Exploring multiple efficacies through sensory relatedness at Restore, an Oxfordshire mental health charity



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Abstract

This thesis responds to the demand for an anthropological evaluation of the service at Restore. It is an exploration of the multiple efficacies in this community mental health charity. Empirically, I work with archival materials about the hospital and community spaces where Restore was incubated and founded. I also present ethnographic accounts of the gardening, craftwork, and catering work at Restore's three recovery groups in Oxford and Banbury. I use a diversity of research methods to study these empirical materials, including participant learning and experience, visual archives analysis, spoken discourse analysis, photo-elicitation and semi-structured interviews.

Guided by the approach of Sensory Medical Anthropology, I emphasise the therapeutic efficacies generated through the restoration of the body's orientation to others, a problem identifiable from the lived experiences of mental illness. I propose that the gardening, craftwork, and catering work at Restore's recovery groups are intrinsically intercorporeal, and the processes for members (service users) to learn the body techniques and collaborate in groups cultivate vital and productive relations.

Moreover, the transmission of body techniques and the collaboration in groups cultivate care, which enables many members to transit into volunteering roles within Restore. Many members become empotted and emplaced as skilful workers for Restore's shops and cafes that cater for the local community. Providing the multiple trajectories for a service member to become 'better' at Restore, the Oxfordshire Mental Health Parnership (OMHP)'s monitor of the 'discharges' of service users into paid employment, which is the most valued outcome that directly informs the statutory funding for Restore, needs to be re-considered. The definition of 'moving on' within the charity could also include more diverse possibilities to enable creative and long-term recoveries.

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Prologue: The demand of an anthropological evaluation

Vignette 1. The Recovery Star

One afternoon at the Elder Stubbs, I saw Robert [1] sitting in the corner of the dining room completing a Recovery Star. The other members, staff, and volunteers had left for the gardening work in the allotments, and the room became a quiet place for him to do the evaluation.

Robert had me look at the Star on the table, which was still blank. I said it looked complicated and asked if there was any difference between 'social networks' and 'relationships', the two indices on the Star. Robert explained that the 'social networks' referred to more general relations such as friends and colleagues at work, while the 'relationships' were more intimate. However, he agreed that the two areas could overlap in real life.

I nodded, and Robert commented, 'It's making some sense. What the Star includes are important in life.' He paused, had a glance out of the window, and added, 'I don't mind doing it. It's just not telling a lot about what we do here.'

Vignette 2. Ready to 'move on'

When Ariel, Ronald, and I were digging on the raised beds in the Nature Garden at the Elder Stubbs recovery group of Restore, I asked about their views regarding the requirement to 'move on' from their recovery group in two years.

Ariel said it was a reasonable arrangement because Restore could be a helpful 'stepping stone' for people to access work opportunities elsewhere. Ronald agreed and said the recovery group at Restore 'should not be a forever place', although the gardening work could be so 'chill' and 'comfortable' that made some members 'unwilling to leave'. Ariel then added that the experience of the work here and the attitude towards leaving 'really depends on the individual.'

Both Ariel and Ronald 'moved on' from the Elder Stubbs in two years. Ronald was enrolled as a student at the Recovery College. Ariel started the traineeship in catering in a downtown café run as a social enterprise.

Joseph who worked in Restore's Garden Café recovery group also planned to move on from his recovery group in two years. He wanted to find a paid job in catering. 'I am still young and I don't want to end up in a mental health recovery group forever,' he said to me during the interview, 'I want to work and make money, and then enjoy life.'

[1] Names of my research participants are pseudonyms unless otherwise stated.

Vignette 3. Unwilling to 'move on'
Jim told the staff and volunteers in his recovery group that he was 'not well enough' to 'move on' because he was in a 'challenging episode' of his bipolar disorder, and the tense relationship with his son was for him already very stressful.

Nate did not want to 'move on', either. His mother visited the recovery group and said she wished that Nate could continue working at Restore because 'he really enjoyed his time here'.

Tray was having a cup of coffee with his friend in the Garden Café, looking sad. I asked how he was. 'Not so good', Tray said. He then told me his membership at Restore was closing.

After receiving the reminder to 'move on', the carer of George called the recovery worker at Restore and explained that George stayed up all night whimpering in his room. She explained that George fell asleep at dawn and could not make it to the recovery group in the morning.

'You see, I come in late all the time,' Linda said to me after being late for an hour, 'because every morning, I sit on the toilet for forty minutes just to get ready to be out of my flat. I don't think I am well enough to move on from Restore, although I have been working in this group for two years.'

In September 2018, I became an in-house volunteer at Restore, a well-known mental health charity in Oxfordshire. My mission was to conduct an anthropological evaluation of Restore's recovery group service. The charity's co-founder, Peter Agulnik, was unsatisfied with the validity of the standardised measurements that Restore must conduct to sustain the financial support from its statutory funder. He believed that a medical anthropological approach might offer an alternative approach to Restore's service outcome which was more 'down-to-earth' and holistic.

By the time I started volunteering at Restore, I was a Master's student in Medical Anthropology who had just spent a year living and studying in England. At the time, the anthropology department in Oxford had an ongoing project, 'Reconceptualising

Recovery', which aimed to examine the case of positive deviance in mental health services in the UK. [2] I proposed to conduct my Master's and Doctoral research under this project. Through Professor Elisabeth Hsu, the project's Principal Investigator and my supervisor, I was able to meet the leadership of Restore and then become a charity volunteer to conduct my ethnographic fieldwork. My research goal was to explore the 'multiple efficacies' of Restore's recovery group work.

As a charity, Restore relied heavily on statutory funding to sustain its service. Its biggest funder during the time of my fieldwork was the Oxfordshire Mental Health Partnership (OMHP). The OMHP was established in 2014. It integrated the Oxford Health NHS Foundation Trust with five mental health organisations: Restore, Oxfordshire Mind, Response, Connection Support, and Elmore Community Service.

The OMHP identified different areas of responsibility for the five organisations. It defined that the service of Restore's recovery groups should focus on supporting people into paid employment. [3] And all partner organisations should report several incentivised measures to the OMHP as evaluations of their service outcomes. These incentivised measures included [4]

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[2] For more information see: https://www.anthro.ox.ac.uk/epistemologies-healing#collapse396251

[3] Besides, the OMHP expected the Oxfordshire Mind and Response to provide supported housing. The Mind should also organise peer-support groups and run a Safe Haven for mental health service users who needed support beyond other organisations' working hours.
The Connection Support and Elmore Community Service offered floating support services.
And the Recovery College, which became part of Restore in 2017, should promote education about mental health recovery.

[4] In 2020, Restore commissioned an independent survey to improve the monitoring of its service outcomes. The survey was conducted by Camilla Nevill, the Director at Camilla Nevill Evaluation. Nevill developed a 'theory of change' by reviewing all the performance and quality measures Restore must conduct for its external audiences, especially the OMHP. The Restore CEO at the time, Lesley Dewhurst, kindly emailed me the report of Nevill's survey, so I could work out this list of incentivised measures that Restore must conduct to sustain its statutory funding from the OMHP.

- Aggregated improvement in the score of the Recovery Star (target 55% or above)
- Members entering paid employment, structured education or training programme, and structured volunteering (target 60% or above)
- Members who will be in paid employment (target 18% or above)
- Members in stable accommodation (target 80% or above)
- The improved physical health, measured by the members' Body Mass Index (BMI, target unspecified) and smoking (less than 42.5%)
- Satisfaction rates of the carers

Among the above measures, only the Recovery Star collected insights from the mental health service members. The Recovery Star was a standardised evaluation scale which looked at ten areas of people's lives (see figure 0.1 below). In a policy paper published in 2019, the King's Fund, one of the most influential public health thinktanks in the UK, acknowledged that The Recovery Star had been used widely in 'non-medical mental health services', particularly 'voluntary sector services' (The King's Fund 2019:14). The King's Fund also interviewed the leadership of the OMHP, who told the think tank that they found the recovery model of the Recovery Star was more 'holistic' and 'social' than the medical models used in clinical settings. They thus found the Recovery Star a useful apparatus to measure the service outcomes of its partnership organisations (ibid. 16).

The King's Fund recognised the advantages of the Recovery Star. However, it also mentioned two good examples showing the concerns of the service users and the frontline workers. Recovery in the Bin, a user-led group collaborating with mental health activists and critical theorists, produced an 'Unrecovery Star' pointing towards ten social-economic factors which severely impacted people's mental well-being (see fig. 0.2 below). They argued that the focus on capturing only the positive results would leave these critical areas unresolved. Off the Record, the mental health social movement

initiated by young people aged 11 and 25 in Bristol, produced a 'Recovery Octopus' with tentacles pointing towards the other areas they defined as important for their recoveries (see fig. 0.3). These bending and twisting tentacles bore no calculating scores but were painted in different colours. This showed how the interrelating factors contributing to mental health recovery were very personal, and therefore difficult to be quantified.

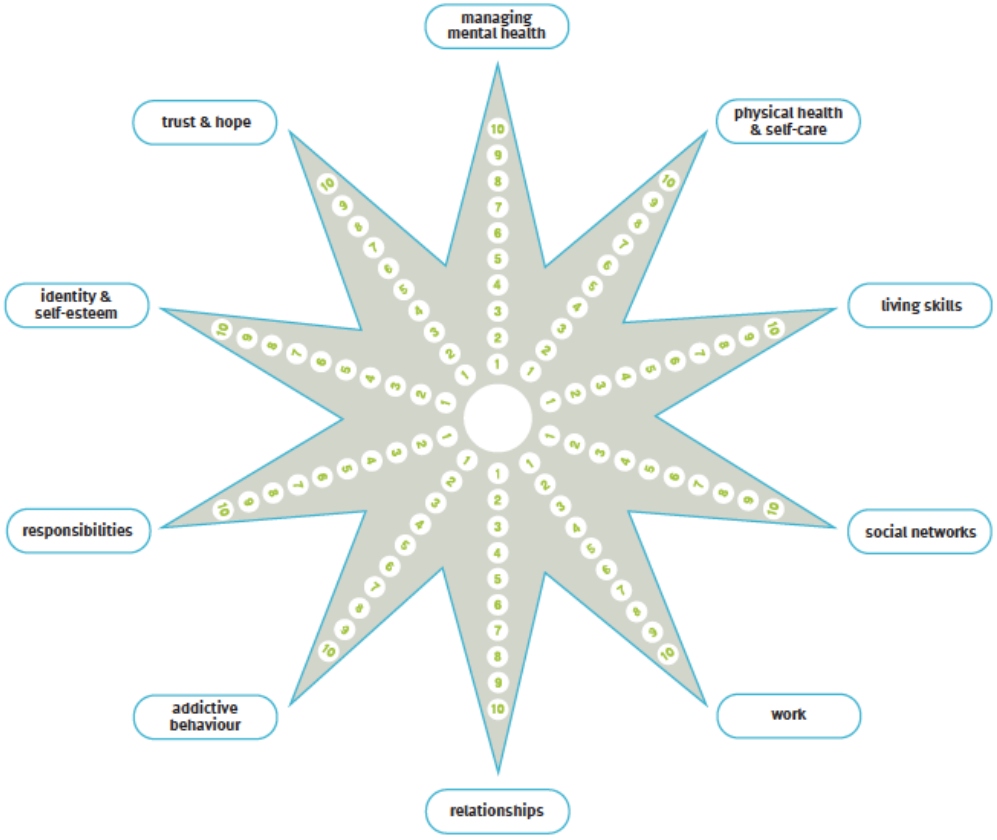


Fig. 0.1 The recovery star (3rd edition, Mental Health Partnerships) [5]

[5] The Recovery Star was first developed in 2008 by a company called Triangle Consulting with the Association of Mental Health Providers, a registered charity functioning as the representative body for the mental health organisations in England and Wales (See: https://amhp.org.uk/) Fig. 0.1 shows the 3rd edition of the Recover Star.

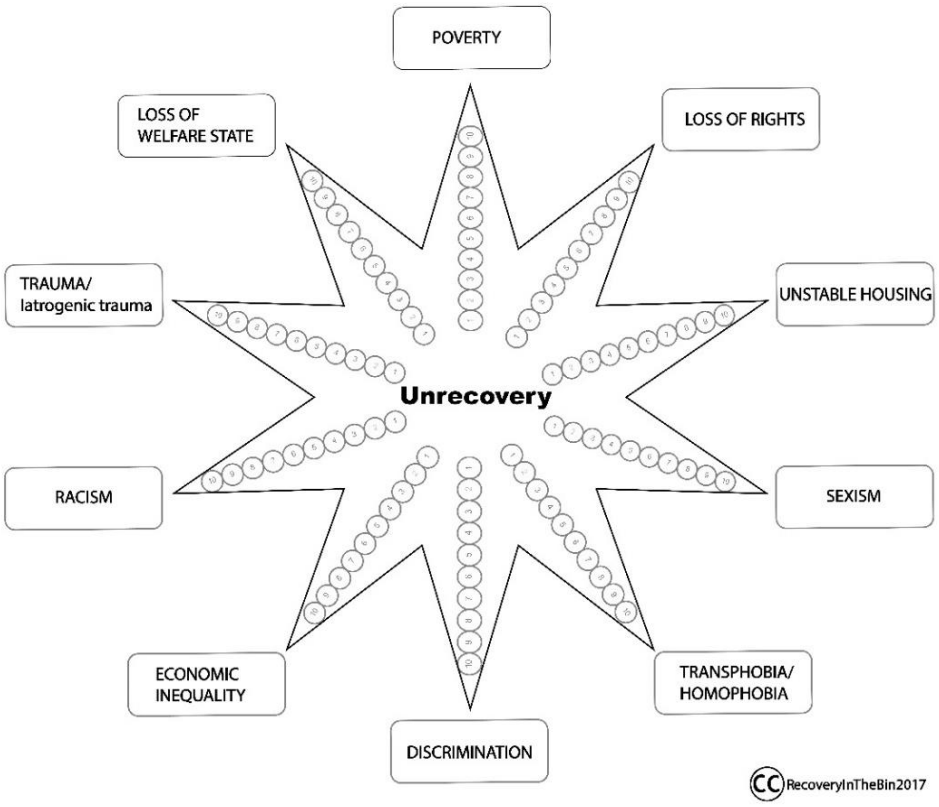


Fig. 0.2 The unrecovery star (Recovery in the Bin)

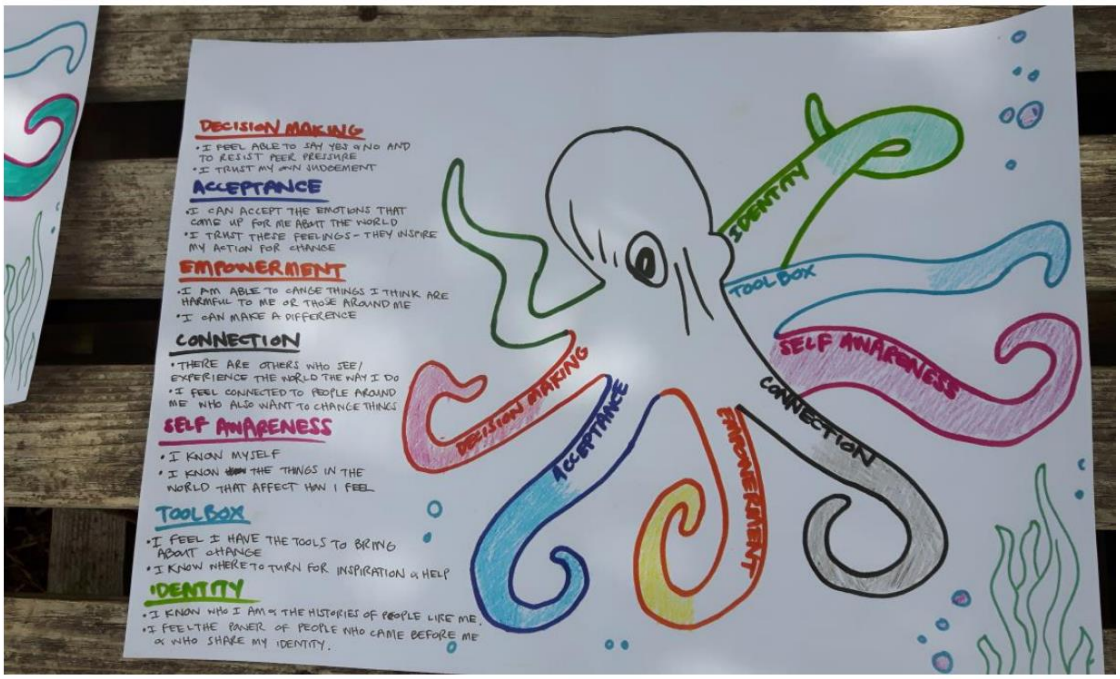


Fig. 0.3 The recovery octopus (Off The Record Bristol)

At Restore, the service members made their first Recovery Star one month after the registration. They then completed a new star every six months until their membership was terminated. The process to complete a recovery star took less than an hour from a common work day at the recovery group. Most members, like Robert, did not seem to mind doing the Recovery Star (see vignette 1 above). As a volunteer, it was not easy for me to observe the evaluation process, because most members did the Recovery Star in a quiet meeting room alone, or only with one of the recovery workers. The conversation with Robert in vignette 1 was the only exception. Nevertheless, the focus of my research was not an examination of the standardised evaluations that the OMHP adopts. Rather, I take one step backwards to look at the therapeutic processes of Restore's recovery group work, precisely how the service members participated in the gardening, craftwork, and catering work and what they valued as efficacious.

To the service members of Restore, what was more concerning than doing the Recovery Star was the pressure to 'move on'. To 'move on' meant to move *out* of one's recovery group at Restore to start paid employment, volunteering, or education programmes elsewhere. The 'moving on' became compulsory after the OMHP used the incentivised measures of 'number of discharges' and the 'destinations of discharge' to evaluate Restore's service outcome.

After the OMHP became Restore's biggest statutory funder in 2014, all service members registered at the Charity would be informed that they were expected to 'move on' in two years. If they felt they needed more time, they could apply for an extension of three to six months. Notably, only members who had an acceptable 'destination' in

the above three pathways would be recognised as successful 'discharges' by the OMHP measures. People who left for no clear reasons or by incidents such as house-moving, hospitalisation, or disagreements with staff or other service members were usually marked as 'dropped out' instead of 'moved on'.

Besides the pressure from the OMHP, there were practical concerns that supported the moving on of service members. A few recovery workers at Restore told me that they thought it was necessary to 'get people moving', or the groups would soon be 'filled up', and there would be no space for newcomers. With old members moving on and new members moving in, a service pipeline was created. The 2018-19 annual report of Restore recorded 40 members who 'moved on' from the Elder Stubbs, and the group welcomed 38 new members. Meanwhile, the Orchard in Banbury 'said farewell' to 31 members, while the 40 new members 'integrated very well to the group'. And the Garden Café 'welcomed' 13 new members, and 'said farewell' to 10 members.

Some members, especially the younger ones in their twenties and thirties, were receptive to the idea of 'moving on' (see vignette 2 above). Some, however, found 'moving on' uneasy and stressful (vignette 3). Many of these members were in their middle and elderly ages, but age was not always the case. Linda in vignette 3 above, for instance, told me she was in her early thirties.

This doctoral study arises from the members' pressure and concern to 'move on'. I question the mindset behind the OMHP measures, which was to regard recovery as being achieved when one was able to move *out* of a place where one might have cultivated vital and productive relatedness to people and the work of the place. Instead,

I present an anthropological evaluation which closely examines the therapeutic processes of the gardening, craftwork, and catering work that Restore's recovery groups organised. Resonating Robert's comment that the OMHP's outcome measures did not reflect what the members 'do' at Restore, my research explores the multiple efficacies generated by people's 'doings' of the recovery group work, which may contest and expand the current outcome areas of the OMHP measures.

Introduction: Anthropological approaches to treatment evaluation

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In this chapter, I first review the ethnographies on mental health that informed my doctoral research on this topic. I then review the literature on treatment evaluation. With the review, I propose to examine the therapeutic processes of Restore's recovery group work for evaluating the therapeutic efficacies. Then in section 1.3, I review studies that adopt a sensory-phenomenological approach to therapeutic processes and highlight the bodily-sensed efficacies that these studies identified. Then in section 1.4, I introduce the approach of Sensory Medical Anthropology that my thesis adopts to explore the multiple efficacies of Restore's recovery group work. The chapter ends with an introduction to the organisation of Restore and an outline of the thesis chapters.

1.1 Ethnographies on mental health

This section reviews ethnographies on mental health in relation to my doctoral research. I organise the ethnographies under three themes, which are the sociogenic of mental illness, the dilemmas in service provision and care, and the narrative approaches to the experiences of mental illness. With the review, I intend to find the niche of my research in medical anthropological studies of mental health.

The sociogenic of mental illness

Classic ethnographies on mental health emphasised the sociogenic of mental illness. [6] Sue Estroff (1981) in her ethnography, *Making it Crazy*, looked at the outpatient clients of PACT, the community mental health program in America. The monograph was published two decades after the nationwide deinstitutionalization movement began in the country. The idea of community treatment, as Estroff noted, expressed 'social and professional values and ideals' within the American society (Estroff 1981:11). These values and ideals were reflected in the goals of the PACT program, which emphasised the clients' vocational and work-related skills and their capability of living independently in community settings.

To Estroff, the values and ideals of employability and self-independency were evidently lack of nuance. After working closely with the clients of the PACT program, Estroff noted the challenges for them to live a happy, safe, and productive life in the community. The challenges had diverse origins, many of which were highly social. The

[6] For sociological and psychoanalytic literature on this topic, see the review in Chapter 2, Section 2.

first-generation antipsychotic medications prescribed to the clients could be inefficacious or have side effects. [7] The clients were also faced with the dilemma between getting employed and losing wages, which enhanced their psychiatric patienthood. Most importantly, the labelling of 'normies' and 'crazies' constructed what Estroff calls, 'a crazy reality' in community life (ibid. 213). The labels inscribed on the PACT clients perpetuated the control on their access to vital resources such as money, medications, living space, and employment opportunities, which further exacerbated their dependence on others.

Although the community in Oxford where my fieldwork took place between 2018-2020 was arguably less hostile to people living with mental illness, the ideals of employability and individual independency remained as significant indicators of 'normality'. To the Oxfordshire Mental Health Partnership (OMHP), Restore's biggest statutory funder, the 'discharge' of users into paid employment was a highly valued outcome (see Prologue). One goal of my thesis, therefore, is to further challenge the values of employability.

Tanya Luhrmann (2007) who also looked at American society after the mental health deinstitutionalization emphasised the sociogenic of mental illness as did Estroff. Specifically, Luhrmann developed the idea of 'social defeat' to conceptualise the high incidence of schizophrenia in American society. Luhrmann defined 'social defeat' as 'an actual social encounter in which one person physically or symbolically loses to

[7] The medications reviewed in Estroff's study belonged to the first-generation anti-psychotic drugs, which were largely replaced by the second generation (newer) antipsychotics since the 1990s. The two generations of anti-psychotic drugs were differentiated by their side effects. See also Chapter 2 for the use of first-generation anti-psychotic drugs in the UK in the 1970s and 80s.

another one' (Luhrmann 2007:151). The encounter should be experienced as contested and the person who encountered the social defeat should experience loss.

In her ethnographic example, Luhrmann discussed the homeless women in Uptown Chicago who confronted social defeat in their everyday life when they navigated between the street, the soup kitchen, the drop-in centre called Sarah's Circle, and other facilities. Luhrmann noted that these homeless women could easily become victims of violence by falling into conflicts with another client. Small humiliation also took place so frequently that one could even be punished for not returning the cup or forgetting to push the chair under the table.

Luhrmann pointed out the fact that the women themselves 'captured the social defeat by their image of madness' (ibid. 160). Calling someone 'crazy' was an insult in Uptown Chicago, because people were aware that the status of being psychotic would make it even more difficult to get housing and much easier to be alienated at the shelter or be bullied on the street. And if one was homeless for too long, one also became 'crazy'. It was a vicious circle generated by the social defeat.

The living conditions of the service members at Restore were in general less severe than the homeless women in Uptown Chicago regarding housing and other types of social care available. However, social defeat could be experienced by people from different social classes, because the process to cope with one's illness already generated experiences of loss, frustration, and guilt. Moreover, if reflecting the OMHP measure of 'discharge' with the theory of social defeat, the stress to 'move on', or the failure to do so, might also generate the experience of social defeat among some service members

of Restore.

Littlewood and Lipsedge discussed the impacts of racism on psychiatric professions and the provision of mental health care in the UK. They noted how (Western) medicine had previously been supporting racist attitudes through, for instance, the modern psychological measurements of IQ to assume that one group is 'more intelligent' than another due to genetic endowment (Littlewood and Lipsedge 1997: 44). They also pointed out that the racist preconception of colonial psychiatry which assumed that 'depression' only existed among Europeans and was absent among Africans and Asians who were 'incapable of examining their feelings' (ibid. 60).

Looking at British society in the late 20th century, Littlewood and Lipsedge pointed out that although 'over discrimination' was rare, patients of ethnic minorities were less likely to be referred to more 'attractive' care such as psychotherapy (Littlewood and Lipsedge 1997: 57). By contrast, black patients were more likely than white patients to see a black psychiatric professional and to see a junior than a senior doctor. Despite the differences in diagnosis, black patients were more likely to receive phenothiazine drugs and electro-convulsive therapy (ECT). The rates of involuntary hospital detainment, which was known as 'sectioned' under the Mental Health Act, were higher among black and Asian-born patients in Britain (ibid. 56).

An Evaluation and Needs Survey that Restore commissioned in 2016 noted the demand for the Charity to increase the number of service users from the black and minority ethnic (BME) population. Between 2018 and 2020 when I did fieldwork at Restore, there was a slight increase of ethnic diversity in the three recovery groups I

volunteered in, although the annual reports in these years did not review the exact numbers of service users who came from BME communities. Providing my role as a volunteer, I did not ask members about their ethnic backgrounds. However, some new members referred to the three recovery groups between 2018-20 disclosed to me that they themselves, or their parents, were born in South Asian, Southeast Asian, Latin American, and African countries. This might indicate an improvement in the recent few decades since Littlewood and Lipsedge's study.

In summary, the ethnographies reviewed in this section presented the sociogenic of mental illness. The social labelling of 'crazies' and the hostile community environment can enhance one's psychiatric patienthood. The experience of social defeat can generate everyday struggles while deteriorating one's health and living conditions in general. The racist attitudes of the society can also increase the vulnerability of patients who were immigrants and/or ethnic minorities and cause hindrance for them to receive better care. These sociogenic challenges, therefore, have direct impacts on how the therapeutic intervention might be experienced as efficacious by its receivers.

The dilemmas in service provision and care

Besides studies of the sociogenic of mental illness, there are ethnographies on the provision of community mental health care. These studies focus on the ethical dilemmas faced by service providers. Lorna Rhodes (1991), for instance, looked at the work of the staff in an emergency psychiatric unit in an American city. The Acute Psychiatric Unit, referred to as the APU by the staff, was set up in the mid-1970s as a response to mental health deinstitutionalisation. The APU had only nine beds and the task for the

staff was intrinsically contradictory since they had to discharge the patients as quickly as possible while treating the patients with adequacy.

Rhodes noted how the unit staff developed strategies to cope with the mandated task of efficiently emptying the beds for newcomers. They would, for instance, specify the service of the APU as an 'in and out place' only to stabilize the patients. They would then clarify to the patients that the place did not offer support on other 'secondary problems' and should not be misused as a haven (Rhodes 1991: 58). The staff at the APU also talked about 'relabelling' the patients from 'horrible' to 'unusual opportunity' to other mental health services, such as hospital wards or 'aftercare' provided by the outpatient clinics, so these services could quickly take in the patients referred from the APU (ibid. 59).

The APU in Rhode's ethnography is fundamentally different from the recovery group service at Restore. However, the ethnography shows that the strategic framing, assessment, and negotiation regarding the referrals of patients (or service users) would directly impact the evaluation of the efficiency and efficacy of the service. The referrals to Restore should have also gone through screenings. The charity had a waiting list for its recovery group service due to the large demand. While people could refer for themselves or apply through their GPs or community mental health nurses, the referral forms they filled in for application collected information about their diagnosis as well as their expectations from the service at Restore. My role as an in-house volunteer did not lead me to the referring processes, which were highly confidential. However, there was a common understanding which I found from fieldwork that the new referrals

would be expected to be 'not too ill' for doing gardening, catering, or craftwork in the recovery groups. The referrals who had an interest in these hands-on activities, or had a goal to get paid employment, should also be more likely to be considered. [8]

More recently, Neely Myer's (2015) ethnography, *Recovery's edge*, looked at the Peer Empowerment Program (PEP) programme of a community mental health organisation called Horizons in America. As Myers noted, the staff of the PEP programme were ex-service users. They offered peer-support to the clients of Horizons while working as community advocates for mental health recovery. [9]

While the envisioning of the PEP programme at Horizons was ambitious, Myers's rich ethnographic descriptions revealed the uncertainties and dilemmas encountered in individual journeys towards recovery. The three steps that Horizons advocated for mental health recovery, precisely taking the medications, self-advocate, and working for intimacy, were very difficult to achieve in reality.

One example about a young man called Maison demonstrated the fluctuation and uncertainties in one's recovery journey. Working as a 'recovery specialist' at Horizons, Maison represented the organisation to give talks about his recovery story around the city and state. He used to live in a fine apartment provided by Horizons, and he decorated the place with plants and an aquarium to make it a social club for other service members. As a peer provider, Maison talked about his story of combating schizophrenia to convince others of the necessity to take medications and to stay away from alcohol

[8] See the link to the online referral form of Restore: https://www.restore.org.uk/get-help/referral-form

[9] This type of mental health programme and advocacy focusing on peer-support emerged in the USA and UK after the 1990s. See also Chapter 3 for a brief introduction to the 'recovery-turn' and the mental health 'survivor movement' in Oxford between the 1990s and 2000s.

and drugs. However, two years after, when Maison's medications unpredictably stopped working, his health deteriorated and he became hospitalised, after being well for eight years. He also lost his position and the apartment at Horizons.

At first glance, the service at Restore seemed to share some similarities with the work at Horizons in Myer's ethnography. Both services were recovery-oriented and referred to their users as 'members'. The members at Restore also had opportunities to become peer-supporting volunteers in the recovery groups or 'tutors by experience' in its Recovery College (see introduction in section 1.5).

However, there is a fundamental difference between the two community programmes which can result in completely different outcomes in mental health recoveries. The recovery group work at Restore does not focus on mental health advocacy. They are rather 'hands-on' and emphasise the learning and practice of skills and body techniques in gardening, craftwork, and catering. Besides generating a diversity of bodily 'doings', the recovery group work also enacts a diversity of 'things' such as plants, animals, gardening tools, woodwork machinery, and culinary materials. The assessment of the service outcome of such recovery group activities, therefore, might need a different approach and conceptual framework in medical anthropology.

The narrative approaches to illness experiences

The last group of mental health ethnographies that I am to review looks at the patients' experiences of mental illness. Most of these ethnographies took narrative approaches to access the experiences. They offered invaluable insights about the lifeworlds of people who were struggling with mental illness.

Arthur Kleinman (1980) compared how the experiences of mental illness were constructed differently in American and Chinese cultures. He noted that the Chinese patients he interviewed often conveyed their emotional sufferings by describing physiological symptoms. For instance, Kleinman noted that his patients would frequently refer to 'a comatic complaint of *suan* (sourness) in limbs, joints, and other bodily locations' (Kleinman 1980: 143). Sometimes they even complained about such feelings of *suan* throughout the entire body.

With a collection of similar examples, Kleinman coined the idea of 'somatization' to refer to such expressions of psychological suffering through physiological complaints. He also compared that while Americans tended to 'psychologize' their problems, the Chinese would 'somatise' similar issues. And people from two different cultural contexts had different 'cognitive coping processes' for their illness (ibid. 174).

The cross-cultural comparison between somatization and psychologization, however, was subjected to criticism. As Thomas Ots (1990) noted, the difference between Western and Chinese views is not that the Westerners had a dichotomized understanding of body-mind while the Chinese perspective is supposedly more holistic. The dichotomy exists in both cultures, each with its own nuances, while the difference 'lies in the Chinese assessment of an emotional body' (Ots 1990: 26). Ots then proposed a phenomenological approach to examine the difference.

From the scope of cultural phenomenology, Thomas Csordas (1990) introduced the idea of 'embodiment' to approach the patient's experiences of illness and healing. Drawing on Merleau-Ponty's phenomenology of perception and Bourdieu's theory of

practice, Csordas defined embodiment as an approach that postulates the body as 'the existential ground of culture' (Csordas 1990: 5). The paradigm of embodiment, as Csordas noted, may collapse the duality between mind and body, subject and object.

With the phenomenological approach, Janis Jenkins (2015) observed the 'extraordinary conditions' experienced in psychosis, trauma, and depression. One of her ethnographic examples is about the psychotic experience of Sebastián, a young man from a Mexican-descent family who had a tense relation with his father. Sebastián was given anti-psychotic medication which provided 'little relief' but made him 'unable to read, concentrate, sit still, hold his hands still, or maintain a conversation' (ibid. 79). He heard voices and was convinced that one voice was of the God (ibid. 80). The God he heard was often 'powerful and merciless' by threatening him to make his experiences of voices even worse (ibid. 85). Jenkins noted that the frequent, chilling exchange of voices between Sebastián and the God, alongside other extraordinary experiences, shows that 'the experience of mental illness is better indexed as struggle than as symptoms' (ibid. 88).

I identify the phenomenological approach to the experiences of patients (or mental health service users) as most correlative to my doctoral research. There are more mental health ethnographies in this direction, some of which were in different sub-directions in phenomenological anthropology than the cultural phenomenology reviewed above. I will continue my discussion of these mental health ethnographies in section 1.4.

In conclusion, existing anthropological studies of mental health have identified the sociogenic of mental illness. Some also presented insightful reflections on the diemmas

in service provision, peer-support, and care. I place my doctoral research alongside the studies of patient experiences. However, the focus of the thesis is not the experiences of illness, but the experiences of therapeutic efficacies. Besides making attempt to elicit narratives from the participants of my research, I trial on a different approach that highlight the bodily 'doings' that often take place without verbal exchanges. I shall elaborate on this thesis in the sections ahead. [10]

[10] I am also aware that mental health is a topic widely studied in medical anthropology. Besides the mental health ethnographies reviewed in this section and the sections below, there are still abundant literature which take a diversity of approaches to address the different questions about mental health. There are, for instance, Tanya Luhrmann's (2000) reflection on psychiatry as a discipline and professions that inherited the Cartesian dualism in its split of psychoanalysis and psychopharmacology.

Paul Brodwin's (2013) ethnography about the frontline workers of the community psychiatry in America reveals similar challenges and dilemmas which were also faced by the Community Psychiatric Nurses (CPNs) in the Adult Mental Health Teams (AMHTs) in the UK.

There are also mental health ethnographies that focus on a global context, such as João Biehl (2005)'s ethnography about people living with mental illness in the zones of social abandonment in urban Brazil and Stefan Ecks (2013)'s examination of psychopharmaceutical pluralism in India.

1.2 A review of the literature on treatment evaluation

In this section, I review medical anthropological literature on treatment evaluation. With the review, I identify different positions and approaches to evaluate the service outcomes of Restore. I then propose a medical anthropological evaluation that emphasises the processual dimension of therapeutic intervention. By conducting such an anthropological evaluation, I argue that multiple efficacies can be generated in the therapeutic intervention of Restore's recovery group work apart from the generalised measures that the statutory funder of Restore used to assess the charity's service outcome.

The statutory funders of Restore expected the service members to complete a standardised evaluative scale called the 'Recovery Star' every six months. They also expected every service member to 'move on' and out of the recovery group within two years to paid employment, structured volunteering, or education programmes. To the funders who did not participate in or observe the recovery group work, the Recovery Star and the 'moving on' are solid evidence of Restore's service outcomes, as the Prologue introduced.

Evidently, the OMHP's measures of service outcomes reflected an audit culture (Strathern 1996, 2000). The measures generated accountability no matter how they define or conceptualise therapeutic efficacy. They adopted material apparatus to monitor the outcomes (Strathern 1996: 16) The registers of names were allocated to each recovery group by week for the staff to record the attendance of each member. Besides, the calculator forms of the body mass index (BMI) and the Recovery Stars

printed on paper were assigned by month. There were bureaucratic necessities for these measures to take place even if the outcome framework was detached from the lifeworlds of service users and grassroot practitioners.

This thesis, however, does not go into details of how the OMHP outcomes were audited or interpreted. It highlights another story about the therapeutic efficacies experienced immediately through the hands-on activities organised in the recovery groups of Restore. Paralleling the OMHP's audit of the numbers and 'destinations' of 'discharges', there were the bodily-felt efficacies generated through the therapeutic processes of the service members' 'doings' of gardening, craftwork, and catering. The OMHP's pursuit of the auditable outcomes regarded the service users of Restore as passive recipients who may (or may not) fit into an institutional expectation, but the ways how the therapeutic intervention of Restore's recovery group service might 'work' multiplied through people's different positionalities, experiences, and expectations. To work with such multiplicity, therefore, demands not only a closer examination of therapeutic processes, but also an openness to diversities, turbulences, uncertainties, and ongoingness of the individual journeys towards better states of health.

To disentangle the complex problem of what worked for whom and how, Elisabeth Hsu summarised the different approaches towards treatment evaluation according to the evaluators' positions, their conceptual frameworks, and the aspects of evaluation (Hsu 1996:38). While the patients evaluate the 'therapeutic quality' with their own body and self, the medical practitioners look for 'therapeutic results'. Meanwhile, 'therapeutic efficacy' and 'therapeutic success' are validated by biomedical or social

science researchers respectively. Actors of either type, Hsu emphasised, may offer invaluable insights to treatment evaluation.

Hsu outlined several methods to collect the patients' insights, such as the 'Quality of Life' (QoL) questionnaire, the practice of diary keeping, and anthropological studies of illness narratives. The processes to conduct these measures can be empowering to the patients. Similarly, the practitioners produce case records which reflect their assessments of the problems. And the case records reveal the specialised knowledge that the practitioners worked with, let it be biomedicine or alternative medicines.

Noticeably, the 'therapeutic efficacy' measured in biomedicine is often strictly assessed by the randomised control trials (RCTs) which only account for therapeutic interventions which are 'standardised, itemised, and time-limited' (ibid. 38). Hsu pointed out from historical perspective that the efficacy should not be regarded as universal but rather as embedded in a local context. Observers with different knowledge and perspectives, therefore, can have very different definitions of therapeutic efficacy.

