relapse being is an important distinction for many patients; the principle of not giving up, and not giving up on someone. It was touching that the audience consisting largely of other patients were able to join in with most of the songs, adding to the sense of unity and community.

Although the group had been predicated upon the idea of the process involved, it seemed here that the performance could galvanise and concentrate the process.

**Conclusion**

Drennan and Wooldridge (2014) explain how important it is for staff to use a strengths-based approach, and so it is necessary to have opportunities for patients to be able to demonstrate these strengths. The Vocal Group demonstrated the importance of encouraging patients to attempt to do things with a real risk of failure, to learn from and support one another; which is surely the key to social inclusion. After the success of this project, and, as they say, due to popular demand, the Vocal Group was resurrected in December of 2013. Phase Two of the group (now renamed The Choir) addressed difficulties in retaining staff members by making it a group for staff first and adding patients when this was somewhat established. As before, the Christmas season provided us with an opportunity to get together and perform, and members of the Senior Management Team (including the Medical Director) attended the carol service and witnessed first-hand the joyful noise created by a mixed group of staff and patients working together “on a level playing field”. This led to encouragement from managers, as well as offers of help with logistical problems, and served to give the Choir “legitimacy” amongst both staff and patients.

We have since performed at the hospital’s 150th anniversary celebrations in 2013, the opening of a new in-house Recovery College and at the Remembrance Day Service, singing a selection of popular songs associated with various conflicts, and the Carol Service 2014, accompanied by the Salvation Army Brass Band. The democratic nature of the Choir means that it continues to offer an opportunity for patients and staff to develop together.

The Choir was highly commended at the Royal Society for Public Health awards in 2013. This allowed us the chance to place a framed certificate on view within the hospital, thereby validating the efforts of those patients who had attended rehearsals and sung in front of others despite suffering severe and enduring mental illnesses.

**References**

Alvin, J. (1966/1981). *Music Therapy.* London: Stainer and Bell.

Bailey, B & Davidson, J (2003). Amateur group singing as a therapeutic instrument. *Nordic Journal of Music Therapy,* 12, 18-32.

Black, D.A. (2003). *Broadmoor Interacts: Criminal Insanity Revisited; a psychological perspective on its clinical development*. Chichester: Barry Rose Law.

Browning, L. D. (1991).Organisational narratives and organisational structure, *Journal of Organizational Change Management*, 4, 59-67. doi.org/10.1108/EUM0000000001199

Bruscia, K.(ed.) (1991). *Case Studies In Music Therapy.* Phoenixville, Pennsylvania: Barcelona Publishers.

Bunt, L. (1994). *Music Therapy: an art beyond words.* London: Routledge.

Bunt, L & Hoskyns, S. (eds.) (2002). *The Handbook Of Music Therapy.* Hove: Brunner-Routledge.

Care Quality Commission (CQC)(2009). *Investigation into West London Mental Health Trust*. London: Care Quality Commission.

Clift, S. & Morrison, I. (2011). Group singing fosters mental health and wellbeing: findings from the East Kent ‘singing for health’ network project. *Mental Health and Social Inclusion,* 15, 2, 88-97.

Clift, S, Morrison, I, Skingley, A, Page, S, Coulton, S, Treadwell, P, Vella-Burrows, T, Salisbury, I & Shipton, M (2012). An Evaluation Of Community Singing For People With COPD (Chronic Obstructive Pulmonary Disease). Retrieved from: <http://www.canterbury.ac.uk/Research/Documents/COPD-Final-Report.pdf#search=%22COPD%22>

Cvetkovich, G. & Baumgardner, S. R. (1973). Attitude polarization: the relative influence of discussion group structure and reference group norms. *Journal of Personality and Social Psychology*, 26, 159-165 doi.org/10.1037/h0034448

Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11,11-19 doi.org/10.1037/h0099565.

Dingle, G, Brander, C, Ballantyne, J & Baker, F. (2013). ‘To be heard’: the social and mental health benefits of choir singing for disadvantaged adults. *Psychology of Music,* 41, 405-421.