Table 1.1 Different approaches towards treatment evaluation (Hsu 1996:38)

the evaluators' positions	their conceptual framework	aspect of treatment evaluation
the actors:		
the patient	own body and self	'therapeutic quality'
the practitioner	the alternative medicine or biomedicine	'therapeutic results'
the observers:		
the biomedical scientist	biomedical subdisciplines, epidemiology, statistics, etc.	'therapeutic efficacy'
the social scientist	the social sciences, e.g., medical anthropology	'therapeutic success'

Christine Ann Barry (2006) also compared the types of evidence that different observers may look for in treatment evaluation. Barry focused on the UK context to examine the evidence-based medicine (EMB) movement in connection to complementary and alternative medicine (CAM). The medical system dominated by the EMB campaign requires RCT-based evidence to integrate the CAM into the National Health Service (NHS). Nevertheless, Barry pointed out that the RCT as a biomedical tool usually omits the measurements of important elements in the CAM which become effective in different ways to pharmaceutical drugs (Barry 2006:2647). From the perspectives of CAM practitioners and users, the evidence relies on a different understanding of therapeutic efficacy. [11]

Having noted the limitation of RCT, Barry proposed to take seriously the anthropological evidence to evaluate the therapeutic efficacy of CAM. She argues that ethnographic research can investigate the contextual features of therapeutic interaction and the focus of the research is neither fully predetermined nor strictly structured (ibid. 2652). Unlike RCTs, the anthropological evidence is not collected through randomisation and standardisation but via 'personal, individual ways of knowing'

[11] Barry used examples in homeopathy to demonstrate the difference. With the principle of 'treating like with like', homeopathic remedies multiply by the 'physical symptoms in multiple body locations, diverse psychological and emotional states, and aspects of behaviours that are not part of biomedical diagnoses' (ibid. 2648). The 'symptoms' identified in homeopathy are very different from the ones recognised in biomedicine. In this way, different homeopathic remedies may be prescribed to people sharing the same biomedical diagnosis. Barry argues that the fundamental differences make it problematic to apply the RCT to evaluate homeopathic remedies.

Apart from conflicts in therapeutic principles, Barry discussed the perspectives of CAM users and practitioners regarding the RCT assessment. Based on ethnographic evidence from her fieldwork in South London, Barry notes that many homeopathy users were happy with their own judgement of the treatments. 'Evidence for them was the evidence of their own eyes and embodied experiences' (ibid. 2654). And the perceived efficacy involved not only the evaluation of their own health but also the emotional network and social connectivity with others. Most users did not find it necessary to see any scientific evidence, because the homeopathic principles have already explained things well. By contrast, the users who felt homeopathy did not work were more convinced by the principles of biomedicine.

which reflexively incorporates the use of an anthropologist's own 'emotions, intuitions, relations with others, and bodily responses' (ibid. 2653). The evidence of therapeutic efficacy captured through an anthropological approach, therefore, can be embodied and intersubjective.

The EBM movement also affected the organisation of Restore. The Charity must produce evidence for its service outcomes. To observers who work with biomedical principles, the recovery group work was inevitably subjected to the assessment of RCTs. In psychiatry and occupational therapy, the effectiveness of similar hands-on activities (i.e. gardening, craftwork, catering) are evaluated by the 'pragmatic trials', a specific type of RCT which aims to compare and evaluate the effectiveness of different therapeutic interventions as applied in 'real world' settings, such as medical clinics that provide routine care. [12] And the 'pragmatic trials' ('effectiveness trials') are considered more suitable than the 'explanatory trials' ('efficacy trials') for evaluating community-based mental health interventions. [13]

Despite the differences, the pragmatic trials applied in psychiatric intervention and

[12] It is necessary to acknowledge that Occupational Therapy adopts a diverse range of methods for treatment evaluation. Besides pragmatic trials, there are semi-structured interviews and clinical ethnography. Some volunteers at Restore were OT students taking a placement for training purposes and the evaluative approaches in the OT contributed great insights for them to tell whether and how the recovery group work might have worked for the service members. The review of the 'therapeutic emplotment' (Mattingly 1998) in Chapter 6 will present more nuance regarding the OT practice.

[13] Currently, two types of RCTs dominate the biomedical approach to treatment evaluation, which are explanatory trials ('efficacy trials') and pragmatic trials ('effectiveness trials'). While the explanatory trials take place in experimental settings (e.g. a lab) with placebo control, the pragmatic trials are not placebo-controlled and take place in routine care settings (MacPherson 2004).

Among the convention of biomedicine, the explanatory trials test casual research hypotheses, such as the cause-effect of drugs. The pragmatic trials, by contrast, compare different caring strategies, such as the effectiveness of cognitive behavioural therapy (CBT), short-term psychoanalytical psychotherapy, and the comparator treatment (Asarnow and Ougrin 2017).

The differentiation between the two types of RCTs sets up a distinction between 'efficacy' and 'effectiveness' in biomedicine (of the English-speaking world). However, the two words are often used interchangeably in social science literature (Craig 2012:8), as so as they are in this thesis.

Occupational Therapy still rely heavily on standardised questionnaires and symptom-oriented scales to assess the treatment outcomes for comparison. The Recovery Star that the members completed at Restore, for instance, is a well-acknowledged apparatus prevalently adopted in the evaluation process of the pragmatic trials for evaluating community-based mental health interventions.

Although health services research tends to include more experience-oriented outcomes reported by the patients, their evaluations are operationalised and quantified for the industries of knowledge production (as some Restore users and their carers say: 'box ticking exercises'). What the 'objective' assessments expect, therefore, are 'highly profession-specific, socially constructed and culturally accepted styles of knowing, ethics and aesthetics' (Hsu 2011:157). Since outcome assessments are conducted in institutions filled with health officers, statisticians, and administrators, the findings of these assessments are still often detached from the worlds lived by the patients and practitioners. As Robert said to me when he was completing a Recovery Star, the measurement 'makes sense' but does not tell a lot about what people 'actually do' at Restore (see Prologue).

In a recent article published on *Transcultural Psychiatry*, Thomas Csordas pointed out that while researchers in clinical psychiatry often rely on evidence-based models to determine the outcomes of therapeutic interventions, anthropological studies prioritised people's experiences of treatments (Csordas 2021:4). To overcome the polarity between psychiatry and anthropology, Csordas revisited an argument he made with Arthur Kleinman in 1996, which is to take a step backward from the pursuit of single standard

outcomes to conduct systematic and descriptive analyses of different therapeutic processes (Csordas and Kleinman 1996:9, as mentioned in Csordas 2021:6). Csordas regards the therapeutic process as the 'intersubjective locus of healing' (ibid.). The process, he argues, can serve as a bridge between efficacy and experience.

This thesis emphasises the diversity of the individual journeys towards better states of health. In response to Csordas's proposal to bridge the gap between efficacy and experience with close examinations of therapeutic process, I experiment with a sensory-phenomenological approach to look at the exact processes of the gardening, craftwork, and catering work at Restore. With this approach, I aim to provide anthropological evidence of the efficaciousness of Restore's recovery group work.

1.3 A sensory-phenomenological approach to therapeutic processes

This section reviews existing research that take a sensory-phenomenological approach to therapeutic processes. I first discuss the problem that Jean-Pierre Warnier defined as 'the Magritte effect', with which he proposed to examine the bodily 'doings' rather than their verbalisation. With the proposal, I review medical anthropological studies which adopt the sensory-phenomenological approach to revealing the bodily-felt efficacy generated alongside treatment processes. These medical anthropological studies directly inspired my exploration of the multiple efficacies of Restore's recovery group work.

In *The Pot-King*, Jean-Pierre Warnier differentiated two types of social research:

one is like the real smoking pipe and the other is the picture of the pipe painted by René Magritte. The *praxic* value of the real pipe is completely different from the *praxic* value of its graphic representation because one could never smoke with a pipe painted on paper. Warnier pointed out an illusion in social research which mistakes the picture of the pipe for the real pipe. While research on 'the picture of the pipe' touches on verbal expressions, ideas, and representations of the body, the research on the 'real smoking pipe' studies the 'sensori-motor culture, body techniques, perception, and everyday practices' (Warnier 2007:6). In other words, based on the identification of the 'Magritte effect', Warnier proposed to examine the bodily 'doings' rather than its verbalisation.

To Warnier, the differentiation of the two 'pipes' was a useful exercise for anthropological analysis. I found his proposal echoed the treatment evaluation in an early ethno-psychiatric study presumably before the RCT became a golden standard for biomedicine and the audit culture dominated the medical institutions. When Margaret Field conducted ethno-psychiatric fieldwork in rural Ghana in the 1950s, she recorded more than 2000 case histories and selected 146 for her monograph, *Search for Security*.[14] When reading these case histories, I found that the patients' verbal accounts of their health conditions did not always convince their family members, friends, neighbours, or the ethnographer. Many patients who said they were better were found hyperactive and restless. By contrast, one's bodily 'doings', precisely their everyday participation in domestic work and community events, were conceived as more valid evidence for health improvement. I here cite two cases as examples:

[14] Roland Littlewood (2002) has insightful and thorough review of Margaret Field's work in the journal *Anthropology & Medicine*.

30.10.56 Quite mute. Lying down in a semi-stupor. She eats and drinks a little with great persuasion, but will not get up and allow herself to be washed.
9.11.56 Much better. Moving slowly about cooking. She slowly moves up her hand to shake hands. She speaks a little in a very low mutter. She looks rather bewildered but shows no confusion in speech or behaviour.
14.11.56 Still improving. Brisker, speaks more freely.
26.11.56 When I called at the house they said she was quite well and had gone with her parents to a place near Kumasi to help them harvest cocoa as she is now able to work hard. Informant was the catechist husband's grandmother, a charming, wise and vigorous women, looking only about half her age.

Case 11 in 'Depression precipitated by converging factors' (Field 1960:171)

12.10.56 She is now very solitary, will not come out of her room and sits shut up in the dark. She eats her meals alone in her room. She would not emerge to talk to me, but did speak. Witness say, however, that she has not run away to the bush and has helped a good deal with the work – cutting firewood, preparing meals, etc.
23.10.56 Distinctly improved. She chatted quite freely and said she was better. Witness say there have been no more disturbed episodes and that she is gardening and doing a good deal of work.
10.11.56 Improvement maintained. For the first time she greeted me spontaneously and smiled warmly as I entered the yard. Asked how she was, she said a lot better. Her daughter, encouraged by the improvement, had gone home but the landlady said the patient was working hard, gardening, cooking, washing clothes and fetching firewood and water.

Case 108 in 'Involutional psychosis' (ibid., 385)

As the above two examples demonstrate, the villagers and the ethnographer could tell that someone was 'better' when she cooked meals, left her house for farm work, went to the stream to wash clothes, or helped fetch and cut firewood. It was the 'doings' of housework and community work that concerned one's family members, friends, and neighbours. The bodily conduct valeted the improvement in one's well-being. In this thesis, I work with a similar emphasis on the bodily 'doings' that echoes Field's fieldwork method and Warnier's conceptual proposal.

Warnier found that nearly all structuralist approaches focus on 'the picture of the

pipe'. The studies of 'the picture of the pipe' examine the representations, structure of the thoughts, or 'symbolism' which he defines as 'what goes on in the mind' (ibid.). Warnier reflected on Mary Douglas (1966)'s writing on the notions of pollution and taboo. He pointed out that the study works with cultural categories and structures of the verbalised norm. However, the conceptual categories can be blurred, contested, and affected by the power dynamics in an ethnographic study of actual practices in a given historical context. (ibid. 7) In other words, there is a difference between the study of notions and the study that involves the lived bodies in motion and material substances of dirt, rubbish, and ritual impurity. [15]

Warnier's reflection on the structuralist approach to symbolic and conceptual representations is grounded in his ethnographic analysis of the Mankon King's power technologies. In medical anthropology, similar critiques can be found in debates around therapeutic efficacy. Arthur Kleinman (1988), for instance, noted that the symbols were not always so closely related to each other to restructure any disorder, although the meanings could mediate changes at different levels. He pointed out that the patients might not be fully aware of the complex meanings of the symbolic system. What turned out to be genuinely efficacious in some treatments, by contrast, were the 'key cultural codes' with direct physiological impacts, such as 'sounds, smells, words, and images' (Kleinman 1988: 134). Kleinman suggested that the key cultural codes constituted

[15] It is necessary to note that the distinction between the 'real pipe' and the 'picture of the pipe' does not presume a radical distinction between the symbolic and the sensory approaches to therapeutic processes. As Warnier clarified, it is difficult to explicate the relation between practices and representations, or between embodied habitus and ideology. He noted that ethnographic studies in given contexts may contain both. In some cases, the representations may impact the practices, and vice versa, such as in the Cartesian thought's influence on the practices of modern medicine (ibid. 7).

efficacy because they were directly perceived and felt by the body. They may thus belong to the 'sensori-motor culture' that Warnier allocates as the range of the 'real smoking pipe'.

Robert Desjarlais did not deny the fact that there are symbolic factors in all therapeutic encounters, either. However, he also pointed out that the symbolic approach was not particularly useful for his research which explored the efficacy of Yolmo spirit-callings in Nepal. In Yolmo healing, the sensory dimensions were 'pivotal'. (Desjarlais 1996:143) What counted as efficacious was not only the alteration in meaning but also the changes in bodily experience. In my view, the comparison that Desjarlais made also reflects the problem of 'the Magritte effect', and Desjarlais's emphasis on the sensory dimensions of Yolmo healing practice was an attempt to study the 'real pipe'.

In the Helambu region of north-central Nepal, the rites of Yolmo spirit-callings aimed to restore the vitality of people who lost their *bla*, a spiritual essence that provided energy and volitional impetus to engage in life. Someone who endured a *bla*-loss 'did not care to eat, talk, work, travel, or socialize' (ibid. 145). Desjarlais noted that the signs and symptoms of bla-loss was very similar to how depression presents according to psychiatric diagnosis, but the form and etiology were different. The person had trouble falling asleep or getting up quickly. The body felt dull and heavy, lacking the 'presence' which was the passion for life and the kinaesthetic attentiveness.

To call back one's *bla*, following Desjarlais's description, Meme Bombo, a Yolmo shaman, lighted up the candle to create a flickering light. He warmed up his palms and applied his hands to different areas of the patient's body. Meme's speech was loud; the

contents of the speech triggered the imagination of different places of a spiritual landscape. A bowl of incense was passed around during the rite, spreading aroma to the room. The drum was beaten with a rhythm, manipulating the 'flowers' of dust to drop on the bowls filled with eggs, milk, and meat. The patient would eat from each bowl, so the food would incorporate lost vitality. Eventually, the rite was considered successful when the patient's eyes brightened and she felt a jolt of electricity in her body. The patient would then want to eat, walk, and sleep again because the *bla* spirit had returned. In other words, the efficacy of the Meme's healing rite was triggered, felt, and validated through the body's sensory experience.

Besides Desjarlais's classic ethnography, there are more recent ethnographies which I regard as studies of the 'real pipe' because of the emphasis on sensory experience. Murphy Halliburton (2010), for instance, studied the bodily-felt efficacy of *talapodichil*, a healing practice in Ayurvedic psychiatry. The *talapodichil* treatment applies on the patient's forehead a cooling 'mudpack' made from natural ingredients (i.e. a piece of banana leaf filled with gooseberries, buttermilk, and other mud-alike ingredients). Halliburton's interlocutors felt 'calm' and 'cool' during the treatment and the experience connotates the 'mental balance' in South Asian contexts (Halliburton 2010:53). Halliburton noted that many patients preferred the *talapodichil* treatment other than the electroconvulsive therapy (ECT, the 'shock therapy') because of the pleasant sensory experience generated by the 'mudpack'. The effectiveness of the treatment in this example turns out to be not only the alleviation of a specific symptom but also the relaxation that the patients experienced throughout the therapeutic process.

The therapeutic efficacy and knowledge can also be made explicit through the sensory experience of sound and rhythm. In *Healing Roots*, Julie Laplante talked about a turning point in her research journey with *umhlonyane* [*Artemisia afra*], a wild ingenious bush in the sub-Saharan region which was in clinical trials of becoming a biopharmaceutical. When Laplante asked Kubukeli, a Xhosa *isangoma* (traditional healer), how *A. afra* works, Kubukeli invited her to a drumming session. The drumming sounds, especially the beats that were felt 'in the guts', deepened her immersion into the *isangoma* lifeworld (Laplante 2015:185). Eventually, the enhanced sensitivities towards being in-the-world helped to make explicit how a plant could be activated in a healing process and thus become efficacious (ibid. 200). Here, the drumming sound and rhythm triggered the intuitive knowing of the *isangoma* healing as well as the perception of its therapeutic efficacy.

Inspired by the above ethnographic studies of the bodily-felt efficacies in therapeutic processes, I propose to adopt a sensory-phenomenological approach to exploring the multiple efficacies generated in the processes of Restore's recovery group work. I regard the approach as both sensory and phenomenological because a phenomenological approach explores 'things as they are'. It aims to capture the lived immediacy of the ways people experience 'time, space, and the world in which they live' (Jackson 1996:12). The same principle also applies to the experience of therapeutic efficacy, because what matters, from a sensory-phenomenological perspective, was not allopathic validity but the resolution of personal crisis, to help people 'regain effective control over their lives' (ibid. 13). A phenomenological anthropologist's pursuit of the

lived immediacy of experience, therefore, is an attempt to approach the 'real pipe', precisely the 'sensori-motor culture, body techniques, perception, and everyday practices' (Warnier 2007:6). [16]

In summary, this thesis highlights the therapeutic efficacies that are bodily-felt and triggered by people's bodily conduct, such as the practices of body techniques and sensorimotor engagements, which Warnier regards as the 'the real pipe' of 'the Magritte effect'. Inspired by medical anthropological studies in this direction, I propose a sensory-phenomenological approach to exploring the multiple efficacies of the gardening, craftwork, and catering work organised at Restore. Providing the rich and diverse directions within phenomenological anthropology (Desjarlais and Throop 2011),[17] I apply specifically a 'sensory medical anthropological' approach to my doctoral research. It is this approach that I learnt as a student at Oxford, which I shall elaborate on in the next section.

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[16] I am also aware, however, that Warnier was not satisfied with the phenomenological approach as applied to his research context. He read Thomas Csordas's (1994b) discussion of the body as 'the verbalisations about the lived experience of the body' (ibid.279). To Warnier, the work did not produce sufficient ethnographic accounts of the 'bodily motions, perception, or emotions', but rather focused on their verbalisations (ibid. 7). However, Warnier regarded the original text of Merleau-Ponty (1945)'s *Phenomenology of Perception* alongside Marcel Mauss (1934)'s *Techniques of the Body* as helpful conceptual tools for exploring the real pipe of material and bodily cultures (ibid. 277-8).

To examine the power technologies of the 'pot-king', Warnier moves on to develop a praxeological and cognitive framework. My thesis, however, stays within the tradition of phenomenological anthropology. This is mainly because the lived realities of mental illness are often fluctuating and less definite than the bodily experiences of power technologies in Warnier's ethnographic context. I shall elaborate on such illness experiences in section 1.4.

[17] As Desjarlais and Throop (2011) summarise, phenomenological anthropology has many directions such as the American cultural phenomenology (e.g. Hallowell 1955, Csordas 1994ab, Jenkins 2010), the existential anthropology of Michael Jackson (2008), and the critical phenomenology which aims to engage more with the social, political, and discursive issues (e.g. Good 1994, Desjarlais 1997).

The sensory medical anthropologists in Oxford (introduction in section 1.4) also acknowledged the work of other phenomenological anthropologists in and of Europe, Africa and the Asia-Pacific, such as Alfred Gell (1979) whose work focused on Umeda selfhood, René Devisch (1993) who studied the weaving rhythmicity in Yaka healing and the generation of the vital flow of life, Tim Ingold (2000) on environmental perception and skilled practice, Marja-Liisa Honkasalo (2001) on the Finnish experience of the chronic pain, Elisabeth Hsu (2000) on tactility and pulse diagnosis, Hughes-Freeland (2008) on the embodied morality in Javanese court dance, and Koen Stroeken (2008) on seeing in Sukuma healing.

1.4 Cultivating sensory relatedness through bodily conduct

To explore the multiple efficacies of Restore's recovery group work, I propose to look at the service members' bodily 'doings', but what exactly to look at, and how? This section elaborates on Sensory Medical Anthropology's approach to this question. In a simple definition, Sensory Medical Anthropology (in Oxford) takes a sensory-phenomenological approach to medical anthropological questions which, as applied to my research, is the question of therapeutic efficacy. [18]

When evaluating a therapeutic intervention, Sensory Medical Anthropology draws on the dynamic relations between people, things, and places to emphasise how the treatment participants gradually become attentive to the materially-textured spaces through bodily movements, sensory engagement, and practices of body techniques. It thus values the therapeutic interventions for one to cultivate and maintain a spatial-bodily relatedness to others. The gardening, craftwork, and catering work at Restore are promising therapeutic interventions from the scope of Sensory Medical Anthropology, because they engage hands-on skills and body techniques for learning and promote group collaborations.

In this section, I review three theoretical stances that my training in Sensory Medical Anthropology has referenced. These theoretical stances directly informed my

[18] I learnt the approach of Sensory Medical Anthropology during my postgraduate study at Oxford. Specifically, I attended several correlating courses during my Master's programme in Medical Anthropology at the University of Oxford, which are 'The Anthropological Approaches to the Phenomenology of the Body' (Lecturers: Elisabeth Hsu and Katherine Morris) in Hilarity Term 2018 and 'Sensory Experience in Therapeutics' (Lecturers: Elisabeth Hsu and Paola Esposito) in Hilarity Term 2018. In 2021 and 2022, I worked as a tutor for the course 'Sensory Experience in Therapeutics' to organise weekly tutorials with a total of seven undergraduate students. The teaching experience also helped with my practice and understanding of the approach.

doctoral research. First, I look at the problem of orientation as experienced in mental illness. Then, I review literature on intersubjectivity and intercorporeality which guided me to look for the therapeutic efficacies generated in people's handling of things and collaboration in groups. Lastly, I compare therapeutic emplotment and empotment, the two concepts that helped me to theorise my fieldwork findings of what 'worked' for the service members who participated in Restore's recovery group work.

The problem of orientation

As I try to understand people's illness experiences by reading existing literature on mental health, my training in sensory medical anthropology draws me to a problem beyond psychiatric diagnoses. It is the problem in one's orientation to being-in-the-world. Merleau-Ponty emphasises the body's role in an 'up/down orientation'. A disoriented body, he notes, would not know which way is up (Merleau-Ponty 1945:100, in Morris 2012: 90).

To analyse the body's up/down orientation, Merleau-Ponty describes experiments in psychology where spatiality is disrupted (i.e. Stratton's inverting spectacles and Wertheimer's mirror-vision of the room). Katherine Morris notes that Merleau-Ponty's discussion of these experiments makes essential use of the language of 'gearing' and 'hold' (Morris 2012: 91). The two words highlight not only the body's movement through space but also its 'inhabiting' of it, since the body which moves through space also takes up spaces. To Merleau-Ponty, what counts for the orientation is 'my body', but not my body 'as a thing in objective space', but as 'a system of possible actions … with its phenomenal "place" defined by its task and situations.' (Merleau-Ponty

1945:249-20, in Morris 2012:92). In other words, it is the body's movement, sensory engagements, and projections into the world that make places, not vice versa.

Applying the concept to medical anthropology, Thomas Csordas (2011) defines orientation as a component of corporeality. [19] It refers to how we inhabit space while creating space as we move alongside others (Csordas 2011:148). In this thesis, I work with Csordas's definition of orientation from the scope of Sensory Medical Anthropology, I review several empirical examples of the lived experiences of mental illness to demonstrate how the problem of orientation affects one's bodily movement through space and sensory-social engagements with others.

Overall, the review below draws on a phenomenological understanding of illness which, as S. Kay Toombs defines, 'is experienced by the patients not so much as a specific breakdown in the mechanical functioning of the biological body, but more fundamentally as a disintegration of his "world"' (Toombs 1988:201, in Morris 2012:126). My aim to review the empirical examples, therefore, is to demonstrate how the problem of orientation may cause severe disturbance in one's immersion in-the-world and social relations in general. I shall review several ethnographies on mental health with a couple of studies in human geography and psychology which take a phenomenological approach to the illness experiences.

In *Shelter Blues*, Robert Desjarlais described the sensory (dis)orientations experienced by people who took shelter at a state-owned mental health service centre

[19] In an introductory chapter on cultural phenomenology, Thomas Csordas summarises and defines ten components of corporeality, including bodily form, sensory experience, movement or motility, orientation, capacity, gender, metabolism/physiology, copresence, affect, and temporality (Csordas 2011:147-8)

in downtown Boston. The place was part of a colony of building complexes with bewildering, Brutalist-style designs. It had many dim caves, winding stairwells, light-fracturing walls, and a semi-open ('inside-out') layout (Desjarlais 1997:68-70). Desjarlais poetically demonstrated how shelter spaces triggered imaginations and how the building provided corners for the residents to take naps or be intimate. However, the architectural features also made it difficult to maintain an orientation in space or time, especially for residents who dealt with illusions and hallucinations. As Desjarlais described:

> For Helen and others, certain spaces directly affected how they walked, spoke, thought, and felt. Richard found that the building's dead spaces consumed people's "well-being" while its directionless stairs coincided with the pill-popping, channel-switching actions of its residents. Stuart found that the sea of tranquillity carried him along in a slow-motion, shoes-untied gait. The openness of this same space made Helen "feel good" whereas going upstairs scared her and gave her "bad dreams," and her studio apartment choked her breathing. She felt that it was illogical, crazy even, that the size of an apartment could influence one's physiology. (Desjarlais 1997: 58)

Desjarlais empathised with Helen and noted that she was right about the moods and physiologies of spaces. He also proposed that the features of buildings had 'a contagious effect' on the people who lived in those spaces (Desjarlais 1997: 58), and that the place and people who inhabited it had a 'symbiotic relation' (ibid. 87). Another example in Desjarlais's ethnography further demonstrate such relation between the people and the place. Sylvia who had lived in the shelter for more than eight years found it a 'fine' place to live, yet she consistently felt 'paranoid' when she was in the building (ibid.229). At night, she heard people performing operations and was afraid of being taken downstairs and having her body parts changed. The sensory disorientation

penetrated the client's everyday experience of living in the shelter and affected their perceptions of the intentions of others. Desjarlais's close examination of the bodily-sensed spaces and their effects on people's well-being directly inspired my research of the institutional spaces where mental health care was provided.

Emily Martin's (2007) in her study of bipolar disorders demonstrated the bodily 'styles' of mania and depression. Martin drew on Merleau-Ponty's ideas of habitual patterns of action to analyse the body 'as an expressive space' (Merleau-Ponty [1945]1962: 146, in Martin 2007:83). As Martin describes, the bodily style of mania expands into the world, in which the body reaches out in broad gestures, stands tall, speaks loudly, and moves vigorously. The depressed gestures, by contrast, shrunken and contained the body in 'a close space', making the body silent, immobile, and still. (Martin 2007:83)

The styles of mania and depression in Martin's description, in my view, is a vivid account of the problem of orientation. The depressed body in mourning, sadness, or loss is entirely closed-up from the social world. The manic body, by contrast, prohibited itself from effectively reaching the lifeworlds of others because its movements and gestures was regarded as bizarre in a social encounter.

In *Pharmaceutical Self*, Janis Jenkins discussed how the side effects of medications may also affect one's orientation to being-in-the-world and generate direct social consequences. As Jenkins noted, the psychopharmaceutic drugs, such as medications for schizophrenia, can alter one's emotional repertoire by remoting oneself from her own feelings. Such side effects would make people experience anger, become

tough, and lose tender sentiments (Jenkins 2010:29). In other words, the medications can make the problem of orientation even worse as was experienced in mental illness.

Jenkins discussed the example of Kayley, a woman in her early middle age who was a client of an outpatient clinic in a metropolitan area in north-eastern America. Kayley was suffering from a condition diagnosed as schizophrenia and she made great efforts to minimise her illness identity. When Kayley came to the clinic, she put up a lot of makeup, talked in a breathy voice, and walked with her hip swinging. She also frequently showed the others a photograph of her pre-illness youth and asked them why the men were all looking at her. Despite the efforts, the other patients and the staff found what Kayley did hilarious and bizarre and called her the 'female impersonator' (ibid. 30).

I found in this example the social consequences that the problem of orientation may cause. As Jenkins elaborated, the side effects of the psychopharmaceutic undoubtedly affected Kayley's perception of her own body and her femininity. It also changed the ways how she moved her body when walking in front of others, which alienated her from friendship, intimacy, or other types of social relations.

Mette Toft Rønberg discussed people's experiences of depression in Denmark. She framed the experience as an 'out-of-time embodiment' (Rønberg 2019:399). In such a condition, one endures the loss of body resonance and attunement. Rønberg's article starts with an account from Sarah, a woman in her early thirties who suffered from a condition diagnosed as severe depression:

It feels like a big, big knot in the stomach. And then it feels like you lose your entire

> footing, literally speaking. You cannot feel your feet on the ground anymore. And then, a lump in the throat. And just...So all this about feeling yourself within. You cannot feel anything at all. Just dead. Deep emptiness. And sadness. And I felt heavy. As if all life had just gone out of me. Everything was just hard. Felt sort of betrayed. Almost. By myself. So, that is how it feels. (Rønberg 2019:399)

The above narrative shows the sufferings of depression from a bodily-felt 'inside' where pain can be located in different body parts. Sentiments of sadness and emptiness are not disembodied because people talked about the sensory experiences of heaviness, hardness, a knot in the stomach, and a lump in the throat. Overall, the body in depression generates suffering from the inside of one's body, which closed off oneself to others and the world.

In another example, Rønberg presented the narratives of Tina, a woman in her mid-forties who described her experience of depression as being 'wrapped in a cling firm' and 'wearing a close-fitting coat' (ibid. 404). The illness completely changed Tina's relation with her family, her career as a school teacher, and her participation in the local community life. She turned from an 'energetic and sparkling' person to someone afraid of doing groceries in the local supermarket (ibid.). The problem of one's orientation to being-in-the-world, therefore, did not only affect one's bodily experience or movements through space but also generated severe impacts on one's social life.

Besides the anthropological studies reviewed above, phenomenology-inspired psychiatrists and human geographers revealed a similar problem of orientation in their studies of autism autobiographies. [20] Sofie Boldsen, for instance, discussed Charles

[20] Autism spectrum disorder (ASD) is not classified as a mental health disorder, but people with autism may experience mental health problems. Considering many Restore members whom I worked with had diagnoses of ASD alongside other psychiatric diagnoses, I review two examples to demonstrate the conditions one might experience in relation to the problem of orientation.

Hale's autobiography on his experience of autism (co-produced with his mother, Mary Jane Gray Hale):

> [W]hen I should be smiling, sometimes I know that I am not smiling but may be even frowning. This causes me a great deal of pain and makes me look as though I am not comprehending when, in fact, I am crying to respond in an appropriate manner. (Hale and Hale 1999:32, in Boldsen 2018:908)

Boldsen noted that the difficulties in bodily movement, precisely the movements in one's eyebrows and lips, may significantly affect the 'bodily expression in social situations' (Boldsen 2018: 908). The face failed to express the feelings in a social encounter, which caused direct impacts on the orientation to others.

Joyce Davidson highlights the 'shut down' of senses in the autism autobiography of a woman called Gerland:

> They would explode inside me and make me lose all sense of the way my body related to my surroundings. It was like being flung out into space – whoosh – quite without warning. Sometimes I screamed and covered my ears. (Gerland 2003:28, in Davidson 2010:308)

In the narrative above, Gerland described the disturbances caused by passing cars. The body's orientation to its surroundings was overwhelmed by the traffic noise. The sensory attunements shut down to the world in relation to others while a bodily-sensed inner-world encountered a destructive explosion.

In summary, with the scope of sensory medical anthropology, the review above demonstrated a problem of orientation which affects the experiences of people living with mental illnesses. I specify the problem as one being closed-off, puzzled, or disturbed in one's sensory engagement with others and the world. The sensory engagement I mention here is not only manifested in a spatial or sensorial way. It can

also be emotional and habitual. The review above demonstrated that the problem of orientation may cause severe impacts on social life. To overcome the problem, therefore, demands therapeutic interventions which can effectively restore such spatial-bodily orientation to others and the world.

Intersubjectivity and intercorporeality

Providing the problem of orientation experienced in mental illness, the restoration of one's attentive sensory engagement to others and the world became crucial. I propose that the hands-on activities organised in Restore's recovery groups can effectively restore such orientation, because the work induced and maintained different intercorporeal relations. When one works in such intercorporeal relations, one became actively engaged with a diversity of things such as plants, gardening tools, woodwork machinery, and culinary materials. The body opens to the world.

As Marilyn Strathern's remarks, 'the specific capacity of persons to relate to one another is taken as a fundamental truth of human existence. Social life is what goes on between them.' (Strathern 2020:4). I propose that the concept of intercorporeality offers a conceptual stance to examine a specific type of relations which are vital for restoring one's orientation in-the-world, and thus vital for enhancing the capacity which Strathern identifies as fundamental for human existence. This specific type of relations is the intercorporeal relations. I shall review the theoretical discussion around this concept in this section as a preparation for the ethnography ahead.

In 'The philosopher and his shadow', a chapter in *Signs*, Merleau-Ponty

([1960]1964) introduces the word 'intercorporeality' (intercorporéité) when he reviews Husserl's classic example of the touching hands in *Ideen II*. As my right hand touches my left hand, the distinctions between the touching and the touched, alongside the distinction between the object and the subject, are blurred in my body. The two hands become 'coexist' or 'compresent' (Merleau-Ponty [1960]1964: 168). Extending from touching one's own hands to shaking hands with others, Merleau-Ponty proposes that the other person being touched by me is not so different from my left hand touched by my right hand, because 'he and I are like organs of one single intercorporeality' (ibid.) The word 'intercorporeality' was coined for the first time by Merleau-Ponty in this chapter, and I found it a useful concept for my thesis's exploration of the multiple efficacies of Restore's recovery group work.

In *The visible and the invisible*, Merleau-Ponty ([1964]1968) revisits the example of touching hands and the discussion of intercorporeality when he introduces 'the flesh'. The flesh (*la chair*) is a key concept in the later work of Merleau-Ponty when he reflects on the double-edged relationships of Husserl's *Fundierung* (i.e. the relationship between logical objectivity and carnal intersubjectivity). According to Merleau-Ponty, 'the flesh' is an ultimate notion of 'the visible'. It is 'a quality pregnant with a texture, the surface of a depth, a cross-section upon a massive being, a grain or corpuscle borne by a wave or Being.' (Merleau-Ponty [1964] 1968:136). I understand the notion of 'the flesh' as an emphasis on the material dimension of intercorporeality. Using Merleau-Ponty's discussion in *Signs*, the things one 'dwell' in and the 'poles' of one's sensory operation (Merleau-Ponty [1960]1964: 166-7) need to have the quality that made them

sensible to the body, and thus available to be woven into the body's intentional fabric.

Although the word 'intercorporeity' [21] is only mentioned twice in the main chapters of this book, Merleau-Ponty highlights that in the example of the touching hands, 'there exists a very peculiar relation from one to the other across the corporeal space' (ibid. 141). This very peculiar relation, I propose, is not only peculiar to philosophy but also to medical anthropology if related to the problem of orientation. It highlights both the bodily and the spatial dimensions in the processes of one's sensory engagement.

Drawing on the above two books of Merleau-Ponty, Dermot Moran (2017) makes the concept of 'intercorporeality' more accessible to the contemporary readership. Moran notes that Husserl who did not explicitly use the term 'intercorporeality' inspired Merleau-Ponty to think through the 'the reversibility of the flesh and its relationship to the constitution of a sense of a unique, common, shared world accessible to all' (Moran 2017:38-39). The flesh's constitution of a common and shared lifeworld then made intercorporeality a key element of intersubjectivity. As Moran summarises:

> For Merleau-Ponty, intercorporeity or intercorporeality (l'intercorporéité)—the dynamic encounter of one lived body with another—is part of what he calls the "pre-objective world" (l'être préobjectif), that is, the layer of the world that is first encountered in sensory experience and is the ground and condition for the "objective" world (which is always the outcome of intersubjective constitution) but paradoxically is also reconstituted by the objective world. (Moran 2017:38-39)

The above discussion explicates that the lived body's dynamic encounter with another is part of the world that is 'first encountered in sensory experience'. This

[21] The French word 'intercorporéité' is translated as 'intercorporeity' by Alphonso Lingis in *The visible and the invisible*, while in *Signs*, it is translated as 'intercorporeality' by Richard McCleary.

emphasis on the lived body's sensory experience during an intercorporeal encounter, I propose, offers strong theoretical support for sensory medical anthropology. The sensory dimension intersects the conceptual framework of intercorporeality and the lived experience of people who worked in the recovery groups of Restore.

Moran also summaries several real-life conditions which generate intercorporeal relations, such as talking (language), singing, pregnancy, dance, martial art, team sport, kissing, sexual intercourse, and corporeal punishment (Moran 2017: 36). He also notes that medicine has many forms of intercorporeal practice (ibid. 37). The gardening group work at the Elder Stubbs, the craftwork projects at the Orchard, and the catering teamwork in the Garden Café, I propose, should also be the case since they all demanded one's body to be active, open, sensitive, and collaborative with the body of another.

Noticeably, the intercorporeal relations cultivated in gardening included not only humans but also other living beings such as plants and animals. The intercorporeal relations discussed in this recovery group, therefore, should be also grounded in 'interspecies encounter', which Moran draws from the 'interanimality' (*animalia*, *interanimalité*) coined by Merleau-Ponty when he introduces the concept of intercorporeality (Merleau-Ponty [1960]1964:168, Moran 2017:33). I shall elaborate on the interspecies and intercorporeal relations in Chapter 4.

The concept of 'intercorporeality' is not unfamiliar to anthropologists who were inspired by Merleau-Ponty's phenomenology, either. When discussing the embodied dimension of imagination, Thomas Csordas notes that a phenomenological approach

includes corporeality in its definition of consciousness (Csordas 1994a:80). Although Csordas in this early monograph, *The Sacred Self*, did not use the word 'intercorporeality', his ethnographic accounts of the northern American charismatic healing practice (e.g. anointing, the laying on of hands) were highly sensory and intercorporeal.

In his later article published in the journal, *Subjectivity*, Csordas explicitly discusses the term 'intercorporeality' as a crucial dimension of intersubjectivity. He proposes that intersubjectivity should be regarded as a concrete rather than an abstract relationship (Csordas 2008: 110). In this way, cultural phenomenology's examination of intercorporeality and intersubjectivity is freed from the bias of subjective idealism (Csordas 2008:110).

In this article, Csordas makes 'intercorporeality' a useful concept for ethnographic analysis. He introduces the idea of the 'intercorporeal hinge' to highlight the areas of the body which actively participated in an intercorporeal relation (Csordas 2008:111). The idea of the 'intercorporeal hinge' grounds the concept of 'intercorporeality' as concrete as it could be in the lived body and its sensory engagement, making the intercorporeal relations easy to describe in ethnography.

As Csordas vividly demonstrated, the intercorporeal hinge in his ethnographic examples could be either in the hands or in the lips. They were the parts of the body that directed and afforded the attention of oneself and others. The intercorporeal hinge made presence, for instance, when a charismatic healer skilfully laid his hand on the head, shoulder, and back of his supplicant. The touch of the hand was felt by both

himself and his supplicant through the body, and the movement of the hand caught the attention of the other audience of the treatment. Similarly, when a Navajo chanter moved his lips to demonstrate the powerful way of singing, the movement of the lips and the sound that came out through them afforded the attention of the apprentices and might help with their singing practice.

Guided by Merleau-Ponty, Moran, and Csordas's discussions of intercorporeality, my thesis looks at the intercorporeal relations that came up in the recovery group work of Restore. The ethnography ahead will demonstrate how the service members gradually became attuned to other people and things when they moved their hands, looked around with their eyes, and bent their torsos to carry on the tasks in gardening, craftwork, and catering. By paying attention to the intercorporeal dimension of social encounters, the research participant's spatial-bodily orientation became visible. And my ethnographic observation of people's changes in their ways of moving and doing the work could then be seen as evidence of improvement made in their orientation to being-in-the-world.

Therapeutic emplotment and empotment

Empotment works on the intersection between the spatial and the bodily dimensions of therapeutic processes. It reveals how people emplace themselves into places through their bodily movement, sensory engagement, and practice of body techniques. I thus identify the concept with the potential to identify effective therapeutic interventions which may alleviate the problem of orientation.

In ‘Patients, Practitioners and Pots’, a journal article published in 2017, Elisabeth Hsu introduces a preliminary idea of therapeutic empotment. She then further develops the concept in her latest book, *Chinese Medicine in East Africa*, in 2022. Overall, Hsu defines empotment as an idea that embraces and complements Cheryl Mattingly’s discussion of therapeutic emplotment.

Cheryl Mattingly explicates the idea of ‘therapeutic emplotment’ in her first monograph, *Healing Dramas and Clinical Plot*s. She points out that narrative is not only a matter of speech but also a form of clinical action (Mattingly 1998:11). In her ethnographic example of occupational therapy, the therapists and patients managed to create story-like structures for exercising their muscles through their conversations. In this way, illness narratives become no longer the after-the-fact reflections of experience but rhetorical, metaphoric, and phenomenological actions which directly affect the experience. The process to tell a story, therefore, does not only reveal experiences but also constructs them. [22]

While emplotment comes through narratives, empotment emphasises the body’s sensory engagement with space and place and the therapeutic efficacies generated in a learning process. It thus expands the focus from being attentive to narratives to being attentive to the body’s diverse ways of doing, making, and learning.

Moreover, while emplotment focuses on the dyadic therapist-patient interaction and their social entourage, empotment grounds the process in triadic relations. Besides patients and practitioners, there is the third dimension carved out by the ‘pots’. The

[22] I shall elaborate on Mattingly’s ethnographic examples about therapeutic emplotment in Chapters 3 and 6.

‘pots’ are materials with sensory properties and spatial implications which may inflict the body’s orientation in the world. They are not mediums of communication, but ‘pluripotent’ and situation-dependent players in a phenomenological lifeworld (ibid. 29).

As I understand, the ‘pots’ can be regarded as a specific type of ‘things’ in the Ingoldian ecology of materials, the type of ‘things’ that work actively in therapeutic processes. Inspired by two phenomenologists, Heidegger and Merleau-Ponty, Tim Ingold (2012) differentiates between ‘things’ and ‘objects’. While ‘things’ gather the materials in movement and changes, ‘objects’ have completed forms without further movement and therefore stand over and against the perceiver (Ingold 2012: 439). The ‘leaky’ feature of the Ingoldian ‘things’ could be the ‘pluripotent’ and situation-dependent character of the ‘pots’ in empotment. Both Ingold’s and Hsu’s frameworks take a holistic approach to materials. By focusing on the ‘pots’, this thesis aims to conduct an integrated analysis of the recovery group work at Restore which engaged a diverse range of materials (e.g. plants, people, food, tools, animals, and machines).

Besides empotment’s unique approach to body and things in therapeutic encounters, the concept has a spatial dimension. In *Chinese Medicine in East Africa*, Hsu discusses the Rubin vase, a classic example in phenomenology which highlights the contrast between the foreground and the background (or the ‘depth’). Depending on what counts as background and what is foreground, the figure can be seen as either a vase (or a flower pot) or the silhouettes of two people facing each other. One could see both the flower pot and the faces by moving one’s eyes. And the boundary between

what counts as a thing (i.e. vase) is blurred with what counts as the space (i.e. the white background).

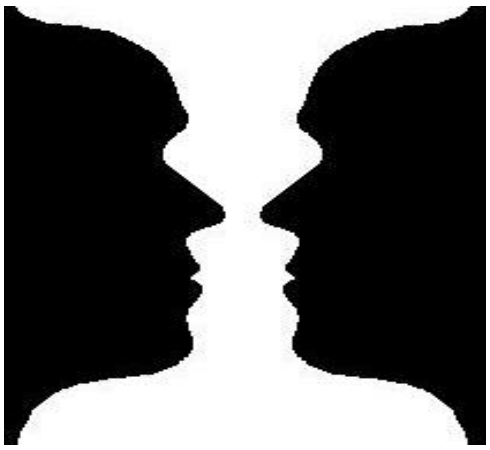


Fig. 1.1 A Rubin vase (Wikimedia Commons)

Hsu adds lines and dots to the figure to highlight how the image is affected by and affecting different spatial textures. This ontological continuity between things and their surroundings, she argues, is core to the socialites to be discussed in the process of empotment (Hsu 2022:48). As I shall elaborate with ethnographic details in Chapter 4, the textured space that Hsu draws from Henri Lefebvre ([1974]1991) contextualises the body's orientation in the world. To become empotted, therefore, is a process of being emplaced in the green space of an allotment or becoming the host of a community café.

In summary, this section introduces sensory medical anthropology's approach in application to my research. Guided by this approach, I review existing literature on illness experience in mental health to identify the problem of the body's orientation to being-in-the-world. I then review the concepts of intercorporeality (in relation to intersubjectivity), and therapeutic empotment (in relation to therapeutic emplotment), as the theoretical stances for my thesis's exploration of effective therapeutic

interventions that can alleviate the problem of orientation. The chapters ahead will continue working with this concept and explain how it helps to explore the effectiveness of Restore's recovery group work. However, before entering those chapters, I shall briefly introduce the organisation of Restore, the charity where I conducted ethnographic fieldwork for my doctoral research.

1.5 The organisation of Restore

Restore was founded by a group of psychiatrists, mental health nurses, and social workers at Littlemore Hospital in 1977. It is one of the longest-established community rehabilitation services in the UK. By 2020, Restore had 40 staff and 150 volunteers who worked with around 850 service users (Leach et al. 2023:48). While I shall look at the founding stories of Restore in Chapter 3, this section briefly introduces its organisation during the time of my fieldwork.

Between 2018-2020, Restore provided services through its recovery groups, employment coaching team, and Recovery College. A service user could choose one or more of these services depending on the need. All services were free of charge.

The Restore recovery groups provided collaborative a work environment for users to learn skills in gardening, craftwork, catering, and sales. The recovery group service of Restore was the primary focus of my doctoral research. The service users of the recovery groups were referred to as the 'members', which my thesis will adopt.

Until 2020, Restore had six recovery groups in Oxfordshire. I was able to volunteer

in three of them before the COVID-19 pandemic abruptly terminated my fieldwork (see section 1.6). In the table below, I summarise the types of work each recovery group organised. [23] I highlight the three groups I worked at in **bold**.

Table 1.2 The six recovery groups of Restore

The Beehive	Manzil Way, East Oxford	1981	gardening, woodwork and other crafts, cooking
Elder Stubbs	Elder Stubbs allotments, East Oxford	1989	gardening, woodwork and other crafts, cooking, marketing
Fleet Meadow	Didcot, South Oxfordshire	2005	gardening, woodwork, arts and crafts
The Garden Café	Manzil Way, East Oxford	2008	cooking, catering, customer service, sales
The Orchard	Banbury, North Oxfordshire	2010	woodwork, arts and crafts, cooking
Littlemore	Littlemore Mental Health Centre, East Oxford	2013	cooking, catering, customer service, sales

Some members who worked in the recovery groups signed up for Employment Coaching when they needed advice and support to write a CV or get prepared for a job interview. An employment coach then came to the recovery group on the scheduled day to have a one-to-one session with the member. The coaching session took place in a small meeting room for an hour. Restore's employment coaches in Oxford had their office in Manzil Way headquarters and they visited each recovery group in East Oxford for one to two days a week, depending on the group size. The Orchard recovery group

[23] See the link to the introduction to each recovery group on Restore's website: https://www.restore.org.uk/get-help/restore-recovery-groups
Restore also worked with another two partner recovery groups. They were the Root and Branch organic farm in Swindon, Southwest Oxfordshire and the Bridewell organic garden in Witney, West Oxfordshire. See the links to the two partner recovery groups of Restore: https://www.rootandbranch.info/ https://www.bridewellorganicgardens.co.uk/

in Banbury had one employment coach of its own who worked in the group every day. Overall, the employment coaches undertook the responsibility to support members 'moving on' to employment, volunteering roles, or education outside Restore. [24]

The Oxfordshire Recovery College became part of Restore in 2017. It adopted an 'educational approach' to organise recovery-focused workshops and courses. The users of the Recovery College were referred to as the 'students', which included not only mental health service users but also volunteers and carers. The courses at the Recovery College were co-produced by two types of tutors: 'Experts of Experience' (those who have lived experience of mental illness) and 'Experts by Training' (mental health professionals). [25]

While my thesis focuses on the work at the recovery groups, some members whom I worked with were students and/or 'experts by experience' at the Recovery College. During my fieldwork, I thus also enrolled as a student at the Recovery College and attended several courses in its Strawbale classroom at Restore's Manzil Way headquarters and the classroom at the Mind's Wellbeing Hub in Banbury, such as 'Introduction to Recovery', 'Sleep and Wellbeing', 'Understanding Psychosis', and 'Mindful Movement with T'ai Chi Chih'. I do not write about the contents of these courses, nor their students, due to the confidentiality agreement made in the class. However, these courses enabled me as an anthropology researcher to listen to the narratives of mental health service users and be more empathetic and understanding of

[24] It seems that people could also attend Restore's employment coaching without joining any recovery group, although my fieldwork did not intersect with the Restore journeys of this group of service users. See the link to the introduction to employment coaching on Restore's website: https://www.restore.org.uk/get-help/coaching

[25] For more information about the Recovery College, see: https://oxfordshirerecoverycollege.org.uk/

their lived experiences.

Besides the major recovery services introduced above, Restore collaborated with Mental Health Frist Aid England to organise mental health first aid courses. The courses took up two days and were organised at Restore's Manzil Way headquarters. The courses were essential and free of charge for all staff and volunteers at Restore for training purposes. [26]

To better demonstrate the organisation structure of Restore, I make the table below and highlight the people whom I closely worked with during my fieldwork in **bold**. These staff and volunteers will come up as individuals in the ethnographic chapters.

Table 1.3 The organisational structure of Restore [27]

Board of trustees eight people including **Peter Agulnik**, the chair and co-founder of Restore
Executive team seven people, including the Chief Executive (CEO)
Operational team (finance, HR, administration, facilities, volunteering, fundraising) two to three staff on each team
Oxford Recovery College five staff with around twenty tutors
Recovery groups three **full-time staff** each group, including one group coordinator and two recovery workers; each group also had one to two **part-time locum workers** and five to ten **volunteers**
Employment coaching averagely one to two employment coach in each recovery group

[26] See the link to MHFA England: https://mhfaengland.org/ See also Chapter 4 for the MHFA training.
[27] The organisational structure demonstrated in this table applied to the time of my fieldwork between 2018-2020. Later on, Restore added the Individual Placement and Support (IPS) service in contract with the NHS Oxford Health Trust. The new service focused specifically on helping the members to move on into paid employment. This highlights that the central concern of my thesis regarding the members' moving on and out of Restore addresses a very timely problem.

1.6 Outline of the thesis chapters

This thesis has seven chapters. After the introduction in this chapter, there are five empirical chapters and a discussion. The empirical materials that the thesis works with include ethnographic records, narratives collected through semi-structured interviews, and digital archives. On very few occasions, I reference social-demographic data as auxiliary notes for my ethnographic analysis.

Primarily, I worked with a diversity of first-hand and second-hand materials as a compromise to the severe impact of the COVID-19 pandemic. The fieldwork terminated abruptly on 10 March 2020, which was six months earlier than scheduled. I had to cancel all the interviews with service members at Restore and was never able to visit all six recovery groups (introduction above) as planned.

The impact of the pandemic directly resulted in the shift of my research from the recovery groups to the desktop. I spent the following year re-anchoring my research in digital archives while organising online interviews with the leadership of Restore. [28] With several attempts of trying out and trialling, I found a coherent way to organise the first- and second-hand materials that I collected during and after the fieldwork. Instead of doing a single, ethnography-centred research, I put together my studies of archival materials (Chapter 2) and narratives (Chapter 3) with my fieldwork observations (Chapters 4-6) to explore the multiple efficacies of the recovery group service at Restore.

[28] Due to ethical considerations, I did not organise online interviews with Restore's service users during the COVID-19 pandemic.

At the beginning of each chapter, there is a methods section explaining the approach I took for examining the empirical materials in the chapter. Together, the five chapters present an anthropological evaluation of the therapeutic interventions that cultivate sensory relatedness and restore one's orientation to being-in-the-world. By presenting the multiplicity of treatment strategies and pathways for the service users to become 'better', I propose an extensive understanding of 'moving on' that is more inclusive and diverse than the current OMHP measures of service outcome.

Chapter 2 examines the visual and audio archives relating to the reforms of spaces at Oxford Littlemore Hospital, the place where Restore was founded. I experiment with a sensory medical anthropological approach and write vignettes of my examinations of the multimodal archives. By looking at two psychiatric reforms that significantly influenced the arrangements of spaces at Littlemore Hospital (i.e. the Moral Treatment in Victorian England and the Therapeutic Community Movement post-war), I discuss how the bodily-sensed spaces constituted an important part of the grassroots mental health practitioners' evaluations of the effectiveness of the psychiatric reforms. Notably, the evaluations discussed in this chapter took place before the RCTs became a golden standard for biomedicine, which indicates that even within the discipline of Western medicine, there used to be multiple approaches to treatment evaluations.

Chapter 3 reviews the founding stories of Restore. I collected the stories through online semi-structured interviews with five leadership persons who contributed to Restore's foundation and development. The stories reveal people's joint efforts and creative place-making when they established Restore at Littlemore Hospital and set up

the first two permanent sites in community settings. The first site on Cowley Road became the headquarters of Restore after the turn of the millennium, and it was the place where the Garden Café recovery group was located during the time of my fieldwork. The second site at the Elder Stubbs allotments accommodated Restore's gardening group at Littlemore Hospital. The relocation of the gardening group from the hospital land to community allotments reveals local collaboration and individual efforts during the nationwide process of mental health deinstitutionalisation. The development of both sites endorsed the ethos of Restore, which is to be a 'store' that transforms its users into skilful workers who catered for the local community. By looking at the stories about the early years of Restore, I discuss the grassroots initiative for Restore's establishment while presenting essential factual details for the ethnographic chapters that follow.

Chapters 4 to 6 are ethnography-based and they respectively look at the service members' participation in the hands-on activities in three recovery groups of Restore. Chapter 4 assesses the therapeutic effectiveness of the gardening work at the Elder Stubbs. Members in this recovery group usually worked in silence but looked relaxed and pleasant. My participant observation, therefore, focused on their bodily 'doings' and the intercorporeal relatedness generated by the gardening group work. I highlight how the allotments' textured spaces became conducive to the therapeutic process of the gardening work by anchoring the members' movements and enacting a diversity of plants into the rhythms of their collaboration. I then look at how the service members in this group became attentive to each other and the plants they grew when they

collaborated in groups to carry out the gardening tasks. I also discuss how the members learnt gardening techniques that emphasised quality and cultivated attentiveness to their customers.

Chapter 5 looks at the service members' 'doings' of their craftwork projects at the Orchard, Restore's recovery group in Banbury, a historical town in North Oxfordshire. The chapter presents how the service members became empathetically oriented to other people, the craftwork materials, and the hand tools for woodwork when they attended to their craftwork projects. I propose that the intercorporeal relatedness cultivated in this recovery group became efficacious when the service members adapted their bodies to the complex situations in craftwork to solve the technical problems they encountered. While doing craftwork was a therapeutic process that generated bodily concentration and sensory relatedness with others, it also enabled people to care for their workmates by helping them with their projects. This 'caring through crafting', I propose, validates some service members' competency for transitioning into volunteering roles at Restore, which is currently under rigid regulations due to the endorsement of the OMHP measures of the 'discharges' of service users.

Chapter 6 discusses the catering work in the Garden Café at Restore's headquarters in East Oxford. Compared to recovery groups doing gardening and craftwork, the Garden Café had an additional goal to promote employment among the service users of Restore. However, both the narratives of former members in this recovery group and my ethnographic observation of the current members' work in the Café demonstrate that the service members could also become 'better' by working continuously in the

Garden Café. While the stories of the former members emplotted them into the roles of good café workers through their narratives, the current members' effortful learning and practice of catering skills, together with their active participation in the fast-paced teamwork during the peak hours, empotted them into the vital and productive relatedness to the Garden Café's calming, safe, and communal spaces. Such processes of empotment transformed the service members in this recovery group into skilful baristas, chefs, bakers, and cashiers for the Garden Café, making them valued workmates to each other and the host of the place. I thus propose that such therapeutic processes of emplotment and empotment should be regarded as service outcomes which are as important as the 'discharge' into paid employment.

The thesis then ends with a Discussion.

Chapter 2. Archival materials on the reforms of space at Oxford Littlemore Hospital

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Vignette 4: creating 'open and large' space

2.3 Conclusion

This chapter studies the archival materials about the reforms of space at Oxford Littlemore Hospital, the place where a group of psychiatrists, mental health nurses, and social workers founded Restore. [29] Instead of writing a historical review of the provision of mental health care in Oxford, I present four vignettes of my medical anthropological examinations of archival materials. I embed the vignettes in their fluid socio-historical contexts, but they do not assume any institutional continuity towards the foundation of Restore. Rather, the four vignettes in this chapter resonate with each

[29] See Chapter 3 for the discussion of the founding stories of Restore.

other by sharing the interest in people's sensory experiences when they lived in, moved through, and adapted to the reforms of the institutional space of Oxford Littlemore Hospital.

After the fieldwork abruptly terminated in 2020, I returned to the writing desk with my laptop. When I tried to review the provision of mental health care in Oxford with the digital archives online, I was instantly intrigued by the archival materials' rich contents and openness to sensory engagements. The archives include images, texts, and audio recordings which draw on memories, things, and events that anchor in the past. They made me realise that a plain summary of historical facts might inhibit such sensory engagements. Overall, doing anthropology should be a process of opening rather than closing (Laplante 2020:21). I thus trialled an alternative way to work with these archival materials, which was to write vignettes that analysed their contents and backgrounds with my sensory engagements and imagination.

The chapter has two sections, each present a study of archival materials about the reform of space at Oxford Littlemore Hospital. Section 2.1 examines the bodily-sensed spaces of Littlemore Hospital when it was constructed and enlarged as a public lunatic asylum in the Victorian time. I looked at the archival images while reading the Victorian physicians' and architects' writings to discuss how the reform of asylum space might have affected the lived experiences of the residents who, once sectioned, spent their whole life in the mental health institution. I propose that the socio-historical changes are made significant through people's sensory experiences of sunlight and air. [30]

[30] The study in sections 2.1 is published in the Journal of the Anthropological Society of Oxford (JASO) in 2020 (volume 7, issue 2) titled 'Spatial changes in an Oxford public asylum'

Section 2.2 then looks at the opening-up of hospital spaces during a therapeutic community (TC) reform at Littlemore Hospital during the second half of the 20th century. I listened to audio recordings of a witness seminar attended by people who used to work at Littlemore during the reform. With linguistic anthropology's method to transcribe spoken discourses, I present how the seminar participants became attuned to each other when they talked about the effectiveness and limitations of the reform of space at the Hospital. Their mutual attunement affected me as a listener, with which I propose that the resonance in people's talking had a truth value for my anthropological exploration.

2.1 A study of the visual archives of the Oxford County Asylum at Littlemore

This section works with archival images about Littlemore Hospital when it was constructed and enlarged as the Oxford County Asylum in the 19th century. It starts with a review of the 'moral treatment' reform that influenced the architectural design of the Oxford County Asylum. After an introduction to my research methods for the study in this section, I present three vignettes to look at the changes in the asylum residents' access to sunlight and fresh air, which were significantly affected by the extension projects to enlarge the Oxford County Asylum during and after the era of mental health institutionalisation.

The 'moral treatment' and its influence on the layout of asylums

The Oxford County Pauper Lunatic Asylum was opened on 1 August 1846. The Oxfordshire Health Archives records that the Oxford County Asylum was one of the earliest public asylums to be constructed after the 1845 Lunacy Act, the legal document which gave local authorities the responsibility for creating suitable institutions for people living with mental illness. [31] While the Wynn's Act of 1808 permitted counties and boroughs in England and Wales to build public asylums, the 1845 Lunacy Act made it a legal obligation for them to do so.

The 1845 Lunacy Act established a public body called 'The Commissioners in Lunacy' to guarantee the welfare of asylum residents. When representatives of The Commissioners in Lunacy gathered to work out the guidelines for local authorities to

[31] See link to the archives: https://www.oxfordshirehealtharchives.nhs.uk/hospitals/littlemore_hospital/

construct county asylums, they followed the advice of Samuel Tuke (1784-1857). As a reformer of 'moral treatment', Tuke advised that the new asylums should be constructed in small sizes to provide healthy environments for the asylum residents.

Moral treatment, also known as moral therapy, was a series of therapeutic strategies for mental disorders which were advocated by reformists from the late 18th to the early 19th century. In England, there was The Tuke Family who established and maintained The Retreat, a charitable Quaker asylum in York. In France, there was Philippe Pinel (1745-1826), the medical superintendent who initiated a series of reforms at the Bicêtre Asylum and Salpêtrière Asylum in Paris.



Fig. 2.1 *Philippe Pinel à la Salpêtrière*, oil on canvas by Tony Robert-Fleury depicting Philippe Pinel releasing asylum residents from their chains at the Salpêtrière Asylum in Paris in 1795, Wikimedia Commons

The moral treatment adopted humane approaches to manage and care for the residents of lunatic asylums. One significant approach was to remove the chains and other forms of physical restraints. When Michel Foucault examines the birth of asylums, he discusses the reforms of Pinel and Tuke and argues that, by removing the chains, the moral treatment transferred the terrors of madness from prison-like physical constraints to the 'seals' of conscience (Foucault [1961]2001: 234).

Apart from the removal of physical constraints, the moral treatment advocated for the improvement of the living environment at the lunatic asylums. Samuel Tuke, the grandson of William Tuke who founded The York Retreat in 1792, emphasised the tranquil outdoor areas at The Retreat for patients to do gardening and farming. They helped the asylum to be self-sufficient at the time and were also employed as a therapeutic tool.

> There are eleven acres of land belonging to the Institution. This little farm is chiefly occupied in the growth of potatoes, and the support of the cows, which supply the family with milk and butter.
>
> The garden is on the north side of the house, and contains about one acre. This furnishes abundance of fruit and vegetables. It also affords an agreeable place for recreation and employment, to many of the patients; being divided by gravel-walks, interspersed with shrubs and flowers, and sheltered from the intrusive eye of the passenger, by a narrow plantation and shrubberry.
>
> (Tuke 1813: 94-5)

The Swiss physician Charles-Gaspard de la Rive, who visited The Retreat in 1798, presented a detailed description of the place in his letter to the editors of *Bibliothèque Britannique*, a monthly journal of sciences and arts in Geneva. To Dr. de la Rive, The Retreat which was located 'in the midst of fertile and smiling countryside' was more of

'a large rural farm (*une grande ferme rustique*)' than a prison (quoted in Tuke 1813: 221-4, also in Foucault [1961]2001: 229-30). [32]

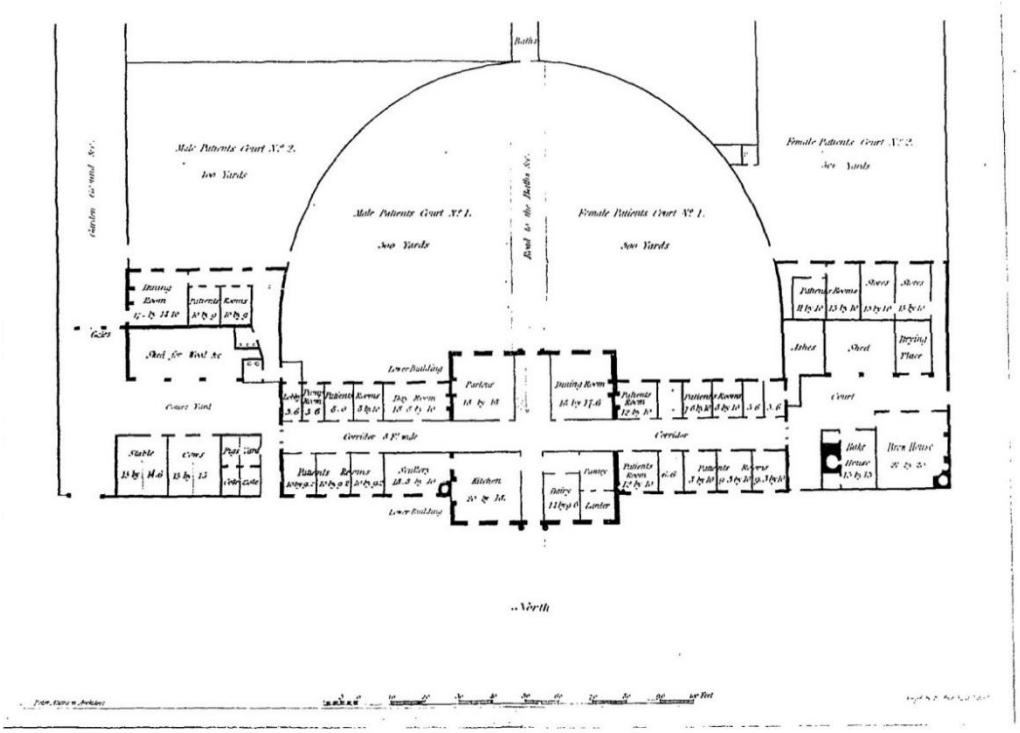
When Samuel Tuke, the third generation of The Tuke Family, took over the responsibility to manage The Retreat, he linked the moral treatment to the practices of 'the intelligent Dr Pinel' who also set up a farm at the Bicêtre Asylum in Paris (Tuke, 1813:132). Pinel discussed the health benefits of farmwork. He argued that the work to cultivate plants and breed farm animals had 'salutary and refreshing' effect on the patients' 'convalescents' due to its 'natural propensity to motion' which induced 'tranquil and refreshing sleep at nights' (Pinel [1801]1806: 193-4). Pinel also reviewed the other regimes in Amsterdam and Spain to advise the lunatic asylums to convert the enclosed land into farms that were maintained and cultivated by the patients. [33]

Apart from the improvement of outdoor spaces, the moral treatment affected the architectural design of the lunatic asylum's building blocks. Andrew Scull who also reviewed the book by Tuke pointed out that the staff at the York Retreat insisted upon 'the superior efficacy' of the mild system of moral treatment (Scull 1989:222). Specifically, Scull noted that the building blocks at The Retreat were 'moral architectures' (ibid. 232). As the floorplans of The Retreat demonstrate, the patients' bedrooms were situated in a long corridor (Tuke 1813: 95,102). Victorian physicians who adopted the approaches of moral treatment argued that the corridor-plan layout

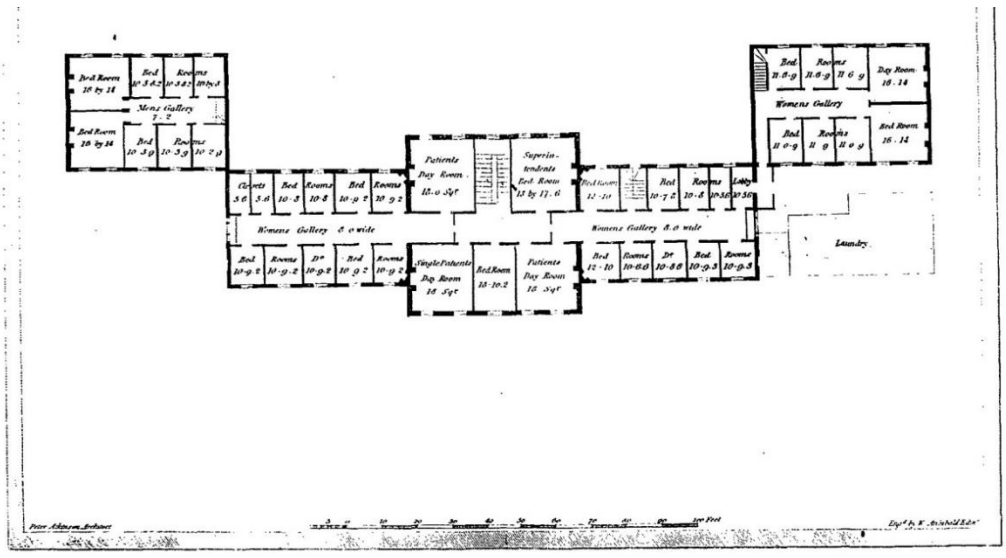
[32] Sarah Rutherford notes that Pinel might have access to de la Rive's description of The Retreat and his project in Paris might have been inspired by the moral treatment advanced by The Tuke Family (Rutherford 2003: 79).

[33] Despite the differences in social-historical contexts, Pinel's discussion of the health benefits of farming and gardening can be considered alongside the gardening work at the Elder Stubbs recovery group of Restore, which I shall discuss in Chapter 4.

improved the quality of air and natural life of the asylum's indoor spaces. It is thus a more humane choice than the prison prototype originally adopted by the lunatic asylums before the moral treatment.



GROUND PLAN of the RETREAT near YORK.



PLAN of the SECOND FLOOR of the RETREAT near YORK.

Figs.2.2 & 2.3 The building layout of The Retreat, ground & second floors (Tuke 1813:94 and 100)

John Conolly (1794-1866), a resident physician at London Hanwell Asylum, embraced the corridor plan layout of The York Retreat in his book with pieces of advice for the purpose-built public asylums. The Hanwell Asylum opened in 1831 with three hundred beds. [34] It was much larger than The Retreat which was a private, charitable asylum with only 24 men and 38 women patients in 1813 (Tuke 1813:96). However, as a public lunatic asylum, it met the criteria set by The Commissioners in Lunacy after the 1845 Lunacy Act, which was to limit the patient number below 300 and to provide 'arity and healthy' living environment (Taylor 1991:136). A Quaker architect, William Anderson, designed the asylum building. Anderson claimed to have been influenced by Tuke and the Hanwell Asylum he designed adopted a similar corridor-plan layout to that of The Retreat (Taylor 1991: 134). As a resident physician, Conolly was able to live in the asylum alongside the patients. He noted that the architectural layout made life at Hanwell more comfortable because the long and narrow building had better ventilation and more natural light.

> It is evident that a building of this shape, long and narrow, consisting of a succession of galleries or corridors, with bedrooms on one side only, may be moderately perflated by every wind that blows – an advantage extremely salutary to those who pass their whole time in it. The want of proper ventilation is chiefly incidental to the angles of the building, and to the centre, and should be carefully provided against. In hot climates, exposure to sun is a frequent cause of cerebral excitement, and many of our patients persist in exposing their bare heads to the sun in the hottest weather, until it is scarcely possible to touch their heads with one's hand. But in this country the hot season is of short duration, and it is especially necessary to consider that no gallery within the house, and no airing-ground exterior to it, should be deprived of some shares of sunshine in the winter, as well as of free access of air, and some shade in summer. Quadrangular buildings, (unless the quadrangle is very large, and the buildings are very low,) and circular buildings,

[34] See the link for more information about the London Hanwell Asylum: https://www.countyasylums.co.uk/st-bernards/

> and central towers or crescents with radiating wings in three or more directions, are open to great objections on every account. (Conolly 1847: 12-3)

Conolly recommended the corridor-plan layout because the wind that ventilates could easily blow through the building which was long and narrow. There was also sufficient sunlight to generate warming heat and illuminate the residents' bedrooms. As a resident physician, Conolly was undoubtedly a member of the Hanwell community, a caretaker who practised moral treatment. The practice enabled him a comparatively more humane approach to the patients at the time, with which he immersed himself in the asylum's lifeworld and provided a lively account of the health benefits promoted by the humane design of the hospital spaces.

From a sensory medical anthropological perspective, I find Conolly's account very intriguing. He looked at the patients and imagined how they might enjoy the sunlight and the fresh air by imagining and sensing the asylum spaces with his own body. He might have also touched someone's head to feel the heat. The focus on the patient's bodily 'doings' and sensory experiences invoked a close examination of 'the real pipe' if considered with Jean-Pierre Warnier's discussion of the Magritte Effect reviewed in Chapter 1. Inspired by Conolly, I will carry on my study of Oxford County Asylum with a focus on the conditions of sunlight and air ventilation enacted in the asylum's changing spaces which directly affected the bodily experiences of its residents.

Working with archival images

The archival images I work with in this section came from Picture Oxon, an open-access digital archive created by Oxfordshire County Council in collaboration with the Oxfordshire Health Archives and the Oxfordshire History Centre. In October 2020, I browsed with the keyword 'Littlemore' on Picture Oxon with time selected between 1840-1999. I was then able to look at 68 images that were available online at the time, including the images of the Oxford County Asylum's building layouts and some old photographs of the wards after the asylum was transformed into Littlemore Hospital in 1922. [35]

I am aware that visual images, when produced, will bear the perspectives of the photographers. And the images available in the digital archives should have also been selected. For some of the images mentioned in this section, my gaze diverted from the gazes of the photographers, which echoes what David Zeitlyn suggests that a subversive analysis of archival materials may disclose novel insights (Zeitlyn 2012: 464).

Technically, I was guided by the picture-reading methods introduced by Marcus Banks and David Zeitlyn. This means that I did not only look at the contents of photographs, but also analysed the context in which they were taken, such as the titles, the name of the photographer, and the years of production (Banks and Zeitlyn 2015:10) My gaze did not always follow what the image-maker wished to communicate, either

[35] Among the 68 photographs, there was also a diet sheet from 1854, a case book from 1852, an admissions certificate for a patient called George from 1880, and aerial views of the hospital in different years, which I also found very intriguing.
See the link to Picture Oxon, now a sub-collection of Oxfordshire County Council's online Heritage Search: https://heritagesearch.oxfordshire.gov.uk/images

(ibid.11). Sometimes, for instance, I paid attention to the marginalised areas of a photo, such as the windows on the buildings behind a group of male asylum residents (see Vignette 3 below), because these marginalised areas contained key information that indicated the residents' bodily experiences of the asylum spaces.

Methodologically, my study of the archival images was inspired by Robert Desjarlais who notes that photography can 'tear the perceiver from itself' by dissolving the consciousness into 'imaginative and empathetic possibilities' (Desjarlais 2019: 19-20). In other words, my intention was not only to look at the marginalised areas in the archival photos but also to imagine with them, feeling how the asylum residents might feel when they sat by their dormitory windows to enjoy the sunlight and the fresh air.

Desjarlais explicates that photography 'disrupts conventional notions of experience' by involving 'complex foldings of past, present, and future, self and other, the actual and the imagined' (ibid. 20). It generates a 'double temporality of past moments and present scenes of looking.' (ibid.) The below vignettes also worked with such double temporality. The moments from the past, which the archival photos captured, flowed with the temporality of my looking at them. To intensify the interrelation between such double temporality, I also use Google Maps to virtually 'revisit' the old buildings of Littlemore to help with my imagination of the residents' experiences of sunlight and air at Oxford County Asylum.

Vignette 1: the improvement in natural light and ventilation

The Oxford County Asylum was constructed during the time of moral treatment. The architect, Robert N. Clark from Nottingham, designed it as a small asylum with only 120 beds (Yorston and Haw 2005). On Picture Oxon, I found a painting of the Oxford County Asylum in 1845 (see Fig. 2.4 below). As the painting demonstrates, the building blocks of the Oxford Asylum formed in a long corridor just like the ones at The York Retreat and the Hanwell Asylum in London. [36] In the centre of the long corridor, there was a three-storey building for administration. The central administrative block was between two flanking octagonal hubs. Each hub overlooked three building blocks with patient dormitories. The hub in the south supervised the rooms for women, while the one in the north looked over the dormitories for men. [37]

Inspired by Conolly's observation of the sunbathing patients at Hanwell, I imagined the feeling of sunlight and fresh air when I looked at the old painting of Oxford County Asylum. The sides of the building that faced the sun seemed to be well-illuminated. The large green spaces in the courtyards looked tranquil and could be counted as the 'airing ground' if reviewed from Conolly's account. The wind should be able to blow through the building blocks if the windows were opened. However, I also spotted a burial ground behind the asylum's corridor-plan building blocks and an even larger field beyond the walls of the asylum.