Drennan, G. & Wooldridge, J. (2014). *Making Recovery a Reality in Forensic Settings*. London: Centre for Mental Health.

Gabriel, Y. (1999). *Organisations In Depth*. London: Sage.

Hooton, C (2014). Hip-hop can help treat depression, psychiatrists claim. *The Independent*, 13th October 2014.

Humphries, R., Hollins, S. & Kilgallon, W. (2008). *A Common Purpose: Recovery in Future Mental Health Services*. London: Social Care Institute for Excellence.

Knoll, J. (2008). The recurrence of an illusion: the concept of “evil” in forensic psychiatry. *Journal of the Americal Academy of Psychiatry and the Law,* 36,. 105-116.

Maguire, A. & Merrick, I. (2013). Walking the line: Music Therapy in the Context of a High Secure Hospital. Chapter in Compton Dickinson, S., Odell-Miller, H. and Adlam, J. (2013)(eds.) *Forensic Music Therapy: A Treatment for Men and Women in Secure Hospital Settings*. London: Jessica Kingsley Publishers.

Malone, G. (2014). *The Choir* Retrieved from: <http://www.garethmalone.com/programmes/the-choir> Morrison, I., Clift, S., Page, S., Salisbury, I., Shipton, M., Skingley, A., Vella-Burrows, T., Coulton, S. & Treadwell, P. (2013). A UK feasibility study on the value of singing for people with chronic obstructive pulmonary disease (COPD), UNESCO journal, 3, 3. Retrieved from: <http://web.education.unimelb.edu.au/UNESCO/pdfs/ejournals/vol3iss3_2013/003_MORRISON_PAPER.pdf>

Mezey, G, Durkin, C & Krljes, S. (2015). Finding a voice – the feasibility and impact of setting up a choir in a forensic secure setting. *Journal of Forensic Psychiatry and Psychology,* 26, 781-797.

NHS London (2009). *Independent inquiry into the care and treatment of Peter Bryan and Richard Loudwell: Executive summary*. Retrieved from: http://www.tsh.scot.nhs.uk/Care\_And\_Treatment/docs/Learning%20from%20External%20Inquiry%20Reports/PB%20RL%20.pdf.

Partridge, R. (1953). *Broadmoor*. London: Chatto and Windus.

Pollard, N., Sakellariou, D. & Kronenberg, F. (2009). *A Political Practice of Occupational Therapy*. Edinburgh: Elsevier.

Reeves, A. (1998). *Recovery, A Holistic Approach*. Runcorn: Handsell Publishing.

Rio, R. (2005). Adults in recovery: a year with the Choirhouse. *Nordic Journal of Music Therapy,* 14, 107-119.

Sharpe, C. (2012). *“It’s paramount for the heart, the mind, and the soul of the body”: high secure service user perspective on the role of music in the recovery process* (unpublished masters’ thesis), UK: University of Surrey.

Short, H. (2014). *Managing verbal boundaries when using rap in Music Therapy; a qualitative study*. Presented at the 31st Arts Therapies Conference hosted by the Forensic Arts Therapies Advisory Group at The Charity Centre, Directory of Social Change, 24 Stephenson Way, London NW1 2DP on 6th June 2014.

Skingley, A., Page, S., Clift, S., Morrison, I., Coulton, S., Treadwell, P., Vella-Burrows, T., Salisbury, I., & Shipton, M. (2014) ‘Singing for breathing’ - groups for people with COPD: participants’ experiences, *Arts & Health: an international journal for research, policy and practice,* 6, 59-74.

Smith, G., Gregory, K. & Higgs, A. (2007). *An integrated approach to family work for psychosis: A manual for family workers*. London: Jessica Kingsley Publishers.

Wigram, T. & De Backer, J. (eds.), (1999), *Clinical Applications of Music Therapy in Psychiatry.* London: Jessica Kingsley Publishers

Wilcock, A. A. (1998). *An Occupational Perspective of Health*. New Jersey, Slack Incorporated.