[36] Other corridor-plan asylums in the same era were found in Nottingham, Lancaster, and Wakefield.
[37] The design indicates that the panoptical form of control was retained in the corridor plan layout despite the humane turn of moral treatment which improved the living conditions of the asylum residents. In fact, there was even a sub-type of corridor-plan asylums called the 'panoptican corridor plan', which had large and complex towers for supervisory purposes. See West Riding Asylum (Stanley Royd Hospital) as an example: https://www.countyasylums.co.uk/stanley-royd-wakefield/

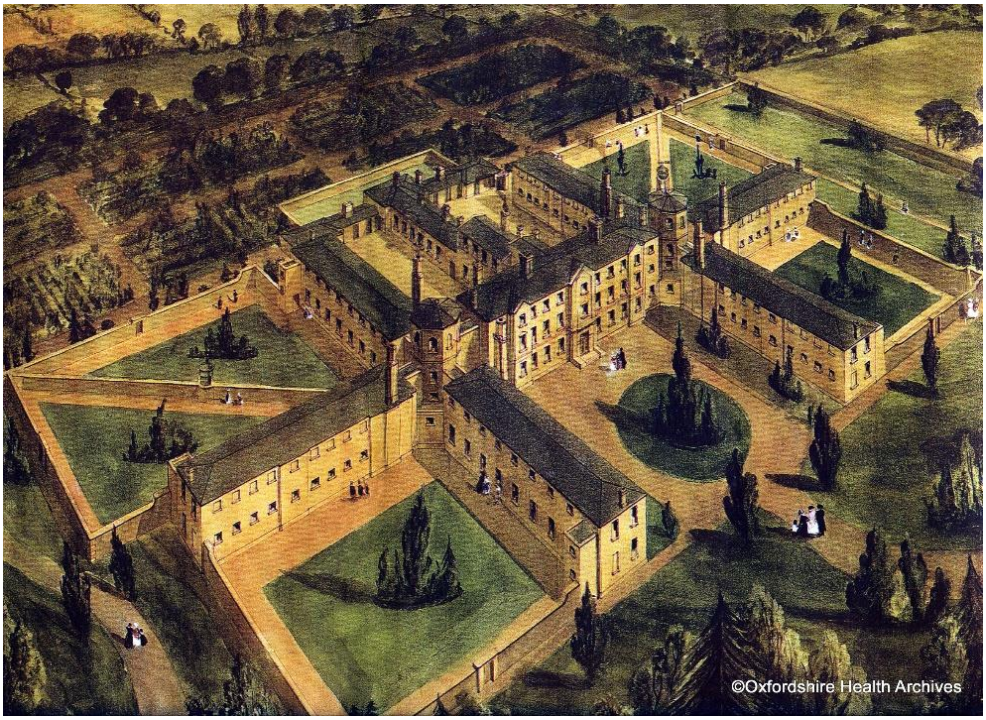


Fig. 2.4 A painting of the Oxford County Asylum in 1845, Oxfordshire Health Archives

When Conolly discussed the benefit of the corridor-plan layout, he objected to the asylum buildings which were quadrangular, circular, or having central towers or crescents with radiating wings (e.g. public asylums in Glasgow and Cornwall). These types of architectural designs had their roots in Jeremy Bentham's panopticon prison, so Conolly's claim could have been read at the time as a critique of the prison prototypes. Compared to building blocks arranged in a long corridor, the prison prototypes had better supervisory efficiency, because one tower overlooked more blocks. [38] The radial-plan asylum was also of higher cost efficiency as the same area of space could accommodate more people (Taylor 1991:136).

Conolly objected to the radial layout due to its awful impact on the building blocks' exposure to natural light and air ventilation. Here, I compare the Oxford Asylum's

[38] Charles Fowler, a Victorian architect, commented that 'the whole and every part and every person is continually under the eye of the Governor or his assistant' in a radial-plan layout (Taylor 1991: 137).

corridor-plan layout to Devonshire County Asylum's radial-plan structure to further elaborate on the difference. Since sunlight and wind are certain climate factors which can be considered continuous from the past to the present, I was able to compare the bodily-sensed spaces of the two asylums.

The Devonshire County Asylum was opened in 1845, one year earlier than Oxford County Asylum. It had 450 patients, nearly three times the number at Oxford. As Fig. 2.5 below demonstrates, the Devonshire County Asylum has a central tower surrounded by a crescent that links to six radiating wings. Charles Fowler, the architect of Devonshire Asylum, explained that the design to have such radiating blocks was to facilitate allocating the patients by class (Taylor 1991: 137). Like in Oxford, the residents were separated by sex.



Fig. 2.5 A painting of the Devonshire County Asylum in 1845, Creative Commons Attribution

Jeremy Taylor notes that the Devonshire County Asylum was designed as an improved version of the classic radial-plan layout. The circular and enclosed design of the traditional panopticon prison was cut into a semi-circular crescent. He notes that the

long building of the crescent, which was stationed between the central administrative hub and the radiating blocks, should have facilitated the delivery of food and medical supplies.

Despite the development from a circular to a semi-circular layout, the Commissioners in Lunacy commented that Devonshire County Asylum had little improvement in the residents' living environment (Taylor 1991: 137). With an interest in the residents' experiences of sunlight and fresh air, I made a comparison between Oxford County Asylum and Devonshire County Asylum. The buildings of both asylums remained in use today as private residential housing, so I can still find them on Google Maps. [39]

Specifically, I compare the conditions of sunlight and air at Oxford Asylum and Devonshire Asylum to discuss how the bodily-sensed spaces might have affected the asylum residents' lived experiences. Figures 2.6 and 2.7 below were screenshots taken on Google Maps with the same zooming scale. In comparison, the Devonshire Asylum had more buildings than the Oxford Asylum on the same area of land in 1846. These buildings in Devon were arranged densely next to each other to accommodate three times the residents as Oxford. The sunlight, therefore, should reach more blocks at Oxford because they were arranged in a line, especially considering that some blocks on the side (highlighted in red) were not yet constructed in 1846. By contrast, the semi-circular crescent and the six radiating blocks at Devon would each block out the light

[39] The buildings of the Oxford Asylum are even sold on the market as high-end, luxurious properties. See, for instance, a four-bedroom apartment converted from the male dormitories sold with a guide price of £600,000 in May 2023. https://www.rightmove.co.uk/properties/132150653#/?channel=RES_BUY

of the other. Moreover, the long, thin, and vertical shape of the building at Oxford County Asylum should be better ventilated than the cluster of building blocks at Devonshire County Asylum.

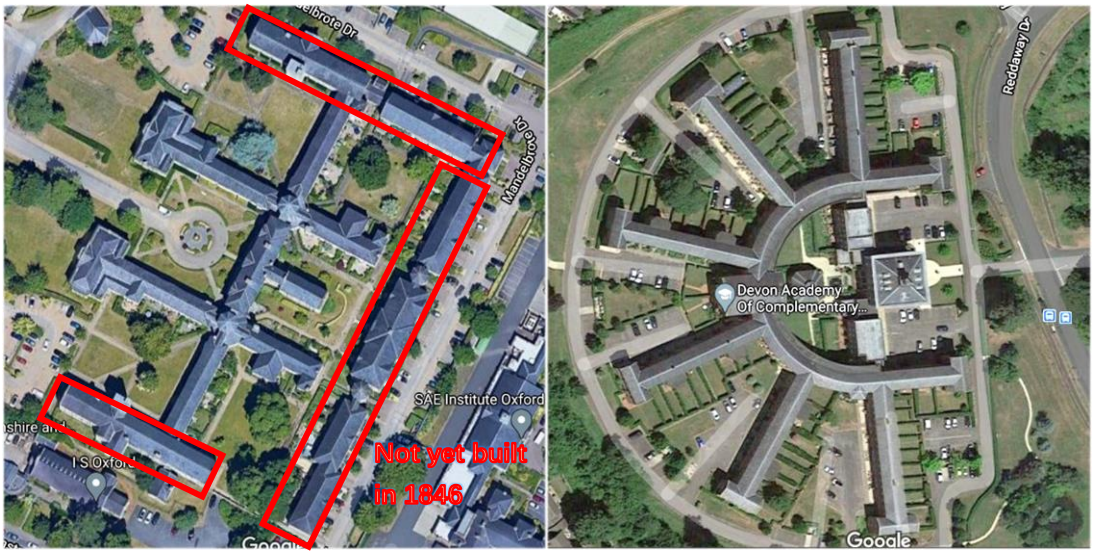


Fig. 2.6 Oxford County Asylum, later known as Littlemore Hospital, *corridor-plan layout* (left)
Fig. 2.7 Devonshire County Asylum, later known as Exminster Hospital, *radial-plan layout* (right)
Screenshot made by the author on Google Maps on 19 October 2020

With the above comparison, I conclude that the Oxford County Asylum, which adopted a corridor-plan layout, had better conditions of sunlight and fresh air than the Devonshire Asylum which evolved from a prison prototype. Following John Conolly's argument, this might mean that the living condition for the residents at Oxford Asylum was better than those at Devonshire Asylum However, the comfortable living conditions did not last long, as the asylum spaces were altered through two extensions.

Vignette 2: the severe impact of the extensions in 1852 and 1902

Ever since the Oxford County Asylum was opened in 1846, it had been faced with increasing pressure to accommodate more people. Although the 1845 Lunacy Act made it a legal obligation for the local authorities in England and Wales to build public asylums, not all counties were able to do so. Berkshire, for instance, made a contract with Oxfordshire to accommodate its patients at the Oxford County Asylum to meet the legal requirement. A new building programme was then commenced in 1848 to enlarge the Oxfordshire County Asylum, as the website 'County Asylum' recorded. [40]

The extension between 1848-1852 was initiated by Oxford architect Henry Jones Underwood and finished by John Chessell Buckler. The project added a three-storey building block and a tower on the northern and southern ends of the building. The extension reduced the corridor-plan layout's original advantages in ventilation and natural sunlight because the new blocks blocked the wind and sunlight that would have reached the patient dormitories from the side.

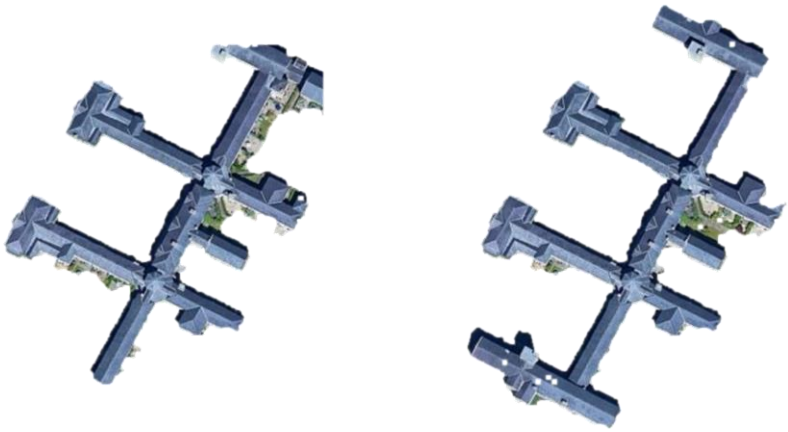


Fig.2.8 Oxford County Asylum before and after the extension in 1852, images made with Google Maps

[40] The website 'County Asylum' was founded by individuals who were interested in the history of lunatic asylums with help and support from NHS Heritage Groups, borough museums, and regional historical societies. See: https://www.countyasylums.co.uk/

Despite the extension between 1848 and 1852, the pressure on the local authorities to accommodate more residents in lunatic asylums remained unalleviated. Andrew Scull comments that the 'mass institutionalisation' of people living with mental illness in the late nineteenth century is a shift from domestic to institutional modes of management. It is a 'quasi-automatic response to the realities of life in an urban-industrial society' (Scull 1981: 216) which indicates that the problems accompanying the Industrial Revolution could no longer be handled within a household or community-based system of relief. Eventually, public asylums constructed and enlarged in the late nineteenth century became the long-term accommodation for people who could not afford private health care for their mental illness (Taylor 1991: 142). Between 1849 and 1909, the number of borough and county asylums in England and Wales jumped from 21 to 97, while the total number of asylum residents increased from 350,000 to 1,008,000 (Taylor 1991: 155).

Due to the escalating increase of demand, public asylums constructed as 'moral architectures' with fewer than three hundred beds were no longer large enough to accommodate the increasing number of residents. As a result, asylums built after the 1860s no longer adopted the corridor plan layout as advised by Tuke and other reformists of moral treatment. Instead, the asylum architects chose the pavilion plan or echelon plan which would contain at least one thousand beds. The *pavilion plan* can be found in public asylums built after 1865, such as the Royal Herbert Military Hospital and St. Thomas's Hospital in London and the Leavesden Asylum in Hertfordshire. A standard pavilion plan is like a corridor plan but with more building blocks added

vertically to the corridor. The *echelon plan* asylums became popular from 1880. It contained many arrow-shaped building blocks, such as at the Coney Hill Hospital in Gloucester. [41]

In comparison to asylums built with more than one thousand beds in the late nineteenth century, small-size, corridor-plan asylums like Oxford and Hanwell were under constant pressure to accommodate more patients. Between 1848-1900, the number of residents at the Oxford County Asylum only increased from 200 to 543 persons (Lobel 1957:206), which was far less than demand. Another extension project was thus initiated to further enlarge the accommodation spaces at the Oxford County Asylum.

The second extension took place between 1898 and 1902. It added a few auxiliary sheds, two single-sex pavilion blocks, and a recreation hall on the southeast side of the original corridor-plan building. They took the place of the burial ground for a cemetery, which was filled up for the extension. When the project was finished in 1902, the Oxford County Asylum added another two hundred beds and was able to house more than eight hundred residents (Lobel 1957:206).

The extension between 1898-1902 was headed by Oxford architect Henry James Tollit (1835–1904). On Picture Oxon, I found a manuscript that Tollit made for the extension project. I highlighted in the manuscript the new buildings constructed during the 1989-1902 extension and made another figure with Google Maps to demonstrate

[41] See the links below for more information about the asylums built in pavilion and echelon plans:
https://www.asylumprojects.org/index.php/Pavilion_Plan_Institutions (pavilion plan)
https://www.asylumprojects.org/index.php/Echelon_Plan_Institutions (echelon plan)

the complete process of Oxford County Asylum's extensions (see Figures 2.9 and 2.10 below). It can be found from these figures that the 1898-1902 extension further reduced the advantages of the original corridor plan layout in respect of air ventilation and natural sunlight. After the extension, a large cluster of new buildings showed up on the southeast side of the old blocks. In some areas, buildings started to form squares and semi-squares, which was contrary to Conolly's original objection to rectangular layouts. The air in these areas would thus become stuck within the enclosed spaces and the buildings would block each other's sunlight.

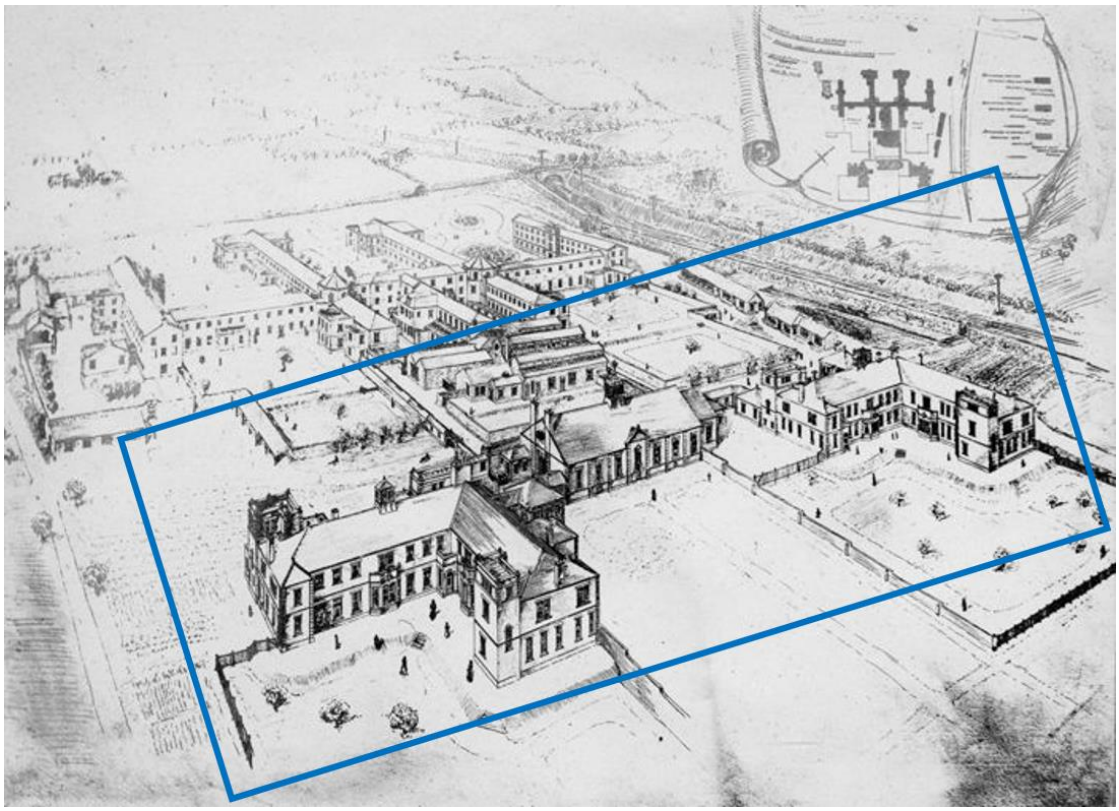


Fig. 2.9. H. J. Tollit's manuscript for the extension project at the Oxford County Asylum between 1898-1902, Oxfordshire History Centre, blue square added by the author to highlight the new buildings constructed during the extension

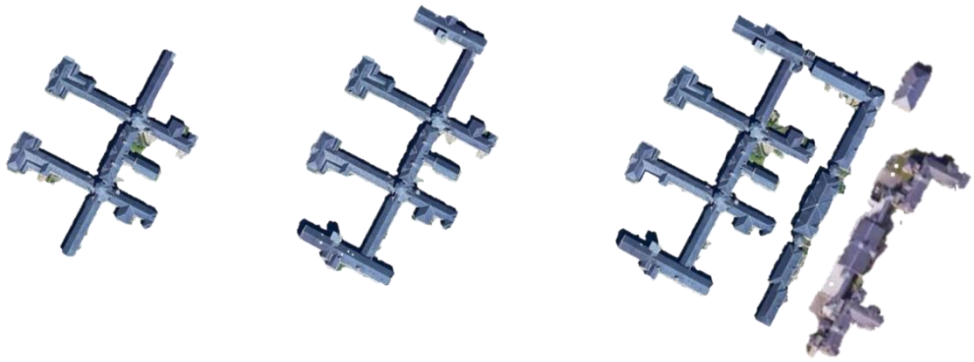


Fig.2.10 The two extensions of Oxford County Asylum, images made by the author with Google Maps from left to right: before 1848, after 1852, and after 1902

The two extensions at Oxford County Asylum increased the number of residents that the asylum could contain. However, the asylum's building layout lost its original advantages in natural lighting and ventilation. The resident's comfortable living environment was compromised. To save money for the extensions, the new building blocks were built with cheaper materials. The first extension between 1848-1852 was smaller in scale and used the fancy 'squared coursed limestone' for the original corridor-plan building. The second extension in 1898-1902, by contrast, turned to cheaper alternatives. Instead of limestone, the pavilion blocks built on the burial ground used yellow bricks. [42]

The consideration of cost efficiency was also reflected in a refurbishment project in 1895. After a destructive fire that removed the roofs on the south block for women, the refurbishment abandoned the old decoration of the overhanging eaves on its shallow-pitched Welsh slate roofs. The change is still visible today on the hospital

[42] For more information and photos about the building materials used in the two extensions, see:
https://britishlistedbuildings.co.uk/101369195-littlemore-hospital-littlemore#.X40RE9AzY2x
https://www.countyasylums.co.uk/wp-content/uploads/2014/11/0837.jpg (Supervisory hub of the original corridor-plan blocks in squared coursed limestones)
https://www.countyasylums.co.uk/wp-content/uploads/2014/11/0982.jpg (Pavilion blocks built in second extension, in yellow bricks)

building converted for residential use: while the overhanging eaves can still be seen on the shallow-pitched Welsh slate roofs on the blocks for men in the north, the refurbished blocks for women on the other side no longer have the same characteristic decoration.[43]

The military interlude during the two world wars

The increase of asylum residents lasted until the outbroke of the two world wars. Many public asylums in England and Wales were transformed into military hospitals during the wars. The Oxford County Asylum, for instance, was turned into Ashurst Military Hospital in World War I. [44] The website County Asylums, introduced above, records that the patients at the Oxford County Asylum were either called up for the military service or transferred to reside elsewhere between May 1918 and August 1922. During World War II, the eastern pavilions of the Littlemore Hospital were borrowed for military usage again. The rest of the buildings, however, remained in use for mental health purposes.

England in the two world wars witnessed radical changes in the public's attitude towards mental health institutions. County asylums of massive sizes that housed thousands of people were criticised for their problems of overcrowding and ill provision of care (Fakhoury and Priebe 2007). The word 'asylum', together with the ways of

[43] South wing for women (without overhanging eaves)
https://www.countyasylums.co.uk/wp-content/uploads/2014/11/04116.jpg
North wing for men (with decorative eaves)
https://www.countyasylums.co.uk/wp-content/uploads/2014/11/0769.jpg
See also photos of women's block after the fire:
https://pictureoxon.com/frontend.php?keywords=Ref_No_increment;EQUALS;POX0112738&pos=45&action=zoom&id=112738 (Picture Oxon reference: POX0112738)
https://pictureoxon.com/frontend.php?keywords=Ref_No_increment;EQUALS;POX0112739&pos=44&action=zoom&id=112739 (Picture Oxon reference: POX0112739)

[44] Other examples of public lunatic asylum turning into military hospitals during World War I are London Horton Asylum and Bristol Asylum.

management it entailed, was detested. As a result, Oxford County Asylum changed its name to Littlemore Hospital in 1922, four years after the end of World War I.

In 1937, two years before World War II, E. F. Pinsent surveyed the mental health services in Oxford City, Oxfordshire, and Berkshire as a commission to the local authorities in the two counties. In the survey, Ms Pinsent recorded 880 patients at Littlemore Hospital. Besides, the medical team at Littlemore consisted of one superintendent, three medical officers, ninety-two female nurses, and sixty-five male nurses (Pinsent 1937:24). Ms Pinsent commented that the problem of overcrowding at Littlemore was not severe in comparison to public asylums in other counties. However, it was still difficult to offer individually tailored treatment. Noticeably, Pinsent recognises that the old asylum building at Littlemore was no longer suitable for the provision of modern mental health care.

Shortly after the end of World War II, Littlemore Hospital initiated a new project in around 1950 to construct buildings which would meet the demands of modern mental health care. The building project took place on a new site on the other side of Sandford Road that was separated from the large cluster of buildings constructed before 1902 (see Fig. 2.11 below). The project added a new admission and treatment centre, a few more patient dormitories, and accommodation for the nurses. Both sites were in use until 1998 when the old asylum building was converted into private residential housing. The new site built after 1950, however, continued to operate as the Littlemore Mental Health Centre for the NHS until today.



Fig. 2.11 The old and the new sites of Littlemore Hospital
image made by the author with Google Maps on 15 May 2023

Vignette 3: windows on the patient dormitories

On Picture Oxon, I found several photos of the patient dormitories constructed before and after the two world wars. The dormitories in new buildings constructed after 1950 looked very different from the ones in the old Victorian asylum. In this section, I analyse the differences in the windows because they were the places where sunlight and fresh air might come through. I present two groups of photos to demonstrate the differences. Group One contains photos of the asylum building on the old site; Group Two are photos of the new site.

Group 1. Windows on the old site



Fig. 2.12 An archival photo titled ‘Male patients and staff’, taken at the Oxford County Asylum in around 1870, which shows the windows of asylum building, Oxfordshire Health Archives

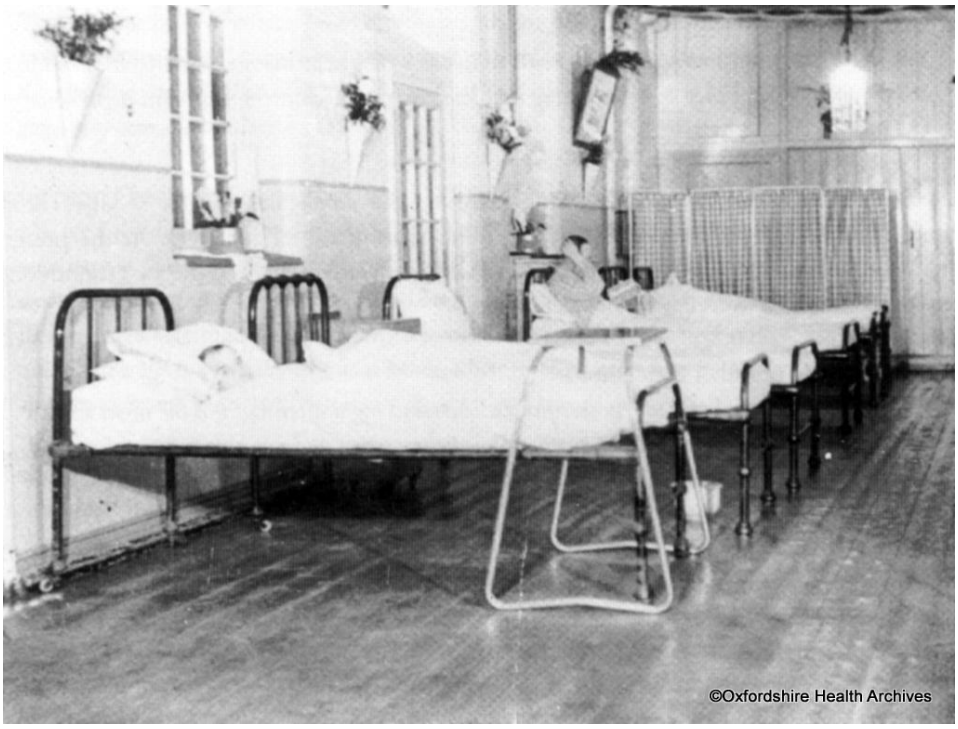


Fig. 2.13 An archival photo titled ‘Ward pre-1930’, taken in the Oxford County Asylum in ca. 1924, which contains details of the windows in patient dormitories, Oxfordshire Health Archives

The two photos in Group 1 above contain details about the windows for the patient dormitories in the old site of Littlemore Hospital. As introduced, the buildings on this site were constructed and extended during the Victorian time as a public asylum. The windows on these buildings were narrow, multi-paned, with frames painted in white. Some windows in Fig. 2.12 were opened with very narrow gaps from the upper sash, which indicates the level of ventilation in the dormitories.

The narrow, multi-paned windows were common in Victorian time England. The design could be found not only in public asylums but also in pubs and private homes. It was the materials for the window frames that made a difference. Leonard Smith found that the windows in Victorian public asylums were often built in cast-iron frames. Some were even protected by iron bars and shutters (Smith 1999: 160-1).

John Conolly also noted that the windows in Hanwell Asylum had cast-iron frames with wire guards which he believed would prevent the patients from escaping (Conolly 1847: 20). Paradoxically, Conolly was also concerned that when the windows were locked, the patients would have to evacuate the building through the long corridor rather than the window in a fire, which would be very problematic.

As the two photos in Group 1 demonstrate, the old site of Littlemore Hospital had a similar type of windows as the ones mentioned by Smith and Conolly. The design of these windows on the asylum buildings had consideration in respect of surveillance and control. This means that although the asylum building's corridor-plan layout could obtain better sunlight and was easier to be ventilated, the patients' comfortable living environment was always in compromise with the asylum's function as a total institution.

The second group of photos, by contrast, show the new wards built around 1950. Both photos in this group were taken by John William Thomas for the *Oxford Mail and Times* in June 1956. Besides photos of the wards, John Thomas took photos of the reception, recreation rooms, canteen, kitchen, and even toilets in the buildings on the new site of Littlemore Hospital.

As the photos below demonstrate, windows in the new buildings were very different from the ones in the Victorian asylum. The window panes appeared to be fewer but much larger and wider. There were no iron bars, shutters or other forms of guard or protection. The degree of ventilation was uncertain because all windows were closed in these photos. However, the wards in both photos appeared to be well-lit by sunlight thanks to the large size of the window panes. The vista outside the windows was also improved. Even though the photos were in black and white, one could see the beautiful, natural landscape of fields and farmhouses from the windows in both photos.

Although the wards looked nicely illuminated thanks to the large window panes, the reason behind such a significant change of design could be complex. There could be a new trend in window design after the two world wars. The development in glass manufacturing might have also reduced the cost to make large window panes. However, the change should not be thought to have been prompted by a humane consideration of patients' welfare primarily, regarding the sunlight and fresh air they could get in the ward.

Group 2. Windows on the new site





Figs. 2.14 & 2.15 Two archival photos titled ‘Interior view of a ward at Littlemore Hospital’ which contain details of the windows in the hospital buildings on the new site constructed after 1950, Oxfordshire History Centre

From a medical point of view, the change in window design also raised some practical issues. For a long period, the windows on mental institutions are connected to the residents' destructive behaviour and attempt to escape. The nineteenth- and twentieth-century literature on public asylums and mental hospitals recorded incidents of patients throwing objects to break the windows in their dormitories. The small windows with cast-iron frames in Victorian times effectively prohibited such behaviours through their physicality, while the large, single-paned windows in the 1950s no longer had the same effect. If, in the 1950s, these protective measures were removed from the windows, there must have been other ways to keep the destructive behaviours under control.

I suggest that the development of the first-generation antipsychotic medication could have been a reason that enabled the change. Chlorpromazine was synthesized in 1950, about the same time when Littlemore Hospital constructed the new wards with large windows. In medical anthropology, Sue Estroff (1981) discussed, in her classic ethnography on a community mental health programme in the USA, how the development of antipsychotic drugs had transformed control through physical constraints, such as high compound walls, barred windows, and locked wards, into the pharmaceutical control over the body. This, she noted, happened at the cost of affecting the quality of one's life. In other words, the dimension of control over the hospital inpatients' bodies shifted from the building's physical design to biomedical practice. I will elaborate on the use of antipsychotic drugs at Littlemore Hospital in the next section.

In summary, the study in this section examines the process of constructing and enlarging the Oxford County Asylum, the place which later became Littlemore Hospital. The process began with a 'humane' turn in the history of psychiatry during which the Oxford County Asylum was designed with a 'corridor-plan' layout. As a type of 'moral architecture', the asylum architects and Victorian physicians of moral treatment argued that the corridor-plan asylums can offer more a comfortable living environment than the prison prototypes. However, due to the increasing demand for asylum beds and the consideration of cost, the two extensions at the Oxford County Asylum in 1852 and 1902 severely reduced the benefits of the original layout.

Experimenting with the approach of sensory medical anthropology, I look at the drawings and photos in visual archives and capture digital images on Google Maps to compare the changes in Oxford County Asylum's architectural layout across different years. By engaging the images with the writings of asylum architects, Victorian physicians, and medical historians, I imagined the asylum residents' experiences of sunlight and air ventilation at the Oxford County Asylum after the two extensions. The comparison of the sunlight and fresh air as experienced and imaged by the body then revealed the entanglement of the asylum architecture with the interplay between the consideration of the patient's comfort and the efficiency of cost and supervision.

After the military interlude during the two world wars, the problem of overcrowding and ill provision of care at the old-style lunatic asylums raised public concern. As a result, the Oxford County Asylum changed its name to Littlemore Hospital and constructed a new site to provide modern health care. Regarding the

extension this time, I look at the changes in the windows of patient dormitories because they were the place where sunlight and fresh air might come through. By comparing the windows on the old asylum building and the ones on the new wards constructed in the 1950s, I suggest that one reason for the radical change in the design of windows is related to the development of first-generation antipsychotic drugs. This finding from a close examination of window designs, I argue, reveals how Littlemore Hospital's bodily sensed spaces were entangled with the care and control of the inpatients.

2.2 A study of the audio recordings of a witness seminar regarding the Phoenix Unit at Littlemore Hospital

This section examines the audio recordings of a witness seminar about the therapeutic community reform at the Phoenix Unit of Littlemore Hospital. I will first review the Therapeutic Community reform in the UK and its influence on Littlemore Hospital's management between the 1960s and 80s. I then discuss the audio recordings of the Phoenix Unit witness seminar with a focus on the seminar participants' observations of people's bodily movements through the open and large spaces they created during the reform at the Phoenix Unit.

A review of Maxwell Jones's therapeutic community reforms

The term 'therapeutic community' refers to a wave of psychiatric movements and reforms which took place in the UK and the U.S.A after the two world wars. In the UK, the concept was in 1946 first coined by psychiatrist Tom Main (1911-1990) from a psychoanalytical perspective (Kennard and Roberts 1983:4). Meanwhile, it is Maxwell Jones (1907-1990) who is credited for later developing the concept into several principles and practical approaches for reforming the organisation of mental hospitals.[45]

David Kennard and Jeff Roberts identified Maxwell Jones's therapeutic community as 'the *Democratic-Analytic* type', which they acknowledged as one of the most common types of therapeutic communities in the UK (Kennard and Roberts 1983:

[45] David Millard (1996) made a thorough comparison between the therapeutic community principles of Tom Main and of Maxwell Jones in his classic article, 'Maxwell Jones and the Therapeutic Community', which is re-printed in the special issue of History of Psychiatry in 2023, Volume 34, Issue 1, with a new introduction, discussion, and editorial note by Craig Fees and David Kennard.

99). [46] Like other types of TC, the one developed by Maxwell Jones had several common features, including an informal and communal atmosphere, a central place of group meetings, the sharing of work to maintain and run the community, and recognition of patients as 'auxiliary therapists' who influence each other's attitudes and behaviour. (Kennard 1983:7-10)

Maxwell Jones developed his therapeutic community principles and approaches through several stages. He worked at Mill Hill Emergency Hospital in London during World War II and observed treatment of 'effort syndrome' among patients who had been in the military service. Jones found that the syndrome was not only about chest pain or heartache but also emotional suffering (Jones 1953:12). He also found that the Unit Discussion Group for patients to raise concerns to hospital staff transformed the patient's role and affected 'the whole social structure of the ward' and generated educational and therapeutic effects (ibid. 13-14).

After World War II, Jones spent a year working in a unit for ex-prisoners of war at the Southern Hospital in Dartford in 1946. He continued to organise group meetings with the patients at Dartford and began finding work opportunities for them in the local community. Meanwhile, the 1944 Disabled Persons (Employment) Act was just published, which made it a legal right for people living with mental illness to get employed. Jones was able to help the patients at Dartford to obtain work experiences

[46] In the book, *An introduction to therapeutic communities*, David Kennard and Jeff Roberts summarise four types of therapeutic communities, which are 1) an Institutional Type of therapeutic community set up by the staff in traditional mental health institutions such as public asylum 2) a Concept-Based House set up by former substance-abusers for rehabilitation purposes, a type commonly found in the U.S.A 3) an Alternative Asylum established with a specific spiritual, moral, or social principle as an alternative institution to traditional public asylums 4) a Democratic-Analytic type of therapeutic communities which usually adopts the approaches developed by Maxwell Jones. (Kennard and Roberts 99-103)

from vocational jobs outside the hospital, such as market gardening, farming, and building construction (ibid. 16-17).

With experiences treating people who had been through and sickened by the wars, Jones started a twelve-year project at the Industrial Neurosis Unit of the London Belmont Hospital in April 1947. He found the patients at Belmont more challenging to treat as they had inadequate or aggressive behaviours, histories of being imprisoned, drug addiction, and other chronic psychiatric and social problems (ibid. 25-26). However, Jones through his interactions with these most troubled patients managed to advance the therapeutic community approaches. To him, the patients' problems reflected 'the symptoms and failures of an ill society' (ibid. xvi-xvii). To effectively treat these patients thus demanded a therapeutic culture with well-defined social structures and well-trained staff who were capable to help resolve the problems.

Maxwell Jones's therapeutic community framework took shape during his time working at the Belmont-Henderson Hospital in London between 1947-1959 and then at Dingleton Hospital in Scotland between 1962-1969. The fundamental principle was to 'democratise' the social relations in mental hospitals (Jones 1968:88). This means reducing medical hierarchies among the staff and motivating patients and their family members to become active influencers of treatments. Jones believed that this would promote 'social learning' and 'personality growth' among the patients and thus generate therapeutic effects (Jones 1976:105).

The most innovative activity to help achieve the above TC principles was the community meeting. Jones pointed out that the approach was inspired by the Unit

Discussion Groups at the Mill Hill Emergency Hospital. At Belmont, the community meeting took place twice a week and then increased to every day. The whole unit of patients (ca. 80-90 people) and most nurses, doctors, and social workers on duty attended the community meeting every morning (Jones 1968:88). At the meetings, people raised 'general sociological problems' such as marriage and employment and everyone could express their views on such 'emotionally toned topics in a relatively controlled circumstance' (Jones 1953:55). With free expressions and empathetic listening, they explored appropriate reactions to intense life-situations (ibid. 56). In later days, people also used the community meeting as an opportunity to bring up concerns on disturbing behaviours of individuals or to discuss the leaving plans of patients.

Jones reflected that ever since the Belmont-Henderson project, his TC approaches became widely acknowledged. He thus regards the London project as the beginning of the nationwide therapeutic community movement (Jones 1982:4). David Cooper who once worked at the Belmont Hospital with Jones later set up a therapeutic community known as 'Villa 21' at Shenley Hospital in 1962 (Crossley 2006: 99). Ronald David Laing (R. D. Laing) who was also interested in Jones's works collaborated with Cooper and other colleagues from the Institute of Phenomenological Studies (IPS) and the Philadelphia Association (PA) for setting up the Kingsley Hall in London between 1965-1970 (ibid. 97). [47]

In contrast to Maxwell Jones's TC reforms, the projects of Cooper, Laing, and

[47] The core members of the Institute of Phenomenological Studies (IPS) included R.D. Laing, David Cooper, Joseph Berke, and Leon Redler. And the eight people who established the Philadelphia Association (PA) were Laing, Cooper, Aaron Esterson, Clancy Sigal, John Heaton, Joan Cunnold and Sid Briskin (Crossley 2006:88).

colleagues were more radical. [48] This to some extent explained why the therapeutic community were often mentioned together with the anti-psychiatric movements (e.g. Littlewood 2002). However, Jones was certainly not anti-psychiatry, as the review of his writings above demonstrates, while it was unsure whether Laing would regard himself as an anti-psychiatry reformist. [49]

The therapeutic community at the Paddington Day Hospital (PDH), following exactly the democratic-analytic style of Maxwell Jones, initiated a patient-lead campaign to defend the hospital from closure between 1971 and 1972. The Mental Patients Union (MPU) set up in this community in 1973 then took great importance in the history of the mental health service user movement and was later marked as the first chain with direct influence on patient activism today (Crossley 2006:128, Spandler 2006: 25).

Maxwell Jones's TC principles and approaches also had influences outside the UK. During the Belmont-Henderson project, Jones received a two-year placement (1950-1952) at the World Health Organisation as a temporary consultant to help develop a rehabilitation concept in mental health (Vandevelde 2008:32). Given this chance, he

[48] R.D. Laing, for instance, completely rejected the diagnostic labels attached to the patients. Rather, he regarded them as people undertaking 'existential voyages' who needed support from others to reach an 'inner peace' through individual journeys (Crossley 2006:88). To achieve a therapeutic goal as such, uniforms of medical professionals at Kingsley Hall were abandoned and doctors would live door-to-door to patients without recognition of their initial diagnoses. Patients' plans to undertake their 'journeys' were prioritised – even if some plans would cause real lifestyle problems such as irregular eating habits and awful personal hygiene.

David Cooper (1967)'s well-known book, *Psychiatry and Anti-Psychiatry*, was another example.

[49] Crossley notes that although R.D. Laing in his writing between 1964-74 was very critical of psychiatry, he openly distanced himself from the label of 'anti-psychiatry' after splitting with David Cooper in the 1970s. Instead, Laing claimed he was 'never' anti-psychiatry and disagreed that there was a movement as such (Crossley 2006: 91). Crossley thus believes that the split with Cooper made Laing 'retrospectively alter his biographical narrative' (ibid. 92).

visited many psychiatric centres and programmes in north European countries and the U.S.A and co-authored a book with Alan Stoller titled *Rehabilitation in psychiatry* in 1952. With the help of the findings in the book, the WHO officially set the minimalization of mental health hospitalisation as one of its work priorities three years later.

Franco Basaglia, the well-known reformist in Italy, also visited Maxwell Jones's therapeutic community at Dingleton Hospital before initiating *Psichiatria Democratica*, the democratic psychiatry movement in Italy. In *Psychiatry inside out*, Nancy Scheper-Hughes and Anne Lovell reviewed and translated Basaglia's writings about his psychiatric reform in Italy. The book mentioned the outcome of Basaglia's visit to Maxwell Jones's TC project in Dingleton. Although Basaglia's primary plan was to set up a similar community in Gorizia, the process turned out to be dreadfully 'long and slow' (Lovell and Scheper-Hughes 1987:13). Eventually, Basaglia gave up on all the 'liberal proposals' to 'humanize' the psychiatric hospital (ibid. 55). Instead, he took more radical approaches to initiate the *Psichiatria Democratica*.

Helped by new anti-psychotic medications developed in the 1950s, the *Psichiatria Democratica* eliminated all forms of violent physical constraints at the asylum in Gorizia. Basaglia and colleagues also organised the *assemblea*, a meeting for patients to express freely their 'anger, passion, and unreason'. No asylum staff would act on the expression and no psychiatric doctor would interpret people's behaviours from the perspective of psychoanalysis. Scheper-Hughes and Lovell comment from a Marxist perspective that the aim for Basaglia to organise the *assemblea* was to directly

‘challenge the underlying structure of power relations’ (ibid. 27). As they note, Basaglia was influenced by many Marxist thinkers, such as François Tosquelles, Antonio Gramsci, and Jean-Paul Sartre.

Eventually, Basaglia’s *Psichiatria Democratica* led to the publication of the Mental Health Act in 1978 (also known as the Basaglia Law or Law 180), the legal document that imposed the closure of all asylums in Italy. The movement also had a global impact. The WHO designated Basaglia’s second project in Trieste as a ‘pilot zone’ for the other countries to reference, which later guided the psychiatric movements in Latin American countries such as Brazil and Mozambique (Pandolfi and Bibeau 2007:125).

In summary, Maxwell Jones developed a democratic-analytic type of therapeutic community in the UK during the twentieth century. Jones developed the TC approaches through several stages. He obtained the preliminary idea of democratic organisation, patient initiative, and community meetings when he worked at an emergency hospital during WWII. He developed the approaches through nearly two decades of practice at London Belmont Hospital and Dingleton Hospital in Scotland. Maxwell Jones’s TC principles and approaches achieved great influence on the psychiatric movements within and beyond the UK.

The reform at the Phoenix Unit of Littlemore Hospital

In 2023, a group of Oxford-based researchers who examined the history of psychiatry in Oxford during the twentieth century revealed the connection between the reform at Littlemore Hospital and Maxwell Jones's therapeutic community principles (Millard et al. 2023). They noted that Benn Pomryn, the deputy superintendent of Littlemore, had experience working with Jones in person at Belmont Hospital (Millard et al. 2023:22). Besides, Dr Bertram Mandelbrote, Littlemore Hospital's superintendent between 1959-1988, was also interested in and had experiences working with Maxwell Jones's democratic-analytic style of therapeutic community approaches. [50]

I studied the TC reform at Littlemore Hospital by listening to the audio recordings in the Oxford Project Archive (TOPA, same below), and by doing so, I found it possible to identify several TC approaches of Maxwell Jones's style. People at The Phoenix Unit witness seminar talked about the reorganisation of hospital spaces (especially the unlocking of wards which was also known as the 'open door' policy), the organisation of community meetings, the approach to motivate patients to help in the treatments for each other and to do contracted work outside the hospital. All these approaches could be found in Maxwell Jones's TC projects, as reviewed above.

The community meetings, for instance, helped to stop the destructive behaviour. A mental health nurse recalled at the Phoenix Unit witness seminar that it was once a

[50] Before coming to Oxford, Mandelbrote received training in psychiatry at the Maudsley Hospital in London (Gelder 2011:158). He was seconded to Warlingham Park as a senior registrar, a post in psychiatric training, and worked under T.P. Rees, who was a pioneer in opening the doors of the hospital wards. After Mandelbrote obtained first-hand experience at Warlingham, he applied the reformative approaches at Horton Road Hospital and Coney Hill Hospital in Gloucester. Both projects turned out to be very successful.

trend among some patients to use cutleries, chairs, or other hard objects to break the windows of their wards. The multi-paned windows constructed during the Victorian time, as introduced in section 2.1, were very expensive to repair (10p/pane in the 1970s). Eventually, someone raised the issue at the morning community meeting and the group of patients and staff at the Phoenix Unit decided that whoever broke the windows again at night would be publicly fined for the cost to repair these windows at the morning group meeting on the following day. This, as the nurse recalled, effectively stopped the destructive behaviours among the patients, 'because it was an embarrassing thing to be publicly fined' in front of everyone (TPOA, archival transcription, OXFORD-4-3, p.19).

Another approach considered characteristic of TC, which the seminar participants found effective, was the inclusion of patients as active participants in the treatments for each other. During the reform, patients at the Phoenix Unit were invited to help with the 'specialling' of someone who was overreactive. Originally, 'specialling' was a method to offer one-to-one care to ensure someone's safety. It is a practice that is still adopted in mental health nursing and other types of acute care today (Wood et al. 2018). At the Phoenix, however, any patient could join the group to special a peer. They would evacuate the furniture in a room or a long corridor, protect the corners and edges with soft cushioning, and let the overreactive person 'physically express himself' in a safe space. (TPOA, OXFORD-4-2, p.3)

Doctors and nurses at the Phoenix Unit found 'specialling' an extremely helpful method in alternative to medications. They recalled the use of a 'monster' amount of anti-psychotic drugs in 1975. People who were 'manic' might have 50mg of haloperidol

injection twice a day, while the therapeutic dose was about 10mg three times each day. Chlorpromazine, on the other hand, could be used for about 2 to 2½ gm a day, which was also at the top of the limit. [51] (TPOA, OXFORD-4-3, p.6) The overdosed drugs, however, could not always alleviate the condition of some patients. The shift to 'specialling' offered an alternative way to prevent them from hurting themselves when they had to run about or bump into the walls in an ill condition. And they believed that the inclusion of other patients to guard the safe space for the person being 'specialled' also contributed to a collaborative communal, and therapeutic environment at the Unit.

The reform at Littlemore also re-organised the hospital spaces. As introduced in section 2.1, the hospital building at Littlemore had a corridor-plan layout which was originally divided into a north unit and a south unit by sexes. The reform reallocated the wards by having patients of both sexes living on both sides. The blocks in the south became Division A under the reform, while the ones in the north became Division B which maintained the old way of management (TOPA, OXFORD/4/3, p. 2).

The two divisions contrasted each other in many ways. While staff and patients in Division B wore uniforms until 1970, people in Division A wore their own clothes (TOPA, OXFORD/2/8, p.9). While units in Division B were labelled with numbers, units in Division A had their unique names (e.g. Phoenix, Mayo-McKnight) (TOPA, OXFORD/2/9, p.6). In Division B, the doctors decided on the treatments for the patients, while in Division A, the patients could feedback on and make suggestions about their

[51] The two drugs mentioned here were among the first-generation anti-psychotics which had entered the market only a decade. Chlorpromazine as the first-ever antipsychotic medication was synthesized in 1950. Haloperidol (tradename as Haldol in the UK) was developed in 1958 and entered clinical trials one year after (Granger and Albu 2005).

treatments to the doctors at the community meetings, such as whether someone should take Electroconvulsive Therapy (TOPA, OXFORD/2/8, p.7-8). [52]

The reallocation of wards also generated different routines and activities. In Division B where the old timetable was maintained, patients got up at 7 am for breakfast. They then spent the major time of the day doing domestic chores or working in sheltered workshops for simple but dull tasks on assembly lines. [53] Both types of work, however, took place only inside the hospital. In Division A, by contrast, how one might spend the day was negotiable through the therapeutic community meetings (TOPA, OXFORD/2/8, p.10). Some Nurses from the Division B who observed the reform did not like the change in the daily structure. They described that many patients in Division A ended up 'sitting around, smoking, and drinking' throughout the day (TOPA, OXFORD/2/8, p.11). The Oxfordshire Health Archives also recorded that the reform generated problems in domestic maintenance because it was no longer compulsory for patients to do housework or other types of domestic chores. [54] Eventually, the maintenance tasks in the hospital were contracted out to professional cleaners (TOPA, OXFORD/4/2, p.7).

However, it was debatable whether the patients in Division A spent the day doing nothing. As the Oxfordshire Health Archives records, the patients (possibly only the ones in Division A) were able to do contracted work *outside* the hospital since they no longer had the responsibility for domestic chores. They then did 'street cleansing' for a

[52] See the medical anthropological discussion of the ECT in the review of Murphy Halliburton's ethnography in Chapter 1.
[53] See Chapter 3 Section 1 for a comparison between the activities at the sheltered workshop in mental hospital settings and the work at Restore.
[54] See the link to the Oxfordshire Health Archives on the history of Littlemore Hospital: https://www.oxfordshirehealtharchives.nhs.uk/hospitals/littlemore_hospital/

Rural District Council and helped the General Post Office to clean telephones, dismantle obsolete exchanges, and lay pipes. They also did ‘light assembly work’ for a factory.

In summary, the review above listed several outstanding organisational changes at Littlemore Hospital under the reform between the 1960s and 80s, which took a therapeutic community approach. Since this section focuses on people’s sensory experience of the hospital space and their bodily movement through the space, I will examine people’s discussion of the ‘open door policy’ which unlocked the ward and created ‘open and large’ spaces at the Phoenix Unit. To resonate with the sound recordings of people’s discussion at the Phoenix Unit witness seminar, I use linguistic anthropology’s transcription method for spoken discourse analysis to look at both the contents of people’s discussion and the ways how they talked about the hospital spaces.

Transcribing audio recordings as spoken discourses

The archival materials that I worked with in this section were part of The Oxford Project. The project adopts historical approaches (i.e. witness seminar and oral history interview) to preserve the memories of people who worked at the mental health system in Oxford during the second half of the twentieth century. [55] It has enabled several completed research from historical perspectives. [56] My study of the project materials, however, take a medical anthropological approach to examine the effective sensory relatedness between the lived body and the spaces it moved through.

At the Phoenix Unit witness seminar, people talked about the impacts of the therapeutic community reform at Littlemore Hospital. Since the approach of sensory medical anthropology emphasises both the contents and the ways how people talk, I adopt linguistic anthropology's approach to spoken discourse analysis to transcribe the correlating sections in the audio recordings of the seminar. The method helps to highlight the stress, latching, overlaps, and pauses in people's speeches.

Technically, I used the coding system that Deborah Cameron (2001) uses for spoken discourse analysis. This method is different from the traditional way to

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[55] The Oxford Project was initiated by a steering group of six people, including Peter Agulnik, John Hall, Craig Fees, David Millard, David Kennard, and Elisabeth Hsu. The project organised four witness seminars and Thu Thuy Phan, a research assistant funded by the Wellcome Trust, conducted another nine oral history interviews with key participants of the project (Grant number: 1086464/Z/14/Z)

See the link to the Oxford Projected archived at the Mulberry Bush Charity: https://archives.mulberrybush.org.uk/records/OXFORD

The Phoenix Unit witness seminar that I work with in section 3.2 took place on 19 October 2016 in Gloucestershire and was attended by seventeen people who used to work at the Phoenix Unit between the 1950s and 90s. This included four senior registrars, two junior doctors, seven nurses, one occupational therapist, one art therapist, and two social workers. Besides, there were two academics and three coordinators presenting at the seminar.

[56] See the special issue of *History of Psychiatry* in 2022 titled 'The processes and context of innovation in mental healthcare: Oxfordshire as a case study' (Volume 34, Issue 1). See also Chapter 3 for more reviews of the articles in this edited volume.

transcribe audio recordings, which usually notes down one speaker's full speech after following another. Rather, it captures the synchronicities of people's speeches. In a way, one can read the transcriptions I made below as pieces of music with different parts played by different instruments.

The transcription method for spoken discourse analysis can record the overlaps and intersections in a group discussion. When one person is talking, the methods can also capture meaningful interjections from the others (e.g. aha, aw, huh, nah). Since the coding system includes signs that highlight the emphatic stress and pauses, it also demonstrates the excitement or nostalgic sentiments of the speakers at the seminar. Most importantly, the overlaps of people's talking to each other, alongside the sentiments they convey, have truth value for medical anthropological exploration because they revealed people's perceptions of the effectiveness of the reformative changes that they made in the hospital spaces. Here, I summarise the codes I will use for the transcriptions in this section.

Table 2.1 Codes for transcription

Codes	**Meaning**
[ ]	overlaps or onset of simultaneous speech
(.)	short pause less than 1 second
(2)	pause duration in seconds
//	latching or turn transition with no gap or overlap
{}	indecipherable or non-verbal sequence
__	emphatic stress

Note: Apart from the above coding system introduced by Debora Cameron (2001), I highlight parts of the transcription in green to reveal the meaningful overlaps of people's speeches.

Vignette 4: creating 'open and large' space

In the morning sessions of the witness seminar, participants were divided into two groups. People in both groups started by talking about their first impressions of the place. Coincidently, they all talked about the 'open and large' spaces created at the Phoenix Unit. I shall present a doctor's account as the first example.

Transcription No. 1

Speakers: **DT**: a registrar (doctor in training) of the Phoenix Unit, a man
U: unknown speakers from the audience

DT: I went there **(.)** and **(2)** it was an incredibly refreshing place to go for me, personally, because **(.)** you know, it was the sort of the '60s hanging on, I had long hair, **(.)**
U: hah
1

DT: a big beard, I dressed how I liked, and that was completely accepted. And **(.)** there was a sort of **openness** and that **(.) space (.)** a **huge** space it was. I remember it had being a sort of a really big **space**. And (.) erm (.) we weren't allowed to linger in the **(.)** erm **(1)** the office, we would get chucked out of there if we sat around
U: mhm
2

DT: chatting, erm, and you **had** to be on the floor all the time. And that was really, really **(1)** great for me, **fantastic**, I **loved** it. And **(.)** erm **(1)** so that there was an equality between everybody. **(1)** From that, erm, maybe that's for the afternoon,
U: mhm
3

DT: from that I learnt that **(.)** we are all the same, really. You might have a mental health problem, but you're the same as me. We're all human beings anyway. So that might come this afternoon.
(*discussion continues*) **4**

(00:07:00 to 00:08:04 of 01:14:55, TOPA, OXFORD/4/3)

DT was the first to speak in Group B. He said he started working at Littlemore in August 1975. He worked at the Phoenix Unit for a year as a registrar (a medical doctor in training). DT compared Littlemore with the Warneford, the other mental hospital in Oxford where he worked before taking the post at the Phoenix Unit. He said the two

hospitals provided treatments for very different groups of patients. While the Warneford was a 'middle-class type student hospital', Littlemore used to be a public lunatic asylum. There was also a sort of 'snobbishness' from people at the Warneford about the Phoenix Unit and the Phoenix was not a popular place for junior doctors to go to. Nevertheless, DT 'loved' the place. As the above account demonstrates, he was intrigued by the Unit's open and huge space. He found himself fit in the place as a young man in the 60s. And he perceived a sense of equality between himself and others, especially with the patients. I sensed a nostalgic sentiment when listening to him talking about his memory of his first impression of the Phoenix Unit.

When DT was talking, his audience made minor interjections as responses. One audience was amused by DT's self-portraiture. The other, perhaps also a doctor, agreed with the fact that people who worked at the Phoenix cannot hang around in their office but had to be on the ground with the patients. One audience agreed with the sense of equality that DT perceived from the open spaces at the Unit. These minor interjections generated overlaps in different people's speeches, which I found were subtle but meaningful. They demonstrate people's attention to DT when he was talking and their agreement with some factual details brought up by his memory.

As the morning discussion in Group 2 progressed halfway, DT brought up the open and large space again. This time, the other participants chipped in to talk about their experiences of the spatial changes. The discussion became heated and lively.

Transcription No. 2

Speakers: **DT**: a registrar of the Phoenix Unit, a man
JB: a nurse of the Phoenix, a man
JR: a senior registrar of the Phoenix, a man
U: unknown speakers from the audience

DT: The changes have been so great, but there was a sense of **(.)** **movement** and **space** and you can't **(.)** erm, separate the Phoenix Unit from the reception area at Littlemore in **[**those days, which was**]** a **really open [space]**. Where patients used
U: **[**Ahem**]** **[**hmm**]** **[**Yeah**]**

1

DT: to be **[welcomed]**. And the receptionists were fantastic **(.)** people who **(.)** who
U: **[**Yeah**]**

2

DT: welcomed them, and they'd hang about there and you could find your patients there – if you wanted to find a patient, or whatever you wanted to do. And that was a sort of sense of those **(1)** Littlemore then, and it probably was in other big mental hospitals, but that **sense of space** and the **lovely grounds**, and the **movement** and the **(.)** erm Phoenix, as I said before, **was a big place**, and there was sort of {sigh} // **[No**, that's, that's absolutely. **]**
JB: // **nobody** was **restricted, (.)** **[**you weren't. There was a **shop]**

3

JB: on the bridge**(.)** **outside** the hospital// //And patients **(.)** there was a regular
JR: //**Yeah**//

4

DT: **[**Or there was a **huge** sort of**]** //At the, at the
JB: **[**troop of patients going **shopping.]** There was **no** restrictions.//

5

DT: entrance there was that massive great sort of **(.)** erm **[shop]** and canteen//
JR: **[Café]** //canteen

6

DT: A **huge** place. //
JR: //Yeah, and when you were going off to the outpatients or something, you had to allow a bit of extra **time**// //because of the
U: **//yeah** {**laugh**}//

7

DT: **[Yeah** {**laugh**} Exactly.**]**
JR: therapeutic encounter in the **[**car park.**]**
U: **[{laugh}]**
(*discussion continues*) **8**

(00:54:50 to 00:56:00 of 01:14:55, TOPA, OXFORD/4/3)

People in the discussion above mentioned how patients at the Phoenix Unit moved through the hospital spaces after the unlock of the wards. DT talked about the patient's visits to the reception which meant that people could move freely within the unit. JB, the nurse, chipped in to emphasise that there was 'no restriction' because patients could even buy things in a shop on the outer side of the hospital. JR, another doctor, talked about himself saving time for the 'therapeutic encounters' with the Phoenix Unit patients in the hospital car park, which made other seminar participants laugh. From the discussion, one could conclude that the TC reform at the Phoenix Unit expanded the hospital places that the patients could visit. The trajectories from the wards to the reception, shop, café, canteen, and car park show not only an increase in the varies of places but also an expansion from the indoor to the outdoor areas.

The three speakers liked the spatial changes that the reform had generated. They saw the change remove the restrictions. DT and JB spoke at the same time for a short while (lines 3-5), both were immersed in the memories of the hospital space and people's movements through it. After the short clashes of speeches, the turn-taking was restored. When one was talking, the others agreed with him by laughing, saying 'yes', and repeating the keywords. These significant responses, I argue, generated outstanding and meaningful overlaps of speeches which reveal the excitement and nostalgic sentiments among the seminar participants in Group 2.

Meanwhile, in Group 1, people also talked about the open and large spaces created at the Phoenix Unit. Curiously, the experiences of the nurses in Group 1 were very different from the seminar participants in Group 2. Below is an example.

Transcription No. 3

Speakers: **NB**: a nurse of the Phoenix Unit, a man
U: unknown speakers from the audience

NB: I remember it as being **noisy**, echoey **(2)** it was **not** a personal, intimate space in any place or form, anywhere, and that seemed to be one of the things that was **sacrificed** for the sense of the communal **(.)** endeavour. I mean, in marked contrast
U: **[**mhm**]**

1

NB: in the way things are or can be at their best now. It was **(.)** linoleum, **[**high ceilings**]**
U: **[**mhm**]**

2

NB: shouty, **(.)** and a very **[big]** environment **[**all the time**]**.
U: **[**mhm**]** **[**mhm**]**
(*discussion continues*) **3**

(00:20:00 to 00:20:30 of 01:01:45, TOPA, OXFORD/4/2)

As a nurse in the Phoenix Unit, NB also mentioned the large hospital space created during the reform. He emphasised it by talking about what he heard by ears, that the place was being 'echoey', 'noisy', and 'shouty'. Unlike the sense of equality perceived by DT, the doctor in Group 2, NB the nurse in Group 1 saw the large space as being disrespectful of human contact. He also emphasised the lack of privacy and intimacy. While DT in Group 2 found the open and large space 'fantastic', NB saw it as a sacrifice for the therapeutic community principles of making the place 'communal'. Some audience in Group 1 seemed to agree with NB's comment, as they had minor interjections with agreements.

As the discussion proceeded in Group 1, a few more women nurses also brought up the problems they found about the large, noisy spaces. They even imagined from the experiences of patients. And the empathetic engagement triggered another round of heated discussion.

Transcription No. 4

Speakers: **AT**: a nurse of the Phoenix Unit, a woman
JK: a student nurse of the Phoenix Unit, a woman
NS: a nurse of the Phoenix Unit, a man
PA: a registrar at Littlemore but not on the Phoenix, group convener, a man
U: unknown speakers from the audience

AT: I was also thinking **(.)** You know **(.)** If there's somebody's struggling with depression then wanting quieter moments, you probably would've been traumatised by the level of **(1)** noise that somebody else was going on, and the shouting, you know. That was the other side of it. I often wondered // //You
JK: //[yeah]//
U: [mhm]

1

AT: know **(.)** that it could be end up being quite a traumatic experience. I don't know. And it [would be interesting] to hear what people say.//
JK: [No, I quite **(1)**]
NS: //I think people found

2

NS: those little **spaces**, because it wasn't, there was, that dramatic bit was going on in one place, but there were [always] quiet, other spaces, somewhere near the
JK: [yeah]

3

NS: office, some were at the back of the kitchen. // //Yeah,
JK: //Yeah, television room. //
U: [mhm]

4

NS: there were quieter spaces people [gravitated to.]//
PA: //So, spaces **(.)** the space point
U: [mhm]

5

PA: is really quite important. //
NS: //I think it was.
U: [mhm]]
(*discussion continues*) **6**

(00:30:35 to 00:31:15 of 01:01:45, TOPA, OXFORD/4/2)

In the above discussion, AT brought up her worry about the reform's impact on patients who struggled with depression. She presumed the difficulties for these patients to find a quiet place for themselves when the unit in reform became shouty and noisy.

She also wondered if the reform might generate traumatic experiences for these patients. AT was not certain when bringing up the point, while JK, another nurse, agreed with her. NS then added his observation that these patients managed to find 'those little spaces' for themselves and JK confirmed that this was true as well. NS and JK then listed several 'quieter spaces' that people 'gravitated' to, including places near the office, the back of the kitchen, and the television room. PA, the group convenor, confirmed that 'space' was an important aspect. The speakers and some audience replied with confirmation.

When NS and JK began listing the spaces, their speeches overlapped, while others from the audience responded to and agreed with the finding with brief words and interjections. These moments, however, took place after a brief exchange of views between AT, NS, and JK. All three nurses empathetically engaged the patients' experiences of the spatial changes at the Phoenix Unit. From their discussion, one may conclude that the creation of open and large spaces was not necessarily a desirable change for every patient. Different people might develop different strategies to adapt to the change. By comparing the views in Groups 1 and 2, one may form a more holistic and nuanced understanding of the effectiveness and limitations of the reformative changes in space at Littlemore Hospital.

In summary, this section works with the audio recordings of a witness seminar to look at people's talking and listening to each other about the therapeutic community reform taking place at Littlemore Hospital from 1959 to the early 1980s. I first review Maxwell Jones's therapeutic community principles and approaches and their influence

on Mandelbrote's reform at Littlemore Hospital. I then adopt linguistic anthropology's transcription method for spoken discourse analysis to compare the seminar participants' very different perspectives on the 'open and large space' created at the Phoenix Unit. By doing so, I demonstrate their observations of the patient's movements through the hospital spaces and summarise their evaluations of the effectiveness and limitations of the 'open door' policy during the therapeutic community reform at Littlemore Hospital.

2.3 Conclusion

In this chapter, I presented two studies of archival materials relating to the reforms of space at Oxford Littlemore Hospital. I engaged my own body to sense and imagine with these archival materials, and wrote four vignettes about people's sensory experiences and bodily movements through the hospital spaces. The first study in section 2.1 emphasised how the architectural layout and the designs of windows affected the asylum residents' access to sunlight and fresh air. [57] The second study then looked at the creation of open and large spaces at Littlemore Hospital during a psychiatric reform in the second half of the twentieth century, and how the reform of hospital space impacted both the patients' and the staff's daily routines, social interactions, and bodily movements through them.

The contents of the archival materials this chapter reviews demonstrated how the Littlemore Hospital spaces were constructed, altered, extended, and reformed throughout different periods of time and how people perceived, imagined, and moved through the hospital spaces that were entangled with their socio-historical contexts. In this way, they respond to Desjarlais and Throop's proposal for a critical phenomenology which attends to social, historical, discursive, and political forces that contribute to life in particular settings (Desjarlais and Throop 2011: 93, see review in chapter 1).

Notably, the relationship between the body and the space that my studies wish to demonstrate is mutual, dynamic, and fluid. Due to the genres of the materials that I work with, there could be a sense that the patients' lived-body were passively affected

[57] Notably, the chapters onwards also emphasise the bodily experiences of the sunlight and fresh air in the building complex of Restore's recovery groups. See details in Chapters 3, 5, and 6.

by the changing spaces and other social, historical, economic, or environmental factors they enacted. However, this was because the archives that I worked with contained perspectives mainly from medical professionals who observed their patients, with great empathy, for sure, but they were also inevitably affected by the medical gaze, if considered by Foucault's ([1963]2003) discussion of the birth of the clinic.

Methodologically, the two studies in this chapter make use of multimodal devices to examine the archival images and audio recordings. These multimodel archival materials mainly draw on experiences and perspectives of (mostly male) medical professionals, which, as reflected, could be conceived as a limitation of the two studies in this chapter. However, some of the medical professionals that the studies brought up were practising from the grassroots, such as the resident physicians of the Victorian asylums in the first study and the reformative doctors and nurses in the second. As the vignettes above demonstrated, these grassroots practitioners empathetically engaged with the patient's experiences and welfare.

I propose that a close examination of the grassroots practitioners' experiences and perspectives may offer valuable insights regarding the treatment effectiveness. As Paola Esposito argues, an expansion of analysis from 'macro-scale, top-down strategies' to 'more coordinated community and grassroot responses' can reveal individual and collective subjectivities and moralities (Esposito 2021:43). In the next chapter on the founding stories of Restore, I will continue the discussion of the grassroots initiatives as they emerge from the founding stories of Restore.

Chapter 3. Setting up Restore in East Oxford: Stories of joint efforts and creative place-making in early years

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3.6 Conclusion

This chapter reviews the founding stories of Restore. It is based on semi-structured interviews with five people who effortfully contributed to the charity's foundation and development before 2000. The stories that my interviewees told during the interviews revealed important factual details about the provision of health and social care in Oxford during the second half of the twentieth century. My aim in this chapter, therefore, is to collect and preserve the stories about people's joint efforts and creative place-making in the early years of Restore while offering an empirical foundation for the

ethnographic chapters that follow.

Story-telling is primarily an issue about time. Drawing on literary theory, Cheryl Mattingly compares narrative time (or emplotted time) with chronological time. The chronological time follows the clock. It is linear or serial. One thing comes after another in a chronological structure. (Mattingly 1998:84)

The narrative time, by contrast, is configured. It is organised by a plot as a 'meaningful whole' with a beginning, middle, and end. (ibid.) As Mattingly explains, the narrative time is structured by actions and motives, while the movement from one point in time to the next is full of 'tricks and reversals' (ibid. 85). [58] Mattingly posits a homology between the lived time and the narrative time. She argues that an analysis of how time is organised in a story can make key aspects of the lived time visible (ibid. 84). In other words, a close examination of how people organise time in their stories, precisely how they put together a series of actions and events around a specific plot, can reveal details of the realities they experience in life. [59]

This chapter weaves together the narrative time and chronological time. On the one hand, it aims to present factual detail about the foundation and development of Restore in chronological order. On the other hand, the chapter itself has a strong narrative character because it is organised around the stories that my interviewees told me in the online interviews. After an introduction to my interviewees (section 3.1) and

[58] As Mattingly specifies, the narrative time could appear as dramatic. It may contain conflict, risk-taking, strong desire, situations that are difficult or frightening, or confrontations with danger. Sometimes the ending of a narrative time can even be uncertain and marked by suspense and surprise beyond the anticipation of the audience. (Mattingly 1998:85)

[59] See more discussion about Mattingly's therapeutic emplotment in Chapter 6.

a review of the methods I used for the interviews (section 3.2), there are three sections that each discuss the founding of Restore at Littlemore Hospital and, thereafter, the translocations to its first and second sites in community settings.

In each section, I discuss different stories that came up from the interviews. The stories are not always chronologically ordered. Nor do they mention every change that took place historically within Restore. Instead, I emphasise the sensory features of the space and places which would have directly affected people's bodily movements and bodily experiences when they worked in the recovery groups. A close examination of how Restore emplaced itself into the community of East Oxford, therefore, can provide informative foundations for the ethnographic chapters that follow.

3.1 Introducing my interviewees

This section introduces my five interviewees who participated in the online interviews in the spring and summer of 2021. They were Peter Agulnik, Jonathan Leach, Liz Hodgson, Neville Scrivener, and Rosie Hallam. [60] They worked at Restore from the late 1970s until today and told stories of people's great efforts to further the charity's development.

Peter Agulnik is the president and co-founder of Restore. As the curriculum vitae he emailed me in 2018 notes, he completed his medical training in London in 1960. He

[60] My interviewees for the online interviews were happy to be mentioned by their real names. However, the names of people I encountered in fieldwork, inclusive of service users and Restore staff and volunteers, were pseudonyms.

then started his psychiatric training at Claybury Hospital in Essex and subsequently at The Midland Nerve Hospital in Birmingham. This was furthered, in 1967, when he went to Boston in the U.S.A. to work as a clinical instructor in psychiatry at Boston State Hospital and subsequently as a research fellow at Tufts University School of Medicine. Peter moved back to England and became a senior registrar in psychiatry at Littlemore Hospital Oxford in 1969. He obtained membership in the Royal College of Psychiatrists in 1972, becoming a fellow in 1985. In 1980, he was appointed as Consultant Psychiatrist with a Special Interest in Rehabilitation and Counselling, based at Littlemore.

In the last decades of the twentieth century, Littlemore Hospital was in the vanguard of reforming institutional psychiatric care, using the therapeutic community approach. [61] Contemporaneously, staff at the hospital were developing several innovative projects in the local community, facilitating the transition from hospital to community care. [62] Prior to his appointment as consultant in 1977, Peter had co-

[61] See details about the reform at Littlemore Hospital in Chapter 2. A thorough review of this part of history is also set out in the articles in a recent special issue of the *History of Psychiatry* (Armstrong and Hall 2023), as Chapter 2 referenced.

[62] Jonathan Leach, Peter Agulnik, and Neil Armstrong (2023) review that, in practice, it was a long and arduous process to move the provision of mental health services out of the hospital into the community. Enoch Powell had given the so-called 'water tower' speech as Minister for Health in 1961 to announce the government's goal to reduce hospital beds and increase community mental health services, but the closure of the old asylums started only in the mid-1970s and lasted for another two decades (Leach et al. 2023:60).

When Restore was founded at Littlemore Hospital in 1977, most mental health services in Oxford were still based in psychiatric hospitals rather than the local communities. The services took place on both the large old asylum site and the small new site right constructed in the 1950s (introduced in Chapter 2). Since the mid-1990s, the old asylum-style hospitals were replaced by smaller and more modern units co-existing with the community-based services (ibid. 50). At Littlemore, the inpatient services were re-organised at a much smaller scale at a new site on the other side of the Sandford Road (see Chapter 2). The old asylum building then started to be closed permanently in 1995.

As Leach and colleagues report, many patients remained connected to the hospital even after their discharge. They would return to Littlemore's new site as day patients to the occupational therapy department or sheltered workshops (ibid. 52).

founded Restore with Michael Young (Lord Young of Dartington), one of the leading researchers and social entrepreneurs of the period (see section 3.3).

Much of Peter's work was in community settings, such as in the counselling service for the general public established at The Isis Centre, later extended to a customised service for the Thames Valley police. Similarly, he was involved in establishing the Ley Community, a residential rehabilitation centre for drug and alcohol dependency. Other community commitments involved establishing a community mental health team serving the Wantage area of Oxfordshire. He retired from the NHS in 2002, but continued his involvement with the police counselling service and voluntary organisations concerned with mental health for some time subsequently, before retiring from medical practice in 2010.

I was introduced to Peter in 2018 through Elisabeth, my supervisor, as he and his colleagues at Restore were looking for a medical anthropologist to conduct a research project about Restore (see Prologue). When I expressed an interest in the project, he instantly arranged to meet me at the Elder Stubbs, the second oldest site of Restore based in a community allotment in East Oxford (see Section 3.5). At the time, I went to the Elder Stubbs allotments in the morning to spend the day working with members. Peter came at lunchtime and we had our meeting in the polytunnel, a place genuinely 'down to earth'.

It was a brief yet informative meeting. After hearing my self-introduction as a student in medical anthropology, Peter expressed his interest in the discipline and said that Michael Young, the other co-founder of Restore, was one of the leading social

entrepreneurs of the twentieth century. Noticing my nervousness, Peter then reassured me that he would offer any possible help, advice, and support on my research. In our meetings thereafter, Peter was always happy to answer questions related to Restore. And during the online interviews, Peter talked about the photos I presented with fascinating details about the charity's history, key persons, and ethos. As the documentation below will show, he was often very explicit and clear about the points he aimed to make.

Jonathan Leach is a retired lecturer in Health and Social Care at the Open University. During the interview with him and his partner Liz Hodgson. Jonathan told me that he worked at Restore for ten years between 1987 and 1997, first as a garden coordinator and then as a training and development officer, before embarking on a journey in academia. The funding application he wrote in 1996 brought in a total of 500,000 pounds to Restore from the National Lottery and Oxfordshire Training and Enterprise Council. This grant enabled Restore to set up a new 'Learning Centre' in Restore's headquarters on the Cowley Road. This centre offered National Vocational Qualification (NVQ) certified training and employment support for their service users.[63]

[63] The 'Learning Centre' was in partnership with another two organisations, Ruskin College and Oxford Survivors. At the time, in the late 1990s, the 'survivors movement' initiated by mental health service users generated a 'recovery-turn' in the history of psychiatry (Crossley 2006: chapter 8). The movement proposed to replace the word 'rehabilitation' with 'recovery', which explains why the Restore projects were later referred to as 'recovery groups' until the time of my fieldwork.

However, the collaboration lasted only for two years due to the lack of funding to keep the service running. The building constructed for the Learning Centre, however, was still in use during the time of my fieldwork. It became the venue for Restore to organise Mental Health First Aid and other training sessions. See the link to the news about the fear of closure of the Learning Centre in 2003: https://www.oxfordmail.co.uk/news/6574016.help-centre-organisers-fear-closure/

Jonathan was also a mentor for my research from 2018 onwards. He offered very constructive feedback on my writing, and when my fieldwork was abruptly terminated by the pandemic, he emailed me the book manuscript about the history of Restore alongside all the annual reports of the charity since 1990, which he photocopied from the Restore archives. These materials contained many useful factual detail and old photos which facilitated my preparation for the online interviews in 2021.

During the interview, Liz said that she joined Restore in the same year as Jonathan. They met each other for the first time at the charity's Town Garden chalet on the Cowley Road (see section 3.4). Liz worked as a garden coordinator at Restore for four years. She described her job at Restore to be coordinating the charity's three gardening groups, including delivering 'seeds, tools, and news' (see section 3.5). Partly because of Restore's growing national reputation as a centre of excellence, Liz was subsequently able to secure a job with Horticultural Therapy (now Thrive), the national charity in the field of horticultural rehabilitation and disability support, which had been her goal for some years. [64]

When my two interviewees invited me for walks in the university park in 2022, Liz introduced me to the trees, bushes, and flowers we encountered. After the walk, Jonathan would email me links and photocopies of the materials that helped with my research. [65] I found the match harmonious between Liz's vibrancy and liveliness and

[64] See the link to the website of Thrive charity: https://www.thrive.org.uk/

[65] With Jonathan's recommendation, I read a chapter in the autobiography, *Seed to Dust* (2021) which contained a gardener's narratives of his sensory and bodily experiences when he was cutting down the meadow and lost in the rhythm of the work that resonates with my ethnographic discussion in Chapter 4. I also watched a BBC documentary on the history of the madhouse. The documentary contained details about the interior spaces of some lunatic asylums, which helped with my imagination of the asylum spaces at Littlemore Hospital (see Chapter 1). See the link to the documentary on YouTube:

Jonathan's calmness and meditativeness, which I shall demonstrate below.

Neville Scrivener is the retired senior lecturer and programme leader in mental health nursing at Oxford Brookes University. He was also a Restore Trustee between 1999 and 2006. I was able to organise one online interview with Neville, thanks to Jonathan's introduction, to hear about his experience of first working at Littlemore Hospital and then with the workers at Restore.

During the interview, Neville introduced that he started at Littlemore Hospital in 1978 as a student nurse. He had been on the rota for training purposes and thus had experience working with both outpatients and inpatients at Littlemore Hospital. Some of these patients were also workers at Restore.

Neville gave several examples of his work at Littlemore Hospital. He recalled that his work on Restore's gardening group at Littlemore was part of an occupational therapy placement. Besides, Neville worked with outpatients of Littlemore Hospital to paint wooden benches for six weeks in November 1979. After that, he supervised another group of patients to sort out the X-ray photos for the general hospitals. In June 1981, he also visited Restore's craftwork projects in community settings during a five-day community nursing experience.

After two years of working on an inpatient rehabilitation ward, Neville was appointed in May 1983 to a Community Psychiatric Nursing (CPN) post. He explained that the CPNs were responsible for referring mental health outpatients to several 'day

https://www.youtube.com/watch?v=oswUssXzFlY

activities', like the groups of Restore, for rehabilitation purposes. They also occasionally helped people move on to employment. [66]

Neville noted that the Community Mental Health Teams (CMHTs) in Oxford acted to support the Restore workers in the equivalent of human resource managers whilst liaising with other clinical teams related to progress issues. The CPNs also offered support and information to Restore's group supervisors who were woodwork, printing, and gardening experts. Besides, Neville said he was responsible for managing the nursing staff employed on Restore's gardening group at Littlemore Hospital until it moved to Elder Stubbs. With Liz and other colleagues at Restore, he helped relocate the group to the new site at the Elder Stubbs allotments (see sections 3.3 and 3.5).

Rose ('Rosie') Hallam was the third director of Restore and she worked in the charity for seventeen years between 1984-2001. She talked about her background during the interview with me and Peter. Before joining Restore, Rosie was the deputy head of occupational therapy at the Warneford Hospital. She said both her parents were artists and they lived in St. Ives in Cornwall, a place very famous for its art and history. She fell onto the idea of Occupational Therapy because her mother told her that it was about working with people and using one's hands to help with rehabilitation. It is all about making and crafting, an ideal combination of her interests, which was to use art

[66] As John Hall reviews, the Community Mental Health Teams (CMHTs) transformed from the nursing team at Littlemore Hospital was led by Helmut Leopoldt, the hospital's senior nursing officer (Hall 2023:38). In the 1960s and 70s, the major work of the community psychiatric nurses (CPNs) was to facilitate the patient's transitions from Littlemore Hospital to East Oxford communities. This included developing supported accommodation through the Oxford Group Homes Organisation (later became the charity Response, which was an organisation funded by the Oxfordshire Mental Health Partnership like Restore, see Prologue) and referring discharged patients to a diversity of daytime activities.

to help people.

Rosie thus went to be trained at the London School of Occupational Therapy. She said she had enjoyable years in the school and later decided to work on mental health. Between 1975 and 1977, she worked at Hillingdon Hospital in London, a place under therapeutic community reform (introduced in Chapter 2). She then moved to Cornwall for a short while and worked in what was then called 'The Adult Training Centre', a community-based service for people with learning disabilities. However, she found the industrial type of work at the training centre very repetitive. The tasks enacted hardly any skill for one to learn.

Then in 1978, Rosie moved to Oxford and spent six years working at the Vaughan Thomas Ward at Warneford Hospital, where she was left with a lot of freedom to run therapeutic programmes for the inpatients and outpatients on the ward. She said she would sit down with patients once a week to plan the whole week's activities, ranging from joining the relaxation group, cooking group, and art therapy. However, she also gradually realised that OT was not very much valued on the ward. The hospital relied heavily on a medical model which prioritised pharmaceutical medications. Rosie found the medical team at the Warneford Hospital had little interest in people's plans for their future, the skills they wanted to develop, or the anxieties they tried to overcome. By the end of the sixth year at Warneford, she was keen to move on and came across the advert of Restore for a new director. She applied for the position and received the offer. And the position became permanent after the first year.

Besides working as the Restore director, Rosie was an artist for the Oxfordshire

Craft Guild. [67] She achieved in her work the goal to 'help people by hands', a fine combination of the art of crafting and the art of caring and healing. In Jonathan's book manuscript, there was a photo of a handmade letter rack that Rosie made as a model for the members at Restore.

During the interview, Jonathan pointed out that the design of the letter rack was inspired by local features. It was thus very different from the design of things made industrially in bulks. As Jonathan noted, one could find the fritillaries in most meadow fields in Oxford in springtime. The white and yellow ones were common, while the patterned ones, as depicted on the letter rack, were comparatively rare. Rosie also explained that she chose to draw the snakehead fritillary as they were the county flower of Oxfordshire.

In summary, this section introduced my five interviewees who had made effortful contributions to the founding and development of Restore in its early years. Apart from the professional expertise to work in mental health, my interviewees were also caught up in the natural and artistic world. Some of them mastered skills in gardening, art, and craft. Their insights regarding the rehabilitation effectiveness of Restore's gardening and craftwork projects were thus very valuable for my thesis's discussion of therapeutic efficacies. [68]

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[67] See the link to Rosie's artist homepage http://www.rose-hallam-jewellery.com/ and her introductory page on the Oxfordshire Craft Guild: https://www.ocg.co.uk/member/rose-hallam/

Rosie sadly passed away on 28 May 2023, when I was finalising this chapter. See the obituary that Nic Hallam, Rosie's husband, wrote on Guardian:
https://www.theguardian.com/society/2023/jul/12/rose-hallam-obituary

[68] Peter added that many leadership members of Restore had a background in art and crafts. Michael Young, the co-founder of Restore, was a painter and all his family were very much caught up in the artistic world. Paul Fletcher, Restore's first director between 1977-1980, had a background in film finance and was very interested in craft and garden design. Sarah Platt, the second director between 1980-1984, came from a family of craftsmen. The art of crafting and the art of healing and caring are deeply



Fig. 3.1 A letter rack with patterns of snakehead fritillaries, designed and made by Rosie Hallam, the director of Restore between 1984-2002 (Leach manuscript, p.18)



Fig. 3.2 Snakehead fritillaries growing in the University Park, a photo taken by the author in April 2023

connected through sensory-phenomenological processes. I shall elaborate on this in Chapter 5.

3.2 Methods: Photo-elicitation and online interviews

During the COVID-19 pandemic, I organised interviews online with my five interviewees. We talked about a diversity of things and events during the interviews. Our discussion flowed from one topic to another. Some topics were invoked by the questions I raised or the photos I presented; some arrived at completely different issues. I do not cover everything mentioned in the interviews in this chapter but rather select stories of people's joint effort and creative place-making for the discussion in this chapter. Here, I name each interview by the main topic it covers for reference in this chapter.

'Grassroots initiative', online interview with Peter Agulnik and Jonathan Leach on 15 April 2021
'Community outreach 1', online interview with Rosie Hallam and Peter Agulnik on 30 April 2021
'Community outreach 2', online interview with Rosie Hallam on 25 May 2021
'The gardening groups', online interview with Jonathan Leach and Liz Hodgson on 14 May 2021
'Stories from a CPN', online interview with Neville Scrivener, Jonathan Leach, and Peter Agulnik on 19 July 2021

Sometimes at the beginning of an interview, my interviewees and I exchanged views about the online platform we used. In a way, the online interviews helped us to see each other in an extraordinary time of quarantine and self-isolation. Peter explained that they were happy to talk because one benefit of being a retired person during the lockdowns was to have plenty of spare time. However, we also perceived a sense of remoteness due to the reduced affinity of human contact. When Liz saw my face turning up on her screen, she exclaimed, 'It's so weird!' And when I watched the video

recording after the first interview, I found it difficult to tell if the silence on the other side of the computer screen was a thoughtful pause or the result of a bad internet connection. [69]

During the first interview with Peter and Jonathan, I shared my screen to present a few old photos that I found from Jonathan's manuscript. It was rather an *ad lib* response to the circumstance and my purpose was simply to facilitate our discussion of the spaces of Restore's recovery groups. The visual presentation significantly facilitated the discussion. With the help of the photos, I was able to ask more specific questions about the spatial arrangements of Restore at the time and my interviewees recalled more stories to tell about the charity's space and places.

After the first interview, I familiarised myself with the method of photo-elicitation and then continued to adopt the method in the remaining four interviews. I selected photos from three sources: Jonathan Leach's book manuscript on the history of Restore, Restore's annual reports, and the digital archives on Picture Oxon. [70]

Photo-elicitation is known to be used to invoke comments, feelings, and memories in a semi-structured interview. Douglas Harper reviews the development of this method in anthropology and sociology. He notes that the method of photo-elicitation was first named by John Collier in 1957 at Cornell University (Harper 2002:14). Collier and colleagues found the method very helpful for their study of the 'environmental basis for psychological stress' among the changing communities in the Maritime Provinces

[69] The transcription method for spoken discourse analysis, as adopted in the study of archival vignettes in Chapter 2, was thus no longer applicable to the study in this chapter.

[70] Picture Oxon is a digitalised archive see Chapter 2.

in Canada (ibid.). Collier found that the photos he and colleagues presented during the semi-structured interviews 'elicited longer and more comprehensive interviews' while 'helped subjects overcome the fatigue and repetition of conventional interviews' (Collier 1957:858, in Harper 2002:14). Collier also found the method triggered 'graphic imaginary', which generated 'compelling effect' upon the participants who offered emotional accounts of their personal lives (ibid.). In my case, some photos also invoked stories. And this indeed yielded longer and more structured accounts from my interviewees.

More recently, Banks and Zeitlyn also identify several benefits of photo-elicitation when it was used in offline, face-to-face encounters. The photographs may serve as a 'third party' between the interviewer and the interviewee(s), so they did not need to maintain eye contact with each other but can look at the photos together instead (Banks and Zeitlyn 2015: 86). This benefit remained in the online interviews from my own experience, because looking at the videos of myself and my interviewees' faces could generate distractions, especially when someone's faces became immobile due to a bad internet connection.

The combination of online interviews and photo elicitation also generated some unexpected moments which significantly contributed to the discussion. When my interviewees participated in the interviews from their homes, they were able to fetch things from their bookshelves and meeting rooms to help demonstrate some points, which might not be possible for the offline interviews scheduled in a public place elsewhere.

However, it is necessary to acknowledge that my choice of methods in this chapter arose from a compromise with the severe impact that the COVID-19 pandemic had on my field research. Speaking online inevitably was a very different way of communicating. The lived bodies in the three-dimensional world were transformed into two-dimensional images. Our movements through the rooms became moving images on each other's computers. Our hands would be out of the others' eyes if we laid them on the laps under the table. If we walked too far away from the camera, we disappeared from the other's screens. I was forced by the pandemic to organise interviews online. If I could choose, I would organise interviews in person, because the face-to-face encounters may present more interesting details regarding the body's 'doings' to a sensory medical anthropologist.

3.3 The founding of Restore

This section presents the stories about the founding of Restore at Littlemore Hospital. It opens with the charity's most well-known story of the two founders' car journey to Botton Village in North Yorkshire, where they formed the preliminary idea of Restore. I then review the discussions around the photos I presented during the interviews, which reveal the steering committee's pioneering proposal to organise creative projects for rehabilitation purposes and Restore's nature as a 'grassroots initiative'.

The car journey that created Restore

During the whole course of my fieldwork, I encountered the story of the car journey several times. Peter told me about it in one of our mentor meetings with Jonathan and Elisabeth at the Elder Stubbs in 2018. Then in 2019, I heard it again at the volunteer induction at the charity's headquarters on Cowley Road. The car journey was also briefly mentioned in Restore's 2017-18 annual report that celebrated the charity's 40th anniversary. When Peter brought up the story again in our interview, he summarised, 'It's a one-plus-one-makes-three model. Restore is a baby of the mind.' (Agulnik, 'Grassroots initiative', 2021)

As the story goes, Restore was made through a car journey that Peter Agulnik and Michael Young undertook from Oxford to North Yorkshire in 1976. Peter was a tenured psychiatrist who worked with Dr Bertram Mandelbrote at Littlemore Hospital. [71]

[71] See Chapter 2 for Dr Mandelbrote's reform at Littlemore Hospital.

Michael was a social entrepreneur who came to see Mandelbrote after hearing about the innovative community therapeutic activities at Oxford. He wanted to find a suitable place offering long-term care for his oldest son, Christopher, who was suffering from a longstanding mental illness.

Mandelbrote suggested Christopher take a trial admission to Peter's ward at Littlemore Hospital. Michael, the father, got therefore into close contact with Peter. It was however unclear whether the hospital ward would be the most suitable place for Christopher for the long term. So, Peter and Michael decided to visit a residential community founded by Camphill Village Trust in Botton Village, North Yorkshire. [72] They thereupon embarked on an eight-hour car journey.

Peter and Michael were fascinated by the vibrant life and work of the residents at the Botton Village. They found it a unique place where people shared responsibilities to run the community. Unlike mental hospitals, the community was not isolated from the outside world. The residents would sell the high-quality products, which they made in the craftwork workshop or grew in the gardens and the farm, to customers who visited the shop. And the customers were either members of their own community or the locals who lived nearby.

On the return journey from Botton Village, Michael and Peter discussed their experiences. Both had been impressed by what they had seen. However, they were also aware that most residents at the Botton Village suffered from learning disabilities and had rather different needs than the Littlemore patients who suffered from severe and

[72] See the link for more information about the Botton Village of Camphill Village Trust: https://www.camphillvillagetrust.org.uk/locations/botton-village/

longstanding conditions classified as mental illness. Nevertheless, they identified that Botton Village residents and Littlemore Hospital patients might encounter similar challenges in social life. In this way, the effectiveness of the hands-on group work at Botton Village would be beneficial also to the patients at Littlemore. Peter and Michael thus decided to adapt the organisation and activities at the Botton Village to create a similar rehabilitation service at Littlemore.

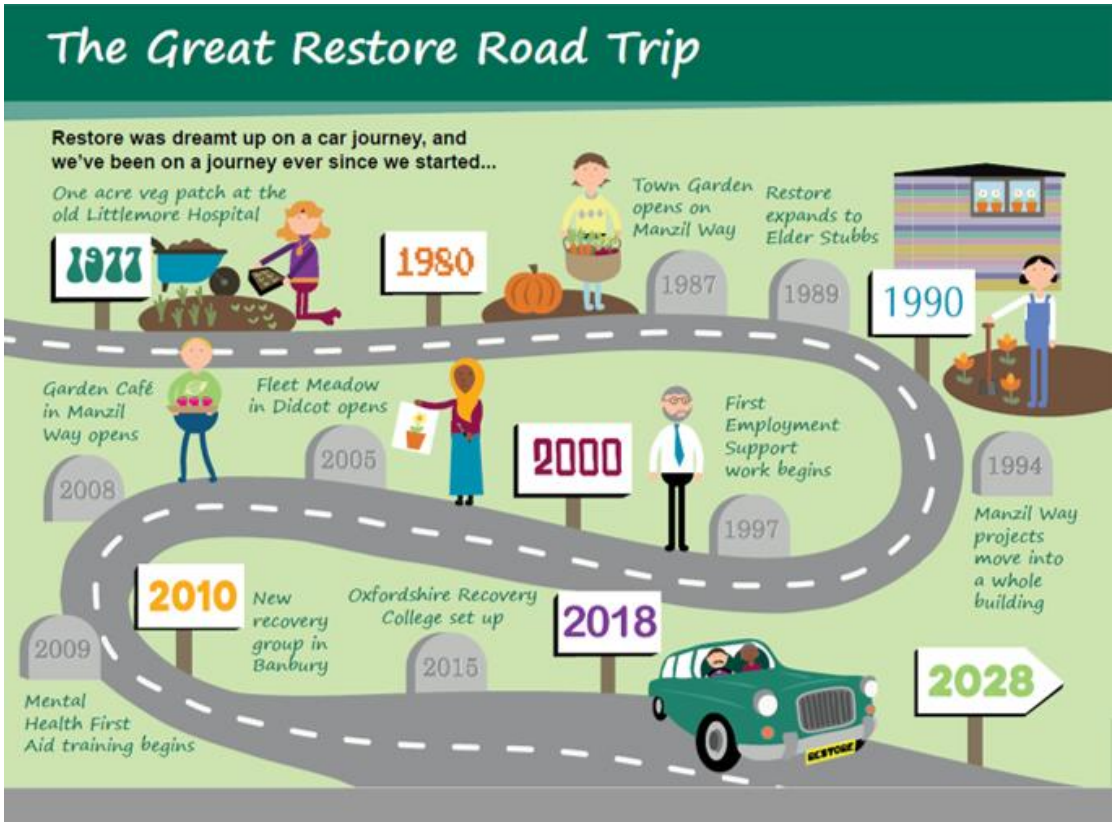


Fig.3.3 'The Great Restore Road Trip', Annual Report of Restore 2017-18

In a way, the story of the car journey worked as a link between Restore's past and the present. By telling the story or writing it down for others to read, one helped preserve an important part of the charity's history. What intrigued me as a medical anthropologist, however, is the fascinating plot in the story of Peter and Michael's journey. The narrative of the story emplots efforts and hope. It reveals 'a sheer

eventfulness of recovery' which is often suppressed in biomedicine. It does so by speaking of a process of healing or health-seeking rather than a definite outcome (Mattingly 2010:114). The founding story of Restore talks about Michael's visit to Oxford and Littlemore and his journey to Botton Village with Peter. Recovery in this hope-plotting story is embedded in the ongoing processes of the founders' attempts to explore new places and try out new therapeutic choices, one after another.

As a story that emplots people's health-seeking efforts and hope, the story of the car journey was easy to relate to for many people who worked or volunteered at Restore. When the volunteer coordinator told the story of the car journey at the beginning of the induction session in 2019, her audience included many ex-service users and people who cared for family members with diagnoses of mental illness. They travelled to the hospital wards and visited places like Restore to try out better things to do and places to be for themselves or their loved ones. They lived the realities that constructed the story.

I identify that the story of the car journey met several common features with many healing rituals or clinical healing dramas examined by Cheryl Matting in *The Paradox of Hope*. There were times when there was 'the heightened attention to the moment, the sense that something important is at stake' (Mattingly 2010:114). When Michael reached out to Bertram Mandelbrote and when Peter and Michael embarked on the long journey to the north, there was the burning question about where and how Christopher would spend a meaningful life with the suffering of his illness being alleviated.

There was also 'the socially shared nature of experience', which is often 'further

intensified through mutual bodily engagements with others' (Mattingley 2010: 114) As Peter commented during the interview,

> The important thing with the long car journey - I know you're talking about spaces - so the point that I would draw to your attention is the small space of the car on a long journey which allows for the elaboration of inventive ideas.
>
> (Agulnik, 'Grassroots initiative', 2021)

The road trip between Peter and Michael was achieved through their bodily presence in the small space of a car that moved on a long journey from the south to the north of England. And when they came back, they were cramped into the small space together again. This bodily co-presence in the small space of a moving vehicle was accompanied by the verbal exchange of inventive ideas. The two co-founders shared experiences of the journey, which made an enthusiastic start of Restore's foundation.

Mattingly also identified that in a healing ritual or clinical healing drama, 'efficacy linked to potential transformations of an individual patient and sometimes a larger social community as well' (Mattingly 2010:114). To Peter and Michael, the activities organised in Botton Village were effective because they transformed the role of the patients into workers who catered for the needs of the members of their community. I shall elaborate on this transformation of patient role in the next subsection.

This transformation of the patient role is directly reflected in the naming of Restore. As Peter had emphasised in our first mentorship meeting in 2018, Restore was a 'store' by its name, because the workers would sell the things they made or the plants they grew to the customers. [73] In this way, the focus of the rehabilitation service was no

[73] As the article co-authored by Peter and Neil Armstrong records, when the project was in its infancy, a meeting took place at Peter's home to name the new service. People in the steering group chose 'store'

longer about what kind of medical or social support one 'needs'. Rather, it emphasised what one 'can do' and how one might get better by becoming a good worker in such instances. This shift of focus, I argue, also resonates with sensory medical anthropology's interest in people's bodily 'doings' by emphasising the enskilment of one's body and the cultivation of social relations through specific body techniques.

In summary, the founding story of Restore tells the car journey that Michael Young and Peter Agulnik undertook to explore a rehabilitation community at the Botton Village in North Yorkshire. Examined from a medical anthropological perspective, the story emplotted people's efforts and hope to look for suitable health care for their loved ones. The plot could thus be widely empathised by the members, staff, and volunteers at Restore.

Moreover, the inspiration that the co-founders obtained from the road trip also enabled Restore to differentiate the work it aims to organise from the existing projects within Littlemore Hospital. This was to be a 'store' that enabled people to become skilful, dignified workers who catered for the needs of their community members. The ethos of the charity hence became embedded in the name of the charity.

to emphasise sales and 'rehabilitation' for its goal. Eventually, the name 'Restore' came up from a combination of the two words. (Agulnik and Armstrong 2020: 899).

The Norfolk Report: Proposing creative projects over repetitive work

During the first interview with Peter and Jonathan, I shared my screen to present an old photo that I found on Picture Oxon. It was a group of male patients making teddy bears at Littlemore Hospital. My original purpose was to see if this activity was related to Restore. Peter was instantly intrigued by the photo. He then pointed out an important difference between the sheltered workshop at Littlemore and the work at Restore.



Fig. 3.4 Male patients at a sheltered workshop at Littlemore Hospital making teddy bears for an outsourced firm in South Wales, Oxfordshire Health Archives

Peter said:

That is important because that was the sheltered workshop. And that was before I came to Littlemore. [74] It was one of the earliest sheltered workshops in the country. And you see, it's important because these people were making teddy bears as part of giving them meaningful work to do. This was long before Restore was ever thought of. What it showed was that people had abilities - that was something taken as special.

It (teddy bear-making) [75] wasn't part of a regular thing, because the sheltered workshop did mostly things like folding gift paper for Oxfam [76], or packaging of sterile supplies for the hospital service. They had a contract to package sterile swabs and cotton wool balls and things like that. It was the arrangement with the General Hospital. And there was a manager of that sheltered workshop that developed these contracts.

So it was very dull, repetitive work. This was something that took place around Christmas time in preparation for Christmas. And these teddy bears were then sold off, you know, just to raise a few funds that it was never part of a commercial operation. But what it did do was to show that people, even with very severe disabilities, have retained certain capacities and abilities.

So as part of a transition from being a patient to a worker, you need a structure away from the hospital, that's the charitable structure. The same activity under different sort of structure takes on an entirely different meaning and nuance. The creation of the Restore structure was very important from that point of view. That was fairly innovative at its time.

(Agulnik, 'Grassroots initiative', 2021)

The presentation of the archival photo invoked an important explanation from Peter regarding the innovation of Restore. Peter noted that the activities at the sheltered workshop had somewhat demonstrated the patients' capability to work. [77] However,

[74] The photo was dated between 1960-1969 on the digital archive of Picture Oxon, while Peter came to Littlemore in 1969.
[75] Information in the bracket is added by the author. Same for the transcriptions below.
[76] Oxfam is a nationwide charity with shops selling fair trade or second-hand goods to alleviate global poverty. It was founded in Oxford in 1942 and has its headquarters in Nairobi, Kenya. See the link to the charity's website: https://www.oxfam.org.uk/
[77] Peter made the same article in an article that he co-authored with Jonathan Leach and Neil Armstrong (Leach et al 2023: 59).

he also noted that the contracted work at the sheltered workshop was repetitive and industrialised. It could be experienced as 'dull and boring' since the patients did not engage in the process of neither designing or marketing. [78] Unlike residents at Botton Village, they did not sell the things they made to the customers.

After the interview, Peter emailed me a key document he retrieved from the Restore archive. It was 'The Norfolk Report', a survey that Michael Young commissioned in 1976 to propose the setting up of an independent charitable organisation at Littlemore Hospital. This, as Peter suggested, might further explain why it was important to differentiate between the sheltered workshop and the work at Restore.

After Peter and Michael returned to Oxford, they set up a steering committee to help establish the new rehabilitation project at Littlemore Hospital. Michael as a member of the Dartington Hall Trust applied for a small amount of money to commission a survey from Mrs J. Norfolk. Mrs Norfolk then assessed if the successful project at Botton Village could be applied or developed to the existing work related to Littlemore Hospital.

The Norfolk Report built on the hospital's steering committee's assumption that 'the capacity to work and be creative is an essential part of a person functioning at his optimum mental capacity' (Norfolk 1976:1). Based on this assumption, Mrs Norfolk

[78] It may still be necessary to acknowledge the nuance that many mental health patients preferred keeping structures and routines at work. Some members I worked with at Restore, for instance, appreciated the timetable of the recovery group because it made their days 'more structured'. Some would stick to a standard procedure to make sandwiches in the Garden Café and would be upset if things went out of schedule. It thus depends very much on individuals regarding the therapeutic indications of routinised work.

suggested that the new charity should coordinate the existing workshops at Littlemore Hospital and to develop new projects in community settings for rehabilitation purposes. Here, I summarise the list of creative activities that the Norfolk Report recommended for the proposed charity, which later became Restore.

Table 3.1 The Norfolk Report's recommendation of activities for Restore

Existing activities • **Craftwork** organised in the Mayo Unit inpatients, Division A and at the outpatient service in the Grove House Group Home. These craftwork activities engaged 20 participants in producing high-quality items for local sales, including knitted coat hanger covers, knitted dishcloths, knitted dolls, patchwork rugs, and rag dolls. • **Pottery** workshop ongoing at the Occupational Therapy Department and in development at the Stapleton House Rehabilitation Hostel. Participants could make bowls, ashtrays, and beakers after learning the essential skills. • **Carpentry** at the Occupational Therapy Department, a workshop making toys, bookshelves, occasional tables, dolls' houses, rabbit hutches, wine racks, spice racks, etc., by order. Currently in need of more space, tools, and jigs. • **Cookery** organised as Occupational Therapy and as a hobby for some patients at the inpatient units and in the Stapleton House Rehabilitation Hostel. The cade made by residents in the Stapleton House was sold in the hospital shop. • **Gardening and Horticulture** organised in three inpatient units at Littlemore Hospital which Mrs Norfolk found as a very therapeutic activity. She also believed that if the groups received more professional guidance, they could grow more plants than vegetables for use in the kitchen and for sale, such as annual seedlings, cut flowers, potted plants, shrubs, and Christmas trees. • **Toy making**, a project in planning between Littlemore Hospital and Desqual Limited, a not-for-profit company in Manchester.
Other activities recommended • **Papier Mache**, craftwork using pulped and mashed papers to make sculptures.
Activities recommended with additional notes • **Sub-contract work** at the (industrial) Sheltered Workshops doing contracted work for external agencies. Norfolk found the work less demanding and should only be organised for patients in very ill conditions.

(Summarised by the thesis author from The Norfolk Report 1976:5-7)

As the table above demonstrates, the work that the Norfolk Report recommended for Restore allowed individual creativity. Norfolk noticed in the report that many patients were interested in the craftwork projects because they could add their own designs to the work to mark their own iniquities with each other (Norfolk 1976:4). This was very different from the industrial type of work at the sheltered workshop, which I have introduced above. However, the difference was not only about the type of works chosen for Restore but also the places they were organised. I shall elaborate on the locations in the next section.

In the other interview on 'Community outreach 1', Rosie also compared the creative work at Restore to the occupational therapy at Warneford Hospital. She noted that the hospital inpatients at Warneford often participated in a variety of activities throughout the week. One might do pottery on the first day and go to the kitchen to cook lunch on the following day. And he might not develop advanced skills for any of these activities. At Restore, by contrast, the workers tended to stay in one group until they mastered the skills to work in this group. There was a strong sense of work in the charity, and people were valued for their input as workers.

Rosie explained that the difference in the organisation of activities was partly influenced by the health conditions of the participants. She noted that some patients at the Warneford were very unwell and had to be inpatient for long-term, while the illness conditions of Restore workers were usually milder, so they could live in supported housing or their own home.

Rosie also emphasised that the staff and workers at Restore talked in more of an

‘everyday language’, which generated a shocking contrast to how people talked to each other in the clinical settings. At Restore, one might even swear and talked a little bit about their home life. This way of talking, however, was strictly restricted to the staff at Warneford. To be a professional staff in the hospital, Rosie explained, one did not talk about oneself at all. She thus found people’s interactions at Restore more natural and humane, and the workers looked more relaxed in such community settings. (Hallam, ‘Community outreach 1’, 2021)

In summary, the discussion around an archival photo of the patients’ participation in a sheltered workshop at Littlemore Hospital revealed an innovation of Restore. This innovation was to organise skill-engaging and creativity-invoking activities for the Restore workers. These creative projects, my interviewees claimed, were more interesting than the industrial work at the sheltered workshop and may thus have higher rehabilitation potential.

The bottom-up grassroots initiative

After showing the photo of male patients making teddy bears, I presented another two photos that I had selected from Jonathan's manuscript. One photo shows a group of women workers knitting in an indoor setting; the other shows two customers standing by the outdoor stalls, purchasing plants for sale. Peter instantly located the two places as the Station Lodge, the place where Restore was established in October 1977. He also recognised that the women workers in the first photo were long-term inpatients from the McKnight Unit in Division A at Littlemore Hospital, the Unit under his supervision as a senior registrar (i.e. psychiatrist). [79]



Fig. 3.5. Restore workers ('The McKnitters') and supervisors knitting in the Station Lodge (Leach manuscript, p.4)

[79] From 1959 and the early 1980s, Division A was under therapeutic community reform initiated by Dr Bertram Mandelbrote. See Chapter 2, Section 2 for details.



Fig. 3.6 The stalls selling plants grown by the Restore workers outside the Station Lodge at Littlemore Hospital in 1979 (Leach manuscript, p.7)

The Station Lodge, Peter introduced, was a small building owned by Littlemore Hospital. It had been unused since the year he moved to Oxford (i.e. 1969). [80] The founding committee of Restore obtained the hospital's permission to use the building for its director's office and the two craftwork groups, knitting, and screen-printing. He noted that the reason to organise the activity at the Station Lodge rather than in the wards was to create a 'fresh base' with a new environment.

Jonathan then added that the place in the second photo was originally the garage of the Station Lodge. People at Restore transformed the place in September 1979 to sell the garden produce they grew on the vegetable plots owned by the Littlemore Hospital. However, the place was open for two hours a day and the customers were hospital staff. Peter then added that the group also obtained another sales barrow at the front gate of

[80] The station lodge was originally constructed as part of the Littlemore Railway Station in 1864. When the station closed in 1963, the building became hospital-owned.

the hospital in 1982, which attracted more customers who visited the hospital from the outside.

The above discussion around the two photos elicited some key points that my interviewees found important in relation to the early years of Restore. There was an emphasis on sales, which was core to the ethos of Restore as introduced. There was also the good use of spaces, which met the charity's primary goal to offer somewhere refreshing for its workers and to do something different from the sheltered workshop.

When I looked at the photos as an outsider and a sensory medical anthropologist, what caught my eye in the first instance was the cosy atmosphere in the first photo, and the contrast in building materials in the second one. When I expressed my impressions of the photos, my interviewees quickly related them to the key points they found important relating to the setting up of Restore. I said that the place for the knitting group seemed much cosier than the patient dormitories I saw on Picture Oxon, and that the white furniture, floral wallpaper, and light, green window shades generated a domestic feel. Peter explained that the room was once upon a time a bedroom for the hospital staff, so as I noticed, the workspaces for the workers had been chosen and organised differently from the common hospital settings even since the earliest years. In this way, my observation reflected the charity's primary goal to create a refreshing base.

I then commented that in the second photo, the light, wooden frames, bathed in sunshine and accompanied by green plants, were attached to the dark, stony wall of the Station Lodge constructed in Victorian times. Different materials and structures led to different tactility: the building on the right was hard, heavy, and cold; while the stalls

on the left generated a sense of softness, lightness, and warmth. I then asked if the wooden frames were built on purpose. Peter confirmed that people at Restore put them up as part of the stalls for sale. This flexible use of spaces and other resources available, he noted, was crucial for a grassroots initiative like Restore. In this way, my interviewees related my observation of the hospital spaces to the Restore ethos they wished to emphasise, which is to be a 'store' that is initiated from the grassroots. [81] Our discussion then emplaced the Restore ethos into the hospital places that the charity made use of in the first two years since its establishment.

To elaborate on the collaborative efforts for succeeding the grassroots initiative, Peter then talked about how the charity managed to obtain the primary funding and recruited its own staff. On the one hand, the funding was added up steps. Michael Young assured backup funding from Dartington Trust that matched the amount available from the Hospital Management Committee and the Mental Health Foundation. This was added to a total of £8500 by a personal grant from a private donor, which was sufficient to kick start the new charitable project.

The issue of staffing, on the other hand, was resolved by making use of a new government scheme. As Peter recalled, although there was no shortage of enthusiastic ideas in the first two years, the full-time staff at Littlemore Hospital already had many

[81] Jonathan in the same interview and his manuscript also noted that Restore as a grassroots initiative needed to set up the places and materials for its workshops from scratch. Before a permanent site was found outside the hospital, people in the charity used the Station Lodge for its office and craftwork projects. They also made use of the one acre of land that was also available at Littlemore Hospital. However, since none of these places was permanent, some projects needed to shift locations several times. The screen-printing group, for instance, moved to the Ashurst Ward at Littlemore in 1979, and in the same year, moved again to the ground floor of the St Gabriel's House originally used as the residence of the Deputy Physician Superintendent of Warneford Hospital (Leach, in progress).

works and responsibilities and could not consistently deploy their time and energy to provide support and guidance for the new charity. Meanwhile, the government introduced a new scheme called the Special Temporary Employment Project (STEP) which was designed to mitigate the high unemployment rate of the time. Restore instantly made use of the STEP scheme to recruit its own staff to supervise the charity's gardening and craftwork projects at Littlemore Hospital. [82]

When we talked about the two places in the photos, my interviewees drew my attention to their emphasis on the charity as a grassroots initiative. They presented rich details which proved that Restore was a local, bottom-up success rather than a top-down process. Our discussion embeds my sensory medical anthropological investigation of the hospital spaces in a changing socio-economic landscape. The knitters in the first photo looked relaxed and cheerful, potentially due to the comfortable and refreshing sense generated by the domestic settings.

In summary, my interviewees' discussion of the photos I presented during the online interview revealed that Restore was a local, bottom-up success. The narratives presented factual details regarding people's joint effort to obtain spaces for its workshops and the funding to pay the salary of its staff. These factual details were elicited through my sensory medical anthropological inquiries about the spaces and places presented in the photos. And my interviewees' replies then emplaced the Restore ethos into the visible details about the hospital places that the charity made use of.

[82] Leach and colleagues comment that 'The STEP programme meant that those initial ideas, hatched as a sort of pipe dream in a long car journey to Yorkshire and back, were viable. The new service provided a structure and a pathway for staff as well as patients to exercise their skills.' (Leach et al 2023:55).

3.4 The first site on Cowley Road

This section looks at people's place-making efforts at Restore's first site in community settings. People at Restore called this site 'The Cowley Road' in the 1980s and 90s and the site later became the charity's headquarters where the Garden Café was located (see Chapter 6). The photo elicitations I conducted during the online interviews revealed two key points about people's creative place-making on Restore's first site on Cowley Road. The first point highlights the collaboration between the woodworkers and the print-makers on this site. And the second point focuses on the interactions between the workers and the customers in the Town Garden Chalet, which Restore set up in 1987 for the workers to sell the garden plants they grew on this site.

Woodworkers and print-makers in collaboration

In March 1981, Restore was able to move its office, shop, and craft workshops to the old site of the Cowley Road Hospital amidst the central commercial area in East Oxford. The place then became the charity's first permanent site outside the hospital setting. People called this site 'The Cowley Road' until 2002 when the street intersects with the road was named 'Manzil Way', and the site of Restore changed its name to the street's name.

When we talked about the first site on the Cowley Road during the online interview, Peter and Jonathan, who were already aware of my research interest in space and places, drew my attention to the building's architectural layout. The hospital building was a purpose-built architecture for dementia care. It had a quadrangular and enclosed layout

with a central courtyard. Peter explained that the design was to enable elderly patients who were in a confused state to walk along the house walls. With the building's circular layout, they would walk merrily in circles without getting frustrated.

Hearing Peter's description, Jonathan added that when Restore first obtained permission to make use of this site in 1981, only half of the building was available while the other half remained in use as a day centre for dementia care. There were doors between the two sides and the doors were not always locked. The workshops sometimes had unexpected visitors from the dementia day centre who would be helped to return to their own side. In 1992, however, Restore was permitted to inhabit the other half of the building of the Cowley Road Hospital, where the day centre for dementia care was located.

After talking about the building layout, I presented the photo of the letter rack that I found in Jonathan's manuscript. Peter instantly identified it to be made by Rosie, the charity's third director (see Fig 3.1 in Section 3.1 above). Noticing that the letter rack was the only photo I prepared for the interview and it was not made by a worker, Peter stood up from his chair and headed to the bookshelf behind his seat. While Jonathan continued talking on his side, explaining that the woodworkers and the print-makers 'worked together' at the site on Cowley Road, Peter fetched a wooden windmill from the top of his bookshelf and returned to the seat. He then presented the windmill close to the camera and rotated its blades to show their flexibility. Seeing the windmill from his screen, Jonathan commented that this was an early-year product, a perfect example of the collaboration between the woodworkers and the printmakers.



Fig. 3.7 Two toy windmills handmade by the Restore workers and supervisors on the Cowley Road Site in the 1980s, an example showing the collaboration between the woodwork and screen-printing groups (Leach manuscript, p. 8)

With the windmill in hand, Peter explained that the Restore workshops in the 1980s tried to make high-quality handmade products. The things people sold from the shop were supposed to break the mental health stigma of the workers. The customers from nearby neighbourhoods came to Restore's shop on Cowley Road not merely for reasons of compassion but also because they were attracted by the quality and design of the products. They bought these products because they wanted to use them, not only because they wanted to show solidarity and make donations.

To further demonstrate the variety of craftwork products that people made through cross-workshop collaborations, Peter went to fetch another piece from his room. This time, it was a wooden bookend, which was in a much simpler design than the windmill. He noted that this bookend was solely completed by workers with no prior experience in craftwork. It was made from synthetic wood planks and was simply put together by

nails. The patterns of the apple trees were duplicated with a single screen-print. In contrast to the windmill and the letter rack, which were exquisitely crafted by experienced workers and supervisors, the bookend had, in Peter's words, a 'rather nice, primitive quality'. The output was nice enough to be sold at the shop of Restore.



Fig. 3.8 A bookstand made by Restore workers with no prior experience in craftwork, a collage of photos taken by Peter Agulnik after the online interview

Peter then summarised that the group collaboration between woodwork and screen-printing revealed a principle of Restore since its establishment. As he said,

> It's a principle. It was there from the start. Any individual might not have the capacity to make a whole object, but together by different people doing different parts of a constructive work, you can create *a whole*.

As it dawned on me after the interview, the group collaboration that created what Peter said, the sense of 'wholeness', might have also been intensified by the group's pragmatic use of the building on the Cowley Road. As Figure 3.9 below shows, the rooms in the building were located densely next to each other and open to the same

corridor. This might have benefited the communication of ideas and the delivery of things between people in the woodwork group and those in the screen-printing group. I imagined how people might relate to each other when making a toy windmill or a book stand in these rooms. Those who hand-sawed the wooden pieces might carefully sand the surfaces till smooth before delivering them to the workmates in the screen-printing room. The workers who added the patterns of flowers or animals on those pieces might then wait until the paint was dry to the touch before returning them to the woodworkers. Most importantly, I wondered if such collaboration by hand would cultivate a sense of closeness thanks to the friendly relations between the workmates.

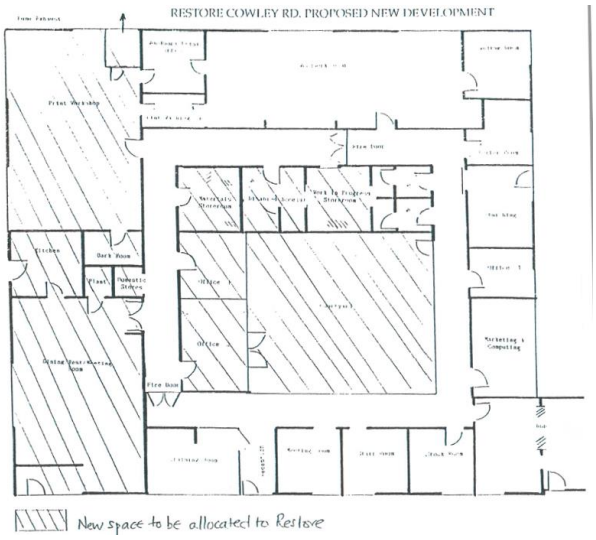


Fig. 3.9 A hand-drawn layout of the Cowley Road Hospital. The quadrangular and enclosed building became Restore's first permanent site in East Oxford. Restore obtained permission to use the right-hand side without shadowing in 1981 and the left-hand side with shadowing in 1992. Annual Report of Restore 1992-93.

In another interview, with 'The gardening groups', Liz also mentioned that people worked together at the site on Cowley Road. Usually, one would stick to one type of work in a room but also visited the other rooms to exchange ideas with workmates. Most importantly, Liz's description proved my assumption about the cultivation of

friendship among the workers. She mentioned that people doing different types of work would 'always' take breaks together in a large room, having tea and cake while chatting with each other.

In the interview, 'Community outreach 1' Rosie also mentioned the large room on Cowley Road for people to take breaks together. Besides, she pointed out an important difference between the Restore workers at the time and the members during the time of my fieldwork. Many workers in the 1980s had a long history of being hospital inpatients and lived a very isolated life after discharge. They were willing to, and were allowed to, work at Restore every weekday, because the site on Cowley Road offered them somewhere safe and comfortable to learn useful skills to do meaningful work and make friends and offer companionship to each other.

However, Rosie was also concerned if the place was made too comfortable that made many new workers with no former experience of long-term hospitalisation unwilling to leave. She was attuned to the idea to have skilful workers move on and get employed elsewhere. During the time of her directorship, Rosie was devoted to helping workers gain qualifications for the skills they learnt at Restore for employment. [83] As she remembered, many Restore workers in the 1980s and 90s managed to find a job working as a craftsperson elsewhere, which was regarded as great achievement at the time. However, Rosie also clarified that it was not compulsory for every worker to find a job within limited years, nor was employment a standard criterion for one's recovery.

[83] Rosie said she was especially inspired by the book of William Antony, a psychologist at Boston University. And her five-week visit to the U.S.A. in 1994 was also an 'eye-opener', because the country was undergoing the recovery movement in the field of mental health. She saw many projects achieving success in supporting service users back in employment or education. (Hallam, 'Community outreach 1', 2021)

In summary, Peter and Jonathan emphasised that the workers collaborated through their craftwork projects on Cowley Road. The woodworkers and printmakers worked together to make high-quality products for sale to the customers, which my interviewees believed to be an effective way to alleviate mental health stigma in local communities. The building where the activities took place might have contributed to the collaboration with its rooms arranged closely next to each other. And my assumption that the workers might cultivate a sense of closeness and companionship by working at Restore was confirmed by Liz and Rosie, who noted that the Restore workers on the Cowley Road site moved between different workshops and took breaks together in the same room.

The Town Garden chalet

This subsection introduces the careful planning of the Town Garden at Restore's Cowley Road site. Unlike the stalls at Littlemore Hospital which were mainly visited by the hospital staff, the Town Garden catered for a diversity of customers. Since the site on Cowley Road was in the central commercial area in East Oxford, it was checked out by the customers who came from nearby neighbourhoods as well as other townspeople, inclusive of tourists. In the interview on 'The gardening groups', Liz commented that the site on Cowley Road was developed as the 'showpiece' of Restore. The charity would invite potential founders, foreign visitors, and educational groups for children to visit this group.

The Restore workers at the site on Cowley Road did not only collaborate with their workmates. They also catered for the customers by introducing and selling them things they made or the plants they grew. And the setting up of the Town Garden facilitated

the interactions between the customers and the workers. As Jonathan records in his manuscript, Restore obtained funding to enlarge the small gardening group on Cowley Road into a specialist garden centre in 1986. One year after, the two co-founders of Restore, Michael Young and Peter Agulnik, launched a petit chalet, which would be used for workers to sell the garden plants they grew on the site to the customers who came from the nearby neighbourhoods.



Fig. 3.10 The opening of the Town Gardens on Cowley Road, Annual Report of Restore 1992-93

When I presented a photo of the Town Garden Chalet in the interview, 'Grassroots initiative', I asked if there were any thoughts behind the design of this petite chalet, since it was one of the very first buildings that Restore constructed for its own use. Jonathan said it might be built as a place for a 'small-scale organisation', somewhere 'not too institutional'. The place should also generate an organic feel and should be at peace with its surroundings. Everything should fit together to generate a comfortable and welcoming atmosphere to attract customers.



Fig. 3.11 The petit chalet in the Town Gardens on Cowley Road (Leach manuscript, p.15)

'While being attractive to customers, the place should also be safe for the workers', Peter added. Considering the rehabilitation purpose of the work at Restore and its charitable feature, the place should make the workers feel safe to be with each other. I could not help but interject that the members of the Garden Café, whom I worked with during the fieldwork, also described the garden as a safe place. Some especially liked the high hedges that surrounded the garden and protected it against the hustle and bustle on Cowley Road (see Chapter 6). Jonathan responded that the hedges were already there when he worked at what he called the Town Garden. He then offered a vivid account of the place as it was in the late 1980s,

> There was an area of green space between Restore and the road. And certainly, when I was working there in the garden, that was not a very safe space. There were quite a lot of people who were drinking alcohol there. There were drug dealers. Sometimes there would be fights. And you could see the police there arresting people. I don't know if it's still like that, but within the hedge, we had a big hedge that was growing up around it. And within that space, it felt fine, it felt like a separate world.

> And I think it still does now, with the Café that you come through, you enter through the gate, through that big hedge, and you can't see or even necessarily hear what's going on outside. It feels like a safe space within another space that didn't feel so safe.
>
> (Leach, 'Grassroots initiative', 2021)

Jonathan also talked about how the petit chalet was used. First by mentioning that it was an important place to him personally, because it was where he and Liz, his wife, first met at Restore when they both started to work as the charity's garden coordinators in 1987. Jonathan then introduced that before the chalet was built, customers had to bring the plants to the shop inside the building to make payment. The chalet as a proper shop built in the centre of the garden outdoors then enabled the group to make sales directly to the visitors. It was also a useful place when it rained, so the gardeners could shift to work inside the chalet.

Being aware of my interest in space, Jonathan pointed out that the chalet, as well as the Town Garden it was located, had several front and back areas. The division of spaces suited different workers' needs depending on whether they wanted to do customer service or not. In the chalet, there was a front area for customers to purchase plants. Besides, the chalet also had a room for three to four people in the back section where plants could be potted up and labelled ready for sale.

The Town Garden also had a front and a back area. The back area, to which the public was not admitted, had three greenhouses, a polythene tunnel, and a shade netting tunnel. This area was large enough for ten to twelve workers to look after the plants before they were moved out for sale. The front area of the Town Garden, by contrast, was open to the customers. It had several 'planted up areas' which demonstrated how

the various plants looked like when growing in the ground. There was also a 'sales area' with plants in pots and other items such as wooden planters, bird nesting boxes, and trellises for sale.

As the garden coordinator, Jonathan recalled how some workers 'gravitated' to the shop at the front because they enjoyed meeting the customers. Some could even identify people they knew and struck up a chat. Jonathan said he often stayed at the plant nursery in the back to encourage such interaction and only went out when he needed to answer some customers' specific questions about plant care.

This front-back dynamic intrigued me. The division in space did not seem to engender segregation. Rather, the option to retreat into the back areas assisted the workers' interactions with customers. The indoor and outdoor spaces of the Town Garden were carefully planned, so it provided a 'front stage' for customer service and a 'back stage' for taking a break and quietness. [84] In this way, the place became a safe place, but not by serving as a private sanctuary. Rather, the careful socio-spatial arrangements and innovative use of spaces generated a balanced rhythm for the workers to interact with others and engage with the community vibes while feeling safe.

In summary, this subsection foregrounded Jonathan's narratives about his time working at the Town Garden chalet. The place had mixed features of being a safe place for the Restore workers and a communal area open to a diversity of customers. We noted that the careful planning of the place, such as the division of the rooms inside the petit chalet and the maintenance of high hedges around the town garden contributed to

[84] See a similar discussion of the front space and back space, as well as the formal and informal stages of the Garden Café in Chapter 6.

the making of a multi-dynamic place.

As one of the buildings that Restore constructed for its own use in the early years, the Town Garden Chalet catered to the needs of different workers who might want to learn some gardening skills in a quiet corner or to introduce the plants and craftwork pieces for sale to the customers. It was a place where multiple social relations could be cultivated, either temporarily or for a longer term, and the workers' movement between the different places by their own choice might also enable them the opportunity to try the different ways they preferred to work, relax, or simply be present with comfort at Restore's site on Cowley Road.

Overall, this section introduced people's place-making efforts in Restore's first site in community settings. The site was based on an old hospital building on Cowley Road. With a sensory medical anthropological examination of the building layout, I propose that the building's dense arrangements of rooms facilitated the collaboration between the woodworkers and print-makers. My interviewees brought up details regarding the collaboration between the craftwork projects. They also recalled that the workers took breaks together in a large room of the building, which cultivated a sense of togetherness and companionship. Moreover, the setting up of the Town Garden project further made the site a community place in East Oxford. The careful planning of the petit chalet, where workers sold the plants they grew to the visitors from the nearby neighbourhoods, also enabled the place to be safe for the workers while attractive to the customers.

3.5 The second site at the Elder Stubbs allotments

This section discusses the setting up and development of Restore's second site in East Oxford. I will first discuss the story about the discovery of the land available for Restore at the Elder Stubbs allotments. I will then present my interviewees' narratives of the gardening group's transition from Littlemore Hospital to the new site at the Elder Stubbs allotment. Lastly, I will discuss how people transform the land at the Elder Stubbs into a suitable place for gardening work, and how they developed a creative way to promote the sales of the garden produce.

The lucky encounter between the two charities

The story of how Restore found the place at the Elder Stubbs allotments was as well-known as the story of the car journey. Since the old site of Littlemore Hospital was in due course of closing from 1995 to 1998, the hospital's farmland where Restore workers grew vegetables for sale was sold off to contractors for the construction of private estates. The charity thus had to look for a new plot of land for its gardening group.

When I volunteered at the Elder Stubbs recovery group in 2019, I heard about the story for the first time from Caroline, the group coordinator at the time. Peter, Rosie, and Liz also mentioned the story during my interviews with them in 2021. Here, I present the version that Rosie told during the interview, 'Community outreach 1'.

> It was just one of those incredibly lucky encounters because I came across this man, John Purves, when the Oxford City Morris Dancers had a dance and raised some

money for Restore. [85]

> And in fact, my first encounter really with John was rather for me a revolting one because we had the local press come to take a picture of them presenting a cheque to Restore. And one of the accomplishments of the Morris men, I think 'the fool' or somebody has a pig's bladder that's blown up, which they carry around with them.
>
> And the amount of the cheque was written on this pig's bladder and John and I had to have our heads together with the pig's bladder – We were holding this pig's bladder between our head. And as a lifelong vegetarian, (laugh) this was something (laugh) I enjoyed in the slightest, but anyway, that's on the side (laugh).
>
> And then, we must have had – I can't remember that early conversation about whether allotment land became sort of available for use. (Asking Peter) You might remember this piece, but it came up somewhere along the way.
>
> (Hallam, 'Community outreach 1', 2021)

Peter then replied to Rosie saying that John was a retired schoolmaster and the secretary of Elder Stubbs Allotments Society. He remembered John saying, 'We're not using all our allotment spaces down at the Elder Stubbs, would you be interested in using it?' And Rosie started a conversation with him regarding this proposal. With Rosie agreeing with what Peter said, I asked if Restore needed to pay any rent for using the plots. Rosie replied,

> I think we had to pay a pound. There was some kind of legal agreement drawn up for us to use the land and for us to build on it. Because, I mean, you know, that was quite amazing as well that the Allotments Committee agreed that we didn't want just a tiny shed to house a few tools, but we wanted a large building to accommodate 20 up to 25 people. And with that came some kind of legal agreement, but which we only paid, I think, a pound for as a token amount of money.

[85] Morris Dancing is a type of English folk dance. Every year, the Oxford locals celebrate the first morning of May with choruses at the Magdalen College with Morris dancers performing on the High Street. See the link to the website of Oxford City Morris Men: https://ocmm.greenius.org/

‘And a rose, Rosie.’ Peter added at this point.

(Hallam and Agulnik, ‘Community outreach 1’, 2021)

In this way, the rent that Restore needed to pay for using the land at the Elder Stubbs allotments each year was one pound and a rose. And it remained this way until the time when I volunteered at the Elder Stubbs for my research between 2018-20, as Caroline, the group coordinator, once noted. Seen in this way, the land was basically a donation to Restore from the Elder Stubbs Society. Despite the £1 rent due to the legal requirement, the deal was intrinsically a gift exchange that was marked by the meaningful rose. The rose that Restore paid as part of the rent to the Elder Stubbs Allotments Charity represented a materialisation of the recovery group workers’ hard work of the year as well as the loving-kindness and goodwill of their friends and supporters.

Overall, the above story depicted the lucky encounter between the managing members of the Elder Stubbs Allotments Charity and of Restore. The story revealed kindness, openness, and friendly support between the two organisations. There was also a sense of good luck since the information about the land available at the Elder Stubbs Allotments was brought up by John out of the blue, contra any expectations of people at Restore.

When I heard the story again from Liz during the interview on ‘The Gardening Groups’, I was able to collect more details about people and places at Restore in the late 1980s. Liz also recalled Restore’s encounter with John and quoted John’s words in exactly the way as did Peter. Afterwards, she talked about her first visit to the Elder

Stubbs Allotments and another site which was not to become the new gardening site for Restore.

> And we went down and looked at these nine plots that were by the road and vacant. There were weeds right over our heads. It was extraordinary because that was a time before allotments became popular again. That was the point when a lot of the older people who had had allotments had died or given up. The demographic of that area of town was changing. It was less working class. It was becoming younger people moving into that area. I moved there myself. And so that meant that there were lots of empty plots.
>
> I remember that Colin, the original Garden Supervisor for all the sites and Roddy, a group coordinator at Littlemore, and I went to the other allotment site on that same road, which is run by the City Council. We went to have a look at that quite early on. That's an allotment site inviting projects in to use the land. But that, they didn't get – they neglected it – because it's very hard if you had weeds everywhere and existing gardeners were having real problem. So Restore had been looking at a different allotment site there in, that was early, I remember, that was in 1987 when I was very new.
>
> (Hodgson, 'The Gardening Groups', 2021)

Like Peter and Rosie, Liz talked about how the Elder Stubbs Charity contacted Restore when the farmland at Littlemore Hospital was no longer available. She emphasised the perfect timing, that the two things happened 'at the same day or the same week'. She was surprised how the two things came together in a 'rather magical way'. However, Liz also talked about the social, geographic, and demographic conditions of East Oxford in the late 1980s. The incredibly lucky encounter between the two charities, therefore, was embedded in the historical context when gardening in community allotments had not yet been popular among the new generation of residents in East Oxford.

Noticeably, Liz mentioned her visit to another allotment site owned by the City

Council. She visited the place in early 1987 with the two garden supervisors, Colin and Roddy, from the gardening group at Littlemore. All three found the place unsuitable for the activities of Restore, yet they had spent time and effort to look at this site that was not only available but also potentially suitable for becoming part of the rehabilitation service of Restore. In this way, the encounter between Restore and the Elder Stubbs Allotments Charity, I argue, did not only build on luck and chance, or effective networking and pragmatic use of resources. It was also a crowning reward for repeated great efforts, not only by Liz, Colin, and Roddy but also by the other staff who had effortfully contributed to the processes to set up Restore's first few sites in East Oxford.

In summary, this subsection discusses two versions of the story about Restore's discovery of the land available at the Elder Stubbs allotments. In one version of the story, Rosie's lucky encounter with John Purves revealed not only chance and luck but also the charity leadership members' quick response to useful information and their good use of a variety of networks and resources. The other version of the very same story then revealed the garden supervisors' great efforts to check out a similar place that had become available, but before the allotment work was back in trend in East Oxford, the land at the Elder Stubbs was deemed the most suitable one for Restore. The two versions of the story are mutually constitutive. They offer a multi-faceted account which shows that the establishment of Restore's second site in community settings was achieved through a combination of expending great efforts and recognising the right moment for the chance to play a role. The process to set up Restore's second site in East Oxford, therefore, was embedded in the local socio-historical and demographic context.

The transition from Littlemore Hospital to Elder Stubbs Allotments

In the autumn of 1988, Restore and the Elder Stubbs Allotments Charity reached an agreement for the workers of the gardening group at Littlemore Hospital to shift to work on the nine abandoned plots at the Elder Stubbs. Two of my interviewees, Neville and Liz, helped with the transition in person. Since I did not find any photo relating to the process of the transition, I asked questions rather than using photo elicitation. I summarise below the findings from our interviews.

The gardening group at Littlemore Hospital [86]

In the interview on 'The gardening groups', Liz talked about her impression of Restore's gardening group at Littlemore Hospital. Liz remembered that the gardening group at Littlemore Hospital had more than twenty workers and two group coordinators in 1988, all of them were men. [87] She was not sure about the age of the workers and explained that it was because people might look older than they were due to their illness and medications.

---

[86] Between 1977 and 1989, Restore set up three gardening groups in Oxford. While the groups at Littlemore and Cowley Road are introduced in the main text, I record the very brief history of the third gardening group at Warneford Hospital in this footnote.

Liz recalled that Restore opened its third gardening group at Warneford Hospital in 1983 and the group closed in 1989 when the funding for its staffing came to an end. She remembered it as a very small group with only 4 to 6 workers; all were men. There was only one supervisor for this group and his salary came from the Special Temporary Employment Project (STEP). The group had only around five plots and a very small shed and they sold the garden produce in a corridor by the hospital gate. Unlike workers at Littlemore, people in the Warneford group were less keen on the transition to the Elder Stubbs. They chose to continue working on the hospital land until the STEP scheme came to an end. (Hodgson, 'The gardening groups', 2021)

Rosie also remembered that a heavy wind blew the roof off the shed owned by this group, which led to its closure. The gardening plots at Warneford were then converted into car parks. (Hallam, 'Community outreach 2', 2021)

[87] The salary for one coordinator, Roddy, came from the NHS, while the one for the other, Collin, came from the Special Temporary Employment Project STEP scheme. When the STEP scheme came to an end in 1989, Collin left. (Hodgson, 'The Gardening Groups', 2021).

Liz remembered that the gardening space at Littlemore Hospital was very private and remote from the public. The workers worked on the land for most of the day and only went indoors for lunch. She remembered the first time she visited the group. 'It was very male and smoky', Liz said. Everyone was standing close next to each other, smoking, and digging on the land (Hodgson, 'The gardening groups', 2021). Liz was especially aware of the hard work of digging and explained this tight formation of men working with hoes in rows might have been a fashion of the time to keep one's land neat and tidy, and because the group grew a lot of potatoes.

When I brought up the gardening group at Littlemore as a men-only place during the interview with Neville, 'Stories from a CPN', Neville commented that it was indeed one of the powerful social expectations of the time. At Restore, likewise, work allocation was gendered. A man would not be referred to the sewing room or the knitting group, while a woman would not be referred to the gardening or woodwork group. However, Neville noted that the situation changed since the mid-1980s. Gradually, woman supervisors and student nurses were being referred to Restore's gardening group at the Elder Stubbs allotments and he remembered Liz was one of the first women that Restore recruited as a garden coordinator in the late 1980s.

Neville also noted that in the mid-1980s, the Restore workers at Littlemore Hospital were no longer only inpatients. Some outpatients had never been hospitalised but joined Restore through the referrals made by their community psychiatric nurses (CPNs). During the lunch break, the inpatients returned to their own wards for lunch, while the outpatients came to the recreation hall to dine with another one hundred

people who were participating in other rehabilitation projects or treatment at the hospital (Neville, 'The stories of a CPN', 2021).

The arrangement of the transition and the result

In the interview on 'The gardening groups', Liz emphasised that the transition from Littlemore Hospital to the Elder Stubbs allotments was a 'step-by-step process'. For several days a week, the workers hopped on the mini-bus at the hospital which transited them to do some gardening work at the allotments. Either Liz or Neville might drive the mini-bus, and it was only a ten-minute drive. Since there were no facilities on-site for a lunch break, the group would return to the Hospital for lunch and come back to the allotments again in the afternoon.

With this step-by-step arrangement, almost all Restore workers managed to move to the charity's new allotment site after the old site of Littlemore Hospital was completely closed. Liz said that there were only two people, out of a group of twenty, who did not make the transition. She did not sit down with them to talk but felt that the change was something too big or too difficult for these two workers. They just could not let themselves leave the little haven at the back of the hospital.

In 'The stories of a CPN', Neville who also helped drive the mini-bus also noted that the group did not move to the new site 'overnight'. He recalled that at the very beginning, the trip down to the allotments only took place for some days a week and workers could choose to join on the mini-bus or stay at the Hospital to work on the old site. There would always be one group supervisor working on either place.

When I asked Neville about the couple of workers who did not manage to make

the transition with the group, Neville, who was the Community Psychiatric Nurse (CPN) for these workers, said one man chose to retire because he was not really interested in gardening. The other man did not want to move because he preferred working on the old site with the two retired nurses who did part-time work for Restore. Neville remembered this man as ‘a very vocal person’ who ‘knew the people’ and ‘had a role in the group’. This was to sell the garden produce by the hospital gate. Neville then recalled a third person who shifted to another gardening project which was still ongoing at the time at Littlemore Hospital. This person said he found the world outside the hospital too difficult for him personally. However, Neville also noted that some workers whom they never expected to move down to the new site at the Elder Stubbs managed to complete the transition. In fact, he and the group coordinator were surprised that most gardening workers eventually made the move. They both thought that it was a great achievement at the time.

In summary, this subsection reviews the gardening group’s step-by-step transition from Littlemore Hospital to Elder Stubbs allotments. The transition was presented in detail through the narratives of Liz and Neville who had been through the process themselves. Overall, it was regarded as very successful because most workers managed to continue working in the group on the new site.

Clearing the land and making new connections

The last subsection introduced the gardening group's transition from Littlemore Hospital to Elder Stubbs allotments. This subsection then looks at how people made a place for the gardening group on the abandoned land of the allotments. During the interviews I organised with each Rosie, Liz, and Neville, I presented two photos of Restore's gardening group at the Elder Stubbs allotments in the 1980s. One photo which I found on Picture Oxon presented three men doing weeding on the abandoned plots at the Elder Stubbs. The other photo came from Jonathan's manuscript and it presented a group of Restore workers and garden supervisors standing next to a large hump of grass they just removed from the plots.



Fig. 3.12 Restore workers and garden supervisors tidying up the abandoned plots at the Elder Stubbs allotments, an archival photo taken in the late 1980s, Oxfordshire History Centre



Fig. 3.13 Restore workers and garden supervisors standing next to a large pile of grass they removed from the abandoned plots (Leach manuscript, p.18)

Upon seeing the photo, Rosie and Liz identified Roger, the garden supervisor who exerted great effort in leading the group to clear up the land. Rosie said that Roger was ‘a complete workhorse’ who headed the gardening group to transform the land at the Elder Stubbs allotments. (Hallam, ‘The community outreach 1’, 2021) And Liz said Roddy was ‘the continuity for the group’. (Hodgson, ‘The gardening groups’ 2021)

Liz also introduced that Roddy and Roger were employed through a Community Programme at Littlemore Hospital before he became a gardening supervisor at Restore. Roger had gardening skills and worked very hard on the abandoned plots at the Elder Stubbs allotments because he ‘really wanted it to work’ for the group. Liz noted that it was not an easy task because the nine plots available for Restore at the Elder Stubbs allotments had been abandoned for years and were overgrown by weeds right up over one’s head. ‘He would not even take a holiday,’ Liz said, ‘On the days when the group

did not come down to the Elder Stubbs from Littlemore, he came to work at the allotments by himself after the work at the Hospital. And he worked on weekends – just to get the plots ready for the group.'

The allotment holders' change of attitude towards Restore workers

The efforts to clear up the land, Liz noted, transformed the other allotment holders' attitudes towards the Restore workers. She remembered the first time when she visited the Elder Stubbs allotments in the representation of Restore to tell these gardeners that 'a group is gonna be coming from Littlemore', and people 'stepped back'. These allotment holders at the Elder Stubbs, Liz recalled, were mainly elderly men who lived in the nearby neighbourhood. They had grown up hearing stories of people becoming very ill who 'ended up at Littlemore'. People living with mental illness were considered frightening in the 1980s and to work alongside them was not a common thing at the time. [88]

However, the gardening group's hard work and visible success in transforming the nine abandoned plots at the Elder Stubbs changed the attitudes of the other allotment holders. Liz noted that the Restore workers, who were also elderly and middle-aged men, were no longer regarded as a crowd of 'mental people from Littlemore'. Instead, these allotment holders started to treat them as 'true gardeners doing really good work'. This observation of the 'doings' of work is no doubt an important way to reveal one's well-being and 'normality'. As the review of Margaret Field's monograph in Chapter 1

[88] Liz also pointed out that even the National Horticulture Therapy Society had once confirmed that Restore's gardening project at the Elder Stubbs Allotments might be one of the very first in the country which had gardeners with mental health histories working alongside the other allotment holders.

demonstrates, it was one's 'doings' of the housework and participation in the community events that mattered to his family members, friends, and neighbours. It was the 'doings' of work that convinced the others that the person they cared for was getting better.

In 'Stories from a CPN', Neville also recalled that the Restore gardening workers were 'being judged' by the allotment holders. However, besides the stigma attached to mental illness, Neville noted that making judgements on each other's work was exactly what (English) gardeners would do to each other. As did Liz, Neville noticed the changes in the interactions between the Restore workers and the other allotment holders at the Elder Stubbs. He recalled people swapping plants and giving assistance or tips in gardening to each other. Rosie in the interview on 'Community outreach 1' also mentioned that when she visited Restore's site at the Elder Stuubs allotments, she saw the workers of the charity and the other allotment holders standing next to each other by the gardening plots, leaning over their spades, and discussing whether their potatoes would sprout or not. It was a natural, everyday conversation, and she found both groups of people looking relaxed and comfortable.

The construction of buildings on-site

In 1989, the nine plots were all tidied up and ready for gardening work. The group then spent another few years constructing some permanent facilities onsite. As Liz mentioned in the interview on 'The gardening groups', the gardeners had only three portacabins with WCs by the road in the first couple of years. These portacabins provided temporary spaces indoors for people to take tea breaks. Then in 1990, Restore

initiated a building project for the Elder Stubbs gardening group which took seven years to complete due to the time taken by the funding applications. Jonathan's manuscript recorded the process, which I summarise in a table and a figure below.

Table 3.2 The three-phase building work at the Elder Stubbs

Year	Work
1990	Development of a 3-phase building project
1991	Completion of Phase 1: a workshop for making holly wreaths and baskets
1992	Substantial grant received from Central TV's Telethon Appeal for Phase 2
1993	Completion of Phase 2: a new day room and a kitchen with canteen facilities recruitment of a catering supervisor, portacabins removed
1996	Grant received from the National Lottery for Phase 3
1997	Completion of Phase 3 few new buildings with a shop, a room for plant propagation, and more toilets

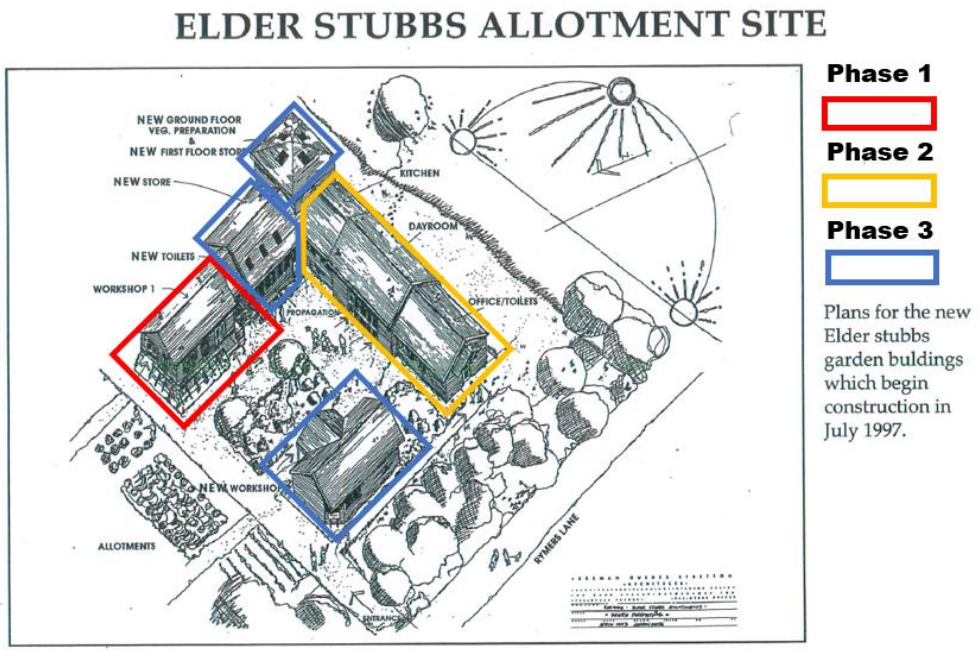


Fig. 3.14 The three-phase building work at the Elder Stubbs, Annual report of Restore 1996-97, modified by the author to highlight the three phases

As Liz recalled, she liaised with the architect for the workshop constructed in Phase 1. And the architects designed the building 'as part of the allotments' in harmony with its natural surroundings (Hallam, 'The gardening groups', 2021). It thus had green walls made from wood planks and looked much more immersed in the greenness of the plants than the white portacabins which stood out from view. The buildings that were constructed onwards in phases 2 and 3 followed the same design.

Liz also recalled that after the completion of the kitchen in Phase 2, the group no longer needed to return to Littlemore Hospital for lunch. Instead, they started cooking with the vegetables they grew from the plots in the new kitchen. Liz mentioned that the new catering supervisor from the kitchen of Littlemore Hospital helped design the cooking areas indoors from scratch and taught the workers the skills of cooking and catering. [89]

A creative way to promote sales

While obtaining friendly relations with the other allotment workers, Restore's gardening group at the Elder Stubbs also developed a method to promote the sales of the plants they grew from the plots. This further connected the workers to people and the world outside the allotments. In 'Community outreach 1', Rosie talked about how people came up with the idea to have a horse and a cart to sell the garden produce. The garden supervisors rented a big, tamed horse from a local breeder. The workers then painted up an old farm cart to pair with the horse. After the group loaded the cart with

[89] These buildings constructed between 1990 and 1997 were still in use during the time of my fieldwork (see Chapter 4).

fresh garden produce, a staff with another couple of workers would lead the horse with the cart to Florence Park located right opposite the Elder Stubbs allotments.

Rosie remembered how people in their elderly ages liked to see the group coming because the horse and the cart ‘reminded them of the old days’ and ‘the old ways’ to buy fresh produce. Many young mothers liked buying vegetables from the cart and their children loved patting the horse. As the small group returned from the park, the workmates who remained in the allotments helped unload the cart and brush down the horse. They seemed to enjoy taking care of the friendly animal.



Fig. 3.15 Restore workers and garden supervisors with the horse and cart loaded with garden produce for sale in the Florence Park (Leach manuscript, p.25)

This creative activity was supposed to enhance sales made by the Elder Stubbs gardening group of Restore, which was by now well-known to the residents of the nearby neighbourhood. While the horse and the cart caught people’s attention in the first instance, the fresh fruit, vegetables, and flowers made them regular customers. As

Peter and Rosie said during the interview on ‘Community outreach 1’, this connection created by the sale of high-quality garden produce was crucial for alleviating the mental health stigma in local communities.

In summary, this subsection reviews people’s place-making efforts at the Elder Stubbs allotments, which I summarise in three steps: the transformation of the abandoned plots, the construction of on-site facilities, and the use of a horse and a cart to promote the selling of garden produce in Florence Park situated next to the allotments. These place-making efforts had many direct impacts. The clearing of land transformed the other allotment holders’ attitudes towards the Restore workers, which reveals the effects of one’s own ‘doings’ in alleviating the mental health stigma. While the Restore workers and the other allotment holders had increased interactions through the gardening work, the promotion of garden produce with a horse and a cart further extended the workers’ relations with customers who came from outside the allotments.

3.6 Conclusion

This chapter reviews a variety of stories regarding the founding of Restore and the establishment of its first two sites in community settings. It acknowledges the entanglement of the narrative time and the chronological time to reveal people's joint efforts and creative place-making at Restore's headquarters on Cowley Road and at the Elder Stubbs allotments. The anthropological theory of therapeutic emplotment guided my review of the story of the car journey. And the method of photo-elicitation facilitated my discussions with my interviewees. With this approach, I was able to collect and present their comments, feelings, and memories about the workspaces at Restore. These factual details about the sites on Cowley Road and at the Elder Stubbs allotments shall lay an empirical foundation for my ethnographic analysis in Chapters 4 and 6 that follow.

Chapter 4. The pleasant work with plants:

Attending the gardening work at the Elder Stubbs

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‘Break the large chunks with your hands, so the roots can breathe.’

In the polytunnel, Caroline was showing us the way to ‘plug plants’. As we gathered around the table by the growing bed, she used the sharp end of a plastic label to rip open a large bag of compost. She then poured the compost into two trays.

Eve fetched a pair of gardening gloves from the shelf. ‘It’s up to you, but I prefer using bare hands.’ Caroline suggested. ‘It’s actually quite nice to feel the compost with your hands.’ Eve then put the gloves back on the shelf.

As we dug our hands into the compost, I was surprised by the crumbliness of its texture. The large chunks broke off easily, although they looked hard and coarse. My fingers sensed the moisture in the compost; the coolness made me feel refreshed. As I withdrew my hands, I saw some black compost in my fingernails. This made me feel prepared for the growing task ahead.

On the table, there were two trays of pansy seedlings and two trays of primrose. Caroline carefully scooped a cluster of pansy seedlings out of a growing tray. She then picked a pot from the shelf and filled the pot with two hands full of compost. Using a marker pen on the table, Caroline dug a hole in the middle of the compost. 'It's a trick to use the pen.' She explained, 'No need to be a deep hole. It's just to cover the root.'

Putting the pot down on the table, Caroline separated a seedling from its cluster. She then held the seeding up to eye level and reminded us that we should always lift the plant 'from its top' to avoid harming the roots. As we nodded in response, Caroline dropped the seedling in the dug-out hole and pressed gently on the compost with her fingers to fix the seedling upwards in the small pot.

After Caroline's clear demonstrations, we began plugging seedlings around a long square table. Eve and Caroline worked quietly and efficiently on one side. They were both in a comfortable standing position, resting their body on the edge of the table. They looked relaxed.

Alice and I worked on the opposite side. Alice introduced herself as a new member who was on her second working day at the Elder Stubbs. She had hardly done any gardening work before and hence attentively focused on Caroline's demonstrations. As

we began plugging, Alice lifted the seedling carefully from its top, as taught. She also made use of the marker pen to dig holes in the compost.

Between Eve and Alice, there were Penny and Nate. While others commenced working, Nate stared at the table in front of him. Penny, a volunteer, gently reminded him about the work. Nate then picked up a pot and began filling it up with compost.

In that moment, Caroline pointed to the raised bed and said, 'Look, a robin!' The petit bird caught our attention with its red breast at once. Alice and Eve took a glance, smiled, and continued plugging, but Nate put down the pot and walked towards the raised bed. 'Hey, Mr Robin.' He called out to the bird while walking. As the robin flew a couple of steps away, Nate chased after it. The robin then disappeared through a small gap in the polytunnel by the water pipe, but Nate did not seem to notice. He continued wandering around the raised bed, looking for 'Mr Robin'.



Fig. 4.1 Seedlings of flowers and gourds in growing trays, placed on the raised beds in the polytunnel, waiting to be plugged into small pots, photo taken by the author in the spring of 2019

The above ethnographic vignette showed how people did 'plugging' at Restore's Elder Stubbs recovery group. Eve did not say a word while working but she looked content and relaxed. As a beginner, Alice focused carefully on the task, applying what she learnt from Caroline in practice. Nate seemed less interested in the task, but he became cheerful when the robin visited the polytunnel.

As members (i.e. service users) of Restore, Eve, Alice, and Nate completed a Recovery Star every six months. [90] This was for the Oxfordshire Mental Health Partnership (OMHP), Restore's biggest statutory funder, to evaluate its service outcomes (see Prologue). However, none of the ten rays of the Star would draw attention to the comfortable silence, the attentive learning, the absentminded wandering, or the cheerfulness and excitement over the spotting of a bird while plugging. Nevertheless, these real-life circumstances were crucial for assessing the multiple efficacies of the gardening work at the Elder Stubbs, which may have a direct impact on future funding. Although they were not included or treated with fair sophistication by the standardised measurements, they are very important if we wish to evaluate a service user's progress. These real-life circumstances revealed the Restore members' sensory relatedness to people, things, plants, and animals when they inhabited and moved through the allotment spaces. Such sensory relatedness, as Chapter 1 argues, is crucial for restoring one's orientation to others and the world.

The primary goal of this chapter, therefore, is to assess the therapeutic

[90] My position as a Restore volunteer did not allow me to have access to the members' profiles, including their Recovery Stars. When in fieldwork, I chose not to breach this boundary but rather focused on how people worked in the recovery groups.

effectiveness of the gardening group work at the Elder Stubbs. My focus in this chapter is on people's bodily 'doings' that always involved an orientation to one another. Specifically, I focus on how people became attentive to each other, the plants they grew, the animals they encountered, and the tools they used when they collaborated in groups. I also look at how they learnt the gardening techniques, which embodied the Restore ethos to be a 'store' that sells high-quality produce for its regular customers, as Chapter 3 introduced. Based on this empirical assessment, I aim to reveal the efficacious sensory relatedness generated in Elder Stubbs's gardening group work.

This chapter has four sections. Section 4.1 starts with an overview of my fieldwork at the three recovery groups of Restore. It then introduces the Elder Stubbs recovery group and my approach to understanding people's gardening experiences when they worked in comfortable silence. Section 4.2 then examines the textured spaces of the Elder Stubbs allotments. Besides, it also introduces the structured time of the recovery group work, how precisely the gardening tasks were scheduled by a timetable, several rotas, and an annual growing plan.

In section 4.3, I discuss people's gardening group work at the Elder Stubbs. I present how members moved through the allotments' textured spaces when they collaborated in small groups. I argue, that by working in groups, some members became attuned to the rhythms of the work. Their wellbeing thus benefited from the pleasant intercorporeal relatedness with other people and plants who were occupying the same space and breathing the same air.

Section 4.4 then looks at how members learnt and practised the body techniques

for gardening. I suggest that the gardening techniques practised at the Elder Stubbs embodied the ethos of Restore. One needed to attend to the quality of the garden produce. The process to learn gardening in the recovery group, therefore, educated not only the attention to the plants but also an awareness of the preferences and demands of customers.

4.1 Fieldwork overview

This section first presents an overview of my fieldwork.[91] I first reflect on my dual role as an ethnographer and a volunteer at Restore and then introduce my fieldwork at the Elder Stubbs, the recovery group this chapter focuses on. Specifically, I reflect on the approaches I took to make sense of people's experiences when they preferred not to talk but enjoyed the comfortable silence while gardening.

Doing fieldwork and volunteering at Restore

I joined Restore as an in-house volunteer to conduct ethnographic fieldwork for my research. The dual role affected the trajectories of my research and the ways I worked with members. It also generated some ethical constraints on my choices of research methods.

At Restore, the primary job of a volunteer was to motivate members to participate in the recovery group work. For instance, a volunteer should remind people when they were distracted from the work, like Penny did to Nate while plugging (see above). A

[91] The fieldwork was conducted with the ethics clearance of the Central University Research Ethics Committee (CUREC). For more information, see: https://researchsupport.admin.ox.ac.uk/governance/ethics/apply/sshidrec#collapse394906

volunteer also helped to progress the work with her own hands. Every day, there was at least one volunteer in each recovery group I worked at. And most volunteers worked for one to two days a week. On the volunteering team of Restore, there were Occupational Therapy students, local artists, people who were retired and had skills in gardening and craftwork, and former Restore members. [92] In June 2023, Restore had 80 volunteers who worked in its six recovery groups across Oxfordshire. [93]

To become a Restore volunteer, I attended several courses at the charity's Manzil Way headquarters. [94] The training included a one-day induction and a two-day course on Mental Health First Aid. The induction introduced the history and organisation of Restore, while we as volunteers also learnt about the regulations of boundary-keeping and adult safeguarding. These volunteer regulations added a few more ethical constraints to my research. For instance, I should not investigate members' personal information, especially their illnesses, when I volunteered in their recovery groups. This ethical constraint limited the types of questions I could ask in semi-structured interviews.

Despite the ethical restrictions, some sessions of the volunteer training turned out to be very rewarding and empowering for my research. The two-day courses on Mental Health First Aid (MHFA), for instance, helped me to experience what it was like to be living with voices. Guided by the MHFA instructors, we formed small groups of three people. One tried to have a casual conversation with another while the third person,

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[92] See Chapter 5 for discussion of the volunteer transition for Restore members.
[93] See the link to the full information: https://twitter.com/oxrestore/status/1666471323676155904?s=20
[94] See an introduction to the place in Chapter 6.

using the texts in the manual, whispered bewildering words in their ears. The practical knowledge of the MHFA also echoes sensory medical anthropology's approach to the 'doings' of the body. We learnt the technique to help someone in a panic attack to regain the rhythm of breathing by moving the index finger of the left hand up and down alongside the contour of the right hand, diverting the person to breathe in when the finger moves up and breathe out when it moves down. The MHFA training also highlighted what to look at when we thought that someone might need help, such as long sleeves worn on a hot day and the sudden retreat from routine events.

As I began volunteering at the Elder Stubbs allotments, in the workshop at the Orchard, and in the Garden Café, my role as a researcher stood out once I introduced myself to others. A group coordinator at Restore pointed out to me that I was a 'gowner' among the 'towners'. [95] Members of the three recovery groups also regularly asked me what I would do for my 'medical anthropology research' in the first few weeks when we worked alongside each other. My initial response was that I was looking at whether and how the recovery group work might work on health.

My appearance as a foreigner also affected my fieldwork encounters. Hearing that I was a Chinese overseas student from St. Antony's College, Jens joked that I could be a spy. He said he had learnt Russian a few decades ago at St. Antony's college and 'heard the rumours' of it being a 'spy college'. Laura was genuinely convinced that I

[95] In Oxford and many other university towns (e.g. Cambridge, Durham, St. Andrews), there is a distinction between the 'Town' and the 'Gown'. The 'Town' refers to the non-academic community while the 'Gown' refers to people in the university. The history of Oxford was marked by the conflicts between the Towners and the Gowners in medieval times.

However, the distinction today is more of a cultural heritage of the town. And the city of Oxford has been organising a sports event called the 'Town & Gown 10k race' to raise funds for muscular dystrophy every year in May since 1982. For more details, see: https://www.townandgown10k.com/oxford/

was a spy. She declared one month after I joined her group that she would not participate in my research because she believed that I was 'video recording everyone'. Moreover, since English was not my first language, I made an effort to memorise the names of different plants, tools, and machines, and to understand the 'knock, knock' jokes around the lunch table. This somewhat also explained why it seemed easier for me to capture people's doings rather than understand every English sentence they said.

Apart from the above few instances where my foreign background instigated reservation, I received far more kindness, patience, and care. Members and staff at Restore watched my 'doings' as I watched them. Whenever I encountered difficulties using a tool or machine, a service member or a recovery worker would reach out to me with help and advice.

The Elder Stubbs recovery group

Restore's Elder Stubbs recovery group opened from Monday to Friday, 9.30 am-3 pm. The group did gardening and craftwork in a community allotment in East Oxford. Some members also learnt cooking when they prepared lunch meals for the group. The group had a shop that sold allotment produce, garden-related woodwork items, and recycled tools.

The recovery group had around forty members during the time of my fieldwork between 2019 and 2020. Every day, there were six to ten members. There were three full-time staff including one group coordinator and two recovery workers. Besides, there was one part-time locum worker who would come to the group when any of the full-time staff was on leave. There was also an employment coach who came to the

group once or twice a week. [96] There were one to two volunteers on each day.

My fieldwork at the Elder Stubbs had two phases covering a total of four months.[97] Besides, I volunteered in the group for roughly one day each week for ten months during the time when I progressed from Master's to doctoral studies. My fieldwork diary recorded the names of fifteen members whom I worked closely with during the first and second phases of my fieldwork. Eleven members were men and four were women. Two members, responded to my invitations to the interviews.

Working with(in) the comfortable silence

When people are willing to talk, one may use narrative analysis to look at their experiences. [98] However, the members I worked with in the three recovery groups of Restore were often reluctant to do interviews with me. Among the thirty-eight members whom I closely worked with at the Elder Stubbs, the Orchard, and the Garden Café, only five agreed to sit down with me in a meeting room to talk about their experiences. In this context, I was glad to know that my theoretical orientation in sensory medical anthropology was on bodily conduct, so to speak the 'real pipe' rather than its verbalisation (see Chapter 1). The real-life situation in fieldwork drove me in the same direction.

When doing gardening at the Elder Stubbs, many members remained quiet but

[96] See Chapter 1 for an introduction to the employment coaching at Restore.
[97] The first phase was a pilot project for my Master's dissertation. It took place between 3-20 September, 2018, with four days each week. The second phase was for the doctoral research, which took place one day each week between 20 November 2019 and 5 March 2020, paralleling the fieldwork in the other two recovery groups (see the sections on methods in Chapters 5 and 6).
[98] For instance, I was able to analyse the founding stories of Restore in Chapter 3 because the leadership members of Restore were happy to participate in the online interviews.

looked relaxed and delighted. Sometimes there was small talk about one's weekend. People also exchanged ideas about the plants and tool use. However, the conversations seldom lasted long and the comfortable silence was widely appreciated. As a volunteer, I worked *in* this comfortable silence with members and staff at the Elder Stubbs, feeling peaceful and relaxed when I immersed myself in the flow of the gardening work. However, as a sensory medical anthropologist, I also needed to work *with* such situations, trying to make sense of other people's experiences without disturbing the comfortable silence in the group.

Anne Jepson recorded similar situations of comfortable silence in the therapeutic horticultural project that she supervised in Scotland. While gardening, Jespon noticed a 'taciturn' man called Alec in her project. (Jepson 2014:154) Alec remained quiet in the group but always went for heavy tasks such as digging and preparing for the vegetable beds. Jespon found he gained confidence from being involved in the work and the learning process.

Josephine Biglin who worked with the asylum seekers in an urban allotment in northwest England also discussed the comfortable silence in gardening group work. Biglin noticed that the participants used their bodies to convey their 'desired level of social interaction' (Biglin 2020: 4). She thus argues that people in her gardening group 'had agency and control in how they decided to use their body to interact with others for their own personal therapeutic needs.' (ibid. 5) If feeling sociable, one would move around the plots to do the gardening jobs while having conversations with each other. Alternatively, one could also concentrate on one's work without talking at all.

Aster, an African refugee who worked in the urban allotment, told Biglin that he did not find it a problem to be quiet at work, because being in the allotments with everyone already meant that he was not alone. Biglin who worked in this small allotment quietly also experienced the 'embodied feeling of the presence of others' (Biglin 2020: 4). One's bodily presence in the gardening group already mattered a lot to oneself and others.

At the Elder Stubbs, people's presence at the allotments also mattered to their workmates. The recovery workers would make phone calls, send text messages, or write emails to members who did not 'show up for the day'. Some members would also be concerned if they did not find a close workmate presenting at the allotments, let the person be a staff, volunteer, or service member.

Apart from being aware of people's presence, the recovery workers and volunteers at the Elder Stubbs had their ways to tell if someone was 'having a good day' without asking the person every time. At the staff meeting in the afternoon, for instance, people reviewed the members' participation of the work and activities. I shall present a short excerpt to demonstrate the staff and volunteers' evaluations.

'Nate seemed quite absent-minded today,' Caroline noted.

'No, he's not very well.' Jason agreed, 'He left Aron with the washing-up – they were both on the rota – but Nate went to the shop to shake hands with a customer and her daughter.'

'He was also yarning when we visited the Naturehood Project in the Flo's Café.' Penny added.

The discussion fell into silence for a couple of seconds.

'Ariel volunteered to do the board again.' Rowland said.

'Yeah, she's getting better, isn't she?' Caroline replied encouragingly, 'Look at the flowers she picked and arranged for the Silvie's (Café)!'

‘And the clearing-up of the raised beds in the Nature Garden last week. It was a tough task that she proposed [to do].’ Jason added.

(Fieldwork Diary in November 2019)

As the above excerpt shows, the common convention of how treatment evaluation was carried out among the staff and volunteers at the Elder Stubbs focused on members’ participation in the gardening group work. It emphasised the completion of the work that one signed up for (or assigned by the rota) as well as people’s experiences in the process. The focus of the staff and volunteers was on ‘doing assigned tasks’, which resonates with sensory medical anthropology’s emphasis on ‘bodily doings’.

However, besides paying attention to what other volunteers and staff noticed, the approach of sensory medical anthropology also had me look at the sensory relatedness emergent from gardening group work. Specifically, I looked at two dimensions of people’s bodily ‘doings’. The first dimension is about people’s movements through spaces and the second is about their sensory engagements with each other as well as with plants and tools. Some of the ethnographic details in relation to these two dimensions caught my attention during the fieldwork; some I had initially noted down intuitively in my diary but later picked these notes up as something highly worthwhile for a sensory medical anthropological analysis. I shall present the ethnographic details in the sections ahead.

4.2 The textured spaces of the allotments

The Elder Stubbs allotments were in East Oxford. [99] The allotments took up 12 acres of land between Oxford Road and Rymers Lane, providing around 100 gardening plots for the nearby residents. [100] In 1988, Restore obtained permission from the Elder Stubbs Allotments Charity to use the nine plots by the allotment entrance. The place gradually developed into Restore's second site in East Oxford, which was twenty minutes' walk away from the charity's headquarters on Cowley Road (see Chapter 3).

The entrance of the Elder Stubbs allotments opened on Rymers Lane, a quiet, two-way street shaded by greeneries. On the opposite side of Rymers Lane, there was Florence Park. It offered a large green space mostly visited by residents from nearby neighbourhoods. Lush hedges marked the boundary of the Elder Stubbs allotments. Two maple trees guarded the entrance. The leafy trees met at their crowns, forming an inviting green arch for people to walk through.

After entering the allotments, there was a sandy road which took one further down to the plots. Looking from the lefthand side of the road, one saw the gardening plots maintained by people at Restore and the other allotment holders. Looking right one saw the recovery group's building complex. The plots were separated from each other by some narrow, grassy pathways. Along the grassy pathways, there were a couple of toolsheds and a small greenhouse.

[99] See Chapter 6 for an introduction to East Oxford and Cowley Road.
[100] For more information about the Elder Stubbs Allotments: https://elderstubbscharityallotments.org/.



Fig. 4.2 The main entrance to the Elder Stubbs Allotments on Google Street View, May 2022 [101]



Fig. 4.3 The Elder Stubbs recovery group on Google Maps, with the recovery group's gardening plots and the orchards at the allotments marked in yellow, screenshot in November 2022

The Elder Stubbs recovery group worked on the nine plots down by the allotment entrance. On my first visit in 2018, I saw vibrant summer flowers growing in the first three plots by the road. The adjacent plots accommodated all sorts of vegetables, such as pumpkins, gourds, and rainbow chards. Strawberries and asparagus were grown on

[101] Due to the abrupt termination of my fieldwork, I did not manage to take many photos while volunteering in the three recovery groups of Restore. I thus used Google Maps and images from Restore's social media and website to demonstrate the spaces in this chapter and the two chapters ahead when needed.

the raised beds; the Borlotti beans were climbing on frames. By the end of the vegetable plots, there was a small orchard with around twenty apple trees and a couple of pear trees.

On the right-hand side of the entrance, there was the building complex that Restore constructed for its gardening group. [102] I learnt from a quick tour with Caroline in 2018 that the one-storey buildings were used - in a clockwise direction - as the plant propagation room (which also stored tools and boots), the shop, the front and the back kitchens, the dining room (also referred to as 'the day room'), the toilets, the recovery workers' office, the small meeting room, and the woodwork shed. Next to the shop, there was the polytunnel where the above 'plugging' took place.

The buildings offered indoor areas for craftwork and cooking. In the woodwork shed, members sharpened their gardening tools and painted on the signboards to advertise the garden produce in the shops. Members also made small garden crafts, such as bird feeders, bird boxes, bug hotels, and Christmas wreaths. In the day room, they labelled the apple juice, honey, and raspberry jam with production dates and prices. In the cold seasons, they printed greeting cards with linocut and learned pyrography to write the cultivar names of the apple trees on wood planks. There were two kitchens on the compound. People cooked lunch in the front kitchen and processed the garden produce in the back kitchen. [103]

Most gardening work at the Elder Stubbs took place outdoors in the plots. The body encountered fewer obstacles set by walls or furniture made from solid and opaque

[102] See Chapter 3 for the process to construct onsite buildings at the Elder Stubbs allotments.
[103] I will discuss craftwork and cooking in Chapters 5 and 6.

materials. There was no roof above one's head, so the eyes could look afar to chase the flight of a bird or a plane. Sometimes, the soft boundaries marked by the edges of the gardening plots were almost invisible. One could easily overlook them or even move across them. This contrast between outdoor and indoor spaces echoes what Tuan Yi-Fu notes that space comes into being by one's ability to move (Tuan 1977: 34). It is thus expressed through the body schema and conditioned by the relations people had with others. [104]

Apart from the gardening plots and the plants growing within and beyond them, the animals caught our attention and brought us excitement, surprises, and joy. We pointed at and talked about the robin that visited the polytunnel, the squirrels climbing on the bird feeders for peanuts, and the quacking ducks kept an allotment holder who worked in the plots adjacent to the ones maintained by Restore. When a frog jumped out from the fallen leaves in the orchard, a member picked it up carefully and transited it to the pound in the Nature Garden. Although the animals came and went, and were not always present, they anchored our attention and movements and made the gardening work fun and pleasant.

The allotments' outdoor space, where the gardening work took place, were thus textured by a great diversity of moving and living beings, soil in the plots and water in

[104] I am aware that among the anthropologists who were inspired by phenomenology, Tim Ingold is against the word 'space' because he finds the term is often regarded as absent and void (Ingold 2011:142). My discussion in this chapter thus works with an alternative definition of the concept which developed from within a phenomenological tradition. Specifically, I am with Tuan Yi-Fu who regards 'space' as a more flexible and dynamic concept than 'place'. Unlike place which can be regarded as a special kind of object in which one can dwell (Tuan 1977:12), space lies at 'the conceptual end of the experiential continuum' which opens to all sorts of old and new relations (ibid. 17).

More recently, the 'relational turn' in human geography also proposes to regard space as a series of lived relations rather than empty containers or disembodied representations (see, for instance, Hall and Wilton 2017, Hall 2019, and DeVerteuil et al. 2020).

the pounds, as well as the gardener's sheds, greenhouses, and poly-tunnels. Drawing on Henri Lefebvre's *The Production of Space*, Elisabeth Hsu discusses how spaces can be perceived and experienced as 'textured'. The spatial textures explicated in this way, Hsu emphasises, are 'concrete, tangible, and material' (Hsu 2022:32). [105] When elaborating on Lefebvre's spatial textures, Hsu also highlights the 'spatio-temporal rhythms of nature as transformed by social practice' (Lefebvre 1991:116-17, in Hsu 2002:119). The spatio-temporal rhythms transformed by social practice are central to my analysis of the gardening group work at the Elder Stubbs, which I will explain with ethnographic details in the two sections ahead.



Fig. 4.4 The textured spaces of the Elder Stubbs allotments. Photos from Restore's website

[105] One example in Hsu's ethnography was about Dr Wu who opened a practice in a supermarket in the southern suburb of Nairobi. The place seemed to be in a deserted no-man's land, but after a few years this seeming void of space produced most of his patients from the refugee community. Athletic young men from Somali came to Dr Wu's practice to treat their wounds developed from marathon runs. The land that they run through became a place 'reanimated by sportive bodily cultivation, ambition and hope' (Hsu 2022: 136). It textured the main complaints presented to Dr Wu, whose medical skill, in turn, allowed his patients to continue running, which in turn populated these waste lands and thereby textured them.

While the allotment space was experienced as textured, the worktime at the Elder Stubbs was clearly structured. In what follows, I present the timetable at the recovery group, which structured the work every weekday.

Table 4.1 The timetable at the Elder Stubbs recovery group

Time	Event	Place
9 – 9.30	Staff meeting	small meeting room
9.30 – 10	Group meeting	dining room, also referred as 'the day room'
10 – 11.15	Recovery group work	(depending on the task one chose) gardening plots, polytunnel, orchards, woodwork shed, day room, shop, kitchens, OR in the small meeting room by the office if one is having a review/employment coaching or completing a Recovery Star
11.15-11.30	Tea break	day room
11.30-12.30	Recovery group work	(see above)
12.30-1.15	Lunch break	day room
1.15-1.30	Daily tasks	(depending on the task one chose) doing washing up in the back kitchen; wiping, sweeping, and mopping in the kitchens, day room, shop, propagation room, and toilets
1.30-2.15	Recovery group work	(see above)
2.15-2.45	Group meeting	day room
2.45-3	Staff meeting	small meeting room

In the morning meeting, people put up all the tasks for the day on a whiteboard and allocated the work to persons. In the afternoon, they erased the completed work on the board and wrote the remaining tasks in the diary for the next day. Caroline, Jason, and Rowland, the three full-time staff at the Elder Stubbs recovery group, often encouraged members to 'do the diary' and 'do the board'. Some members also volunteered themselves for the two tasks. They said it was a challenge they set for themselves to stand in front of everyone and talk, a way to deal with the 'social anxiety'.

After the morning meeting, people negotiated the order to complete the tasks. They formed in small groups of 2-7 people and headed to the plots, the orchards, the polytunnel, the woodwork shed, or the kitchens. For instance, on a Wednesday in September, Kit, George, and Ariel raised their hands for the task to pick apples in the orchard. Jason, the recovery worker, said he would come as well. Penny and Yuxin, the two volunteers, proposed to join them. Caroline, the group coordinator, suggested that we pick apples as a large group before dispersing for the other tasks we chose. Kit said he would then move the woodwork to the afternoon. Kevin and Eve wanted to make a few more birdboxes so they went into the woodwork shed. Rowland, the recovery worker, joined their group to provide technical help. The group also assigned daily maintenance tasks according to a rota. It was Caroline and Eve's turn to cook lunch, while Kit and Jason would do the washing up afterwards.

Members who arrived in the middle of the morning meeting picked the work that remained to be assigned. If someone arrived after the meeting, he joined any group which could still accommodate another pair of helping hands. Sometimes members arrived in the afternoon or left before lunch because they had appointments elsewhere. Sometimes they could not make it for the day but contacted the staff to explain. If there was no update from members who did not show up, Caroline, Jason, and Rowland reached out to check if things were alright. Although the timetable structured the work and the breaks at the Elder Stubbs, the realities diverted and multiplied them.

Nate and Kit, for instance, were often ten to fifteen minutes late. Kit explained to Jason that the bus he took was not always on time. Yet when Nate arrived late one day,

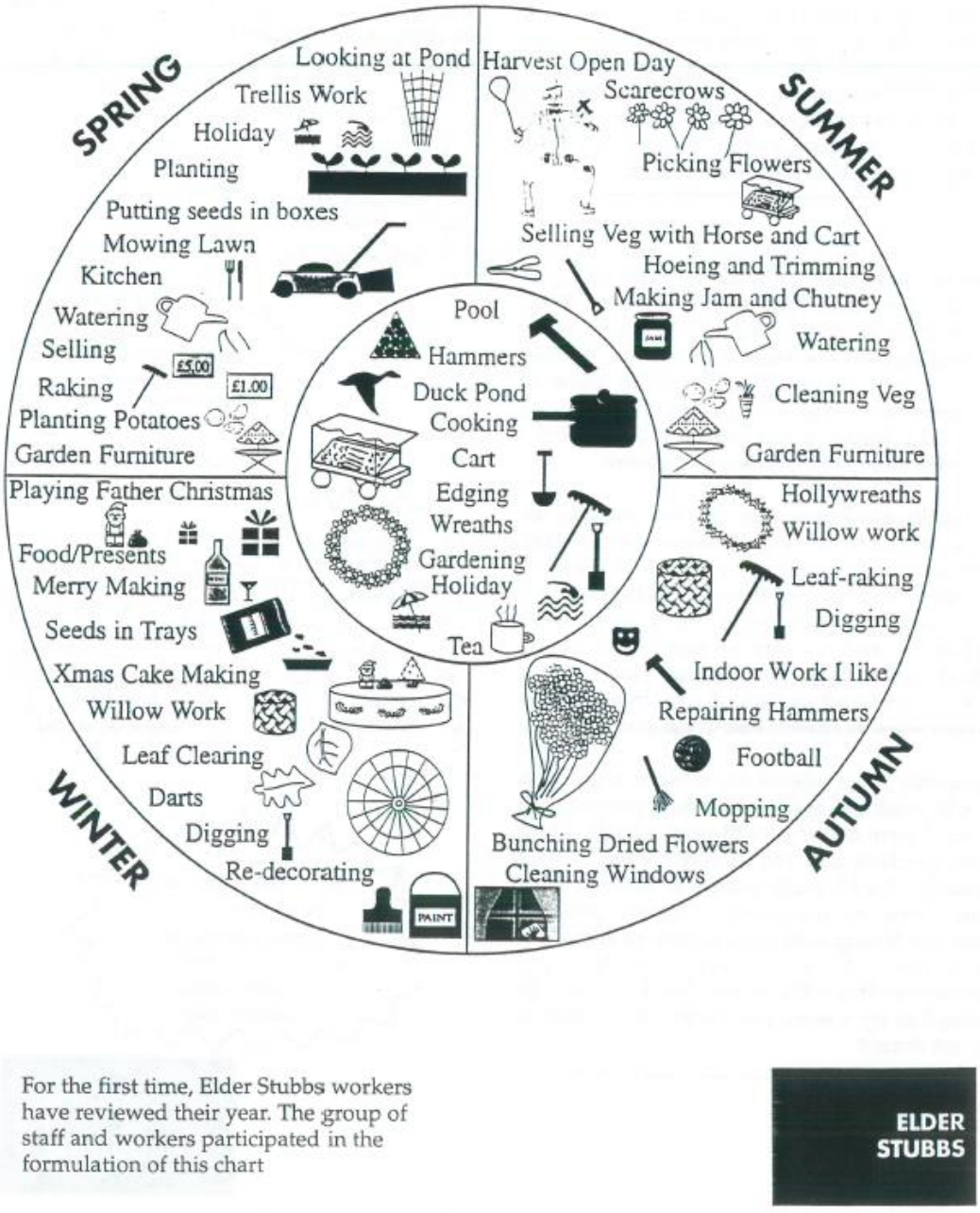
he did not blame the bus. He told us during the tea break in the morning that he could not fall asleep the other night.

'I walked into the garden at 4 am.' Nate said, 'And I heard the frogs croaking in the pond.' Caroline asked what he did then. Nate answered, 'I told them to go back to sleep.' The groupmates around the table burst into laughter. Instead of moaning about the illness, Nate told us a joke to explain why he was late for our group meeting in the morning. Other members empathised with him.

Besides the daily routine, there was a seasonal cycle which coordinated the gardening work at the allotment. When winter came to an end, the group worked out a 'growing plan' for the year (see Figs 4.5 and 4.6 below). However, due to the abrupt termination of my fieldwork in 2020, I was not able to work for a whole year at the Elder Stubbs, but only looked at the gardening works between September and March.[106]

In summary, the space at the Elder Stubbs was experienced as textured, while the worktime was structured. The lived body in the gardening group work thus moved through space in texturing ways while navigating in a time that was structured. The entanglement of the space and the time made rhythms for recovery group work, which I shall elaborate on in the sections ahead.

[106] There were also two annual events: the summer festival in late August, and the winter warmer in late November, which is worth looking into if future research allows.



For the first time, Elder Stubbs workers have reviewed their year. The group of staff and workers participated in the formulation of this chart

ELDER STUBBS

Fig. 4.5 Gardening work in a year, illustrated in a circle, Annual Report of Restore 1993-94



Fig. 4.6 The growing plan at the Elder Stubbs recovery group, photo taken by Caroline in 2021

4.3 Collaborating in groups

At the Elder Stubbs, people did all sorts of gardening work in groups. Some small tasks were done in pairs, such as washing vegetables, picking flowers, and weeding. Some demanded a larger group of four to seven people, such as plugging seedlings and picking apples. When working in groups, people collaborated with each other. I found such collaboration very intriguing from the perspective of sensory medical anthropology. During the gardening groupwork, we consistently moved through the textured spaces of the allotments, responding to each other while attending to the plants and the tools. The movement of the body and the quick responses in work, I propose, may have therapeutic indications if considering the problem of orientations as experienced in mental illness. I shall elaborate on the gardening groupwork with four examples.

Finding the rhythm to wash carrots

One morning, Ariel and I volunteered to wash carrots. Ariel was a new member at the Elder Stubbs. She looked young and slim, but her hair was grizzled, and she kept it short in a crew cut. She was very quiet in the first few weeks when she worked at Restore. Once when we were doing weeding, William asked Ariel if she had done any gardening before, but Ariel only nodded and looked down at the hoe in her hands.

With Caroline, we went into the back kitchen, the place where the group washed all vegetables harvested from the plots. The three of us quickly chopped off the carrots' leaves. Caroline then poured all the carrots into a sink. She put in place a plug on the

bottom of the sink and opened the tap to let the water flow on the carrots.

Ariel and I watched Caroline pick up a carrot, rinse it under the tap, and drop it into another empty sink on her righthand side. We then rolled up our sleeves and walked close to the two sinks by the window. With Caroline leaving the kitchen to supervise another group, Ariel and I began washing the carrots.

Ariel stood on the left by the sink filled with carrots, while I stood by the empty sink on the right. We began fetching carrots from Ariel's sink, and when doing so, our hands clashed. Ariel then lifted her hands to let me fetch a carrot first and I was careful not to clash with her hands again. Gradually, we found a rhythm for our collaboration. When Ariel was washing a carrot top by the tap on her side, I quickly grabbed a muddy one down from her sink; when I was washing a carrot by the tap on my side, Ariel instantly dropped a clean one into my sink.

All carrots weighed on our hands and the process to pick, rinse, and drop these carrots generated similarities between my body and Ariel's body. As Merleau-Ponty notes, when there is a living body that shares with my body a similar way of dealing with the world, our bodies that orient to the similarity became 'one single intercorporeality' (Merleau-Ponty [1960]1964:168). Thomas Csordas when discussing the intercorporeality and intersubjectivity also points out that the recognition of the world and the other is based on the perception of similarities (Csordas 2008:115). By orienting to the picking and shifting process, we became attentive to each other. This mutual attentiveness then helped us to find the rhythm for our collaboration. Both of us focused on maintaining this rhythm to have one carrot being shifted while the other was

being rinsed at the same time.

While working, our eyes glimpsed quickly and frequently at each other. Our hands moved, clashed, paused in the air, and then moved again with better agility. The eyes and hands, alongside the carrots in our hands, became the 'hinges' of our intercorporeal reciprocity (Csordas 2008:114). [107] They revealed and afforded our mutual attention and the rhythm of our collaboration.

The interaction between Ariel and I, however, was not simply dyadic, if reviewed from Hsu's discussion of empotment in relation to Mearleau-Ponty's elaboration on bodily perception. The carrots contributed to the process for us to find and maintain the rhythm. The carrots in the wash thus became the extension of our bodily perception. They were the things that we 'dwell' in and the 'poles' of our body's operation, weaving us into the same intentional fabric (Merleau-Ponty [1960] 1964:166-7). The carrots were also the 'pots' that related Ariel and me into a triad relation sustained by our mutual attention and spatio-temporal orientations. They had their materialities which also affected the rhythm of the work. Some carrots were large, round, and cylindrical, which made them easy to wash. Some, by contrast, were wonky and crooked. We thus had to rub on them under the running water for a while to get away the soil.

When Ariel and I finished washing, we moved all the carrots from the sink to a clean basket. I exclaimed that the carrots had so many colours – not only orange, but also yellow, purple, white, and green. Ariel nodded and smiled. As she carefully

[107] In 'Intersubjectivity and Intercorporeality', Csordas (2008) grounds the concept of 'intercorporeal hinge' in two ethnographic instances: one in the *hands* (e.g. the hands of the guest and the host that reached a doorknob at the same time), the other in the *lips* (e.g. the lips that kissed goodbye).

inspected the carrots, her face lit up. ‘They also smell carroty.’ I commented. Ariel instantly understood me and said ‘yes’. She had smelled the carrots as I did.

Apart from the pleasant sense of achievement and relaxation that ensued, there was a moment of therapeutic efficacy in our attuned work. On her first day working in the group, Ariel only nodded to people’s questions and avoided direct eye contact. However, as we finished washing the carrots, Ariel smiled and said ‘yes’ to agree with my exclamations regarding the colours and the smell of the carrots. To be sure, the observed change in responsiveness did not effect a transformation from ill to well, but even if the intense moment of the unspoken intercorporeal relatedness was temporal, it opened us up and let us experience together a shared lifeworld which was mutually enabling, lively, and productive.

The social life of the carrots, however, did not end in the sink. When Caroline returned to the back kitchen, she suggested Ariel and I to put some nice-looking carrots in the ‘veg bag’ for delivery to the Cultivate Oxford. [108] We also brought the wonky, tiny, and broken carrots to the front kitchen where Lorena and Jess were cooking lunch. Jess exclaimed about the different colours and the ‘funny looks’ of the carrots. Lorena chopped them into small chunks and put them in a baking tray alongside some onions, parsnips, potatoes, and butternut squashes from the Food Bank [109]. When the roasted

[108] Cultivate Oxford is a cooperative social enterprise in Oxford which sells and delivers locally-grown vegetables. For more information, see: http://cultivateoxford.org/

[109] The Oxford Food Bank (name changed to the Oxford Food Hub in 2020) was a local charity in Oxfordshire. It collected surplus food (mainly vegetables and grains) from wholesalers, supermarkets, restaurants, and others, and redistributes it for free to community organisations across the county.
The Food Bank’s van visited the Elder Stubbs once to twice a week. It provided the culinary materials for the recovery group to cook the vegetarian lunch meals. See: https://oxfordfoodhub.org/

vegetables were served for lunch, Caroline pointed out to the group that the carrots came from the plots. The groupmates who helped harvest the carrots smiled and had a taste.

In summary, the work to wash, cook, and deliver the carrots prompted us to move through the textured spaces of the allotments. It related us to people, plants, and places within and beyond the allotments, such as the other workmates who ate the carrots for lunch, the owners and staff of Cultivate Oxford, and the households that purchased the carrots from this small enterprise. As Chapter 1 reviewed, 'empotment' is intrinsically a process of emplacement that initiated by the bodily conduct. The gardening group work at the Elder Stubbs did not only prompt our body's orientation to the other workmates and the plants. It also empotted us into the allotments' interspecies landscape and the vibrant community spaces of East Oxford.

Getting entangled with pumpkins

One day in the autumn of 2018, Jason said in the morning meeting that he was worried about the pumpkins left in the frost. Caroline then suggested we all go harvest the pumpkins as the first thing to do for the day. We went into the propagation room and picked up some secateurs. Jason, Jack, and Kit fetched the wheelbarrows stationed by the allotments' entrance. Penny, Ariel, and I followed them, walking towards the pumpkin plots.

Before we started picking, Jason briefly reminded us to leave a long stem on each pumpkin, so the stem would dry out naturally to prevent the pumpkin from rotting from its top. We then scattered out into the first pumpkin plot and started browsing. As we

moved through the plot, the entangling vines of the pumpkins clung to our legs, making it very easy for us to stumble. When we reached out with our hands to get hold of the pumpkins, the itchy hair on their stems and leaves inflicted a stinging pain on our skin. 'It's like trekking in a rainforest!' Jack, the volunteer, exclaimed.

Treading carefully through the plot, Jason quickly picked up two medium-sized pumpkins. Moving back to the edge of the plot, he carefully placed the two pumpkins in a wheelbarrow, making sure the long stems were pointing upwards. Following Jason, Ariel moved swiftly to the centre of the plot. She spotted a giant pumpkin as large as a car wheel and stretched out her arms with a pair of secateurs in hand to cut the pumpkin stem. The hairy leaf seemed to have stung her skin, as she paused to rub her hands. She then reached out again, cut off the pumpkin, and lifted it up with great effort.

Walking very slowly, Ariel tried to bring the pumpkin out of the plot to an empty wheelbarrow by the plot. Penny, who was a few steps away from Ariel, reached out with her arms to take over the pumpkin from Ariel's hands. Having noticed the transaction between Ariel and Penny, I jumped into the plot from the grassy pathway and fetched the large pumpkin from Penny. Holding the pumpkin with my hands, I felt it weighed heavily on my arms. With an empty wheelbarrow only a few steps away from me, the task was less difficult to complete.

The same sort of collaboration took place on the other side of the plot. Kit helped Jason deliver a pumpkin to another wheelbarrow. Jason handed over a new one from Jack. To avoid the stinging vines and leaves, we looked for the gaps between the plants to step in. To reduce the distance that each of us had to travel, we kept locating the other

workmates, who were moving carefully through the plot as we did. As we only needed to move short distances and took only small steps, the risk of us being stung by the pumpkin leaves and stems was reduced.

The harvest of pumpkins generated intense sensory experiences. Almost everyone who came on the day volunteered for the task, which formed a large group of six people. To 'rescue' the pumpkins from the frost, we browsed quickly with our eyes, bent down with our bodies to pick, and stretched over with our arms to fetch. The pumpkin's stinging hairs also inflicted acute pain on our skins. It was an intense moment experienced by many of us who tried to cut off the pumpkins from their stems. And we experienced with our own bodies while hearing the exclamation and seeing the hand-rubbing of our workmates. The experiences of acute pain were uncomfortable, but they might work as a critical stage in a therapeutic process.

In medical anthropology, there are ethnographic accounts of the infliction of acute pain in therapeutic processes. Margaret Lock, for instance, reviews the moxibustion practice in Japan, during which the burning of a small, pea-size ball of moxa causes sharp pain on the skin. It was a method to treat localised infection, muscle spasms, and other chronic problems, which was widely practised in urban and rural homes (Lock 1978:158). Lock notes specifically that in the local context, efficacy was not only about the removal of symptoms but also the 'psychosocial adjustment' (ibid. 170). She also includes the narrative that the very visibly displayed scar would tell about being loved and cared for. In this way, not only the doctor but also the patient and his family members, were responsible for the healing. Similarly, the harvest of pumpkin at

Restore's Elder Stubbs recovery group might also generate efficacy in a social dimension, because the alerting pain prompted us to become collaborative. By delivering the pumpkins out of the plot with collaborations, we shared the responsibility of the work, achieved increased efficiency, and reduced the risk of being stung by the pumpkins again.

Elisabeth Hsu also reviews the infliction of acute pain as therapy in Chinese acupuncture practice. She presents how the acupuncturist, with skilful movement in hands, inserted the needle to inflict an intense experience of 'de qi' in the patient (Hsu 2005:78). The treatment was perceived as efficacious because the acute pain 'evoked presence and alerted one's sensory attentiveness' (ibid. 84). It generated, as Hsu later argued, a moment of synchronicity in that it heightened the alertness of all people present in the room, causing immediate, bodily-felt social connectedness between the patient, the practitioner, and the audiences who witnessed the treatment. I read this study as one of the earliest examples of effective sensory relatedness discussed in sensory medical anthropology. Comparably, the alerting pain inflicted by the pumpkins' stinging hair also made us more aware of our surroundings and reminded us to move more carefully through the plots. Moreover, the experiences of the stinging pain generated not only a sense of presence but also of togetherness, that we were working hard alongside each other towards the same goal in our gardening groupwork.

Noticeably, the sensory relatedness generated in this gardening group work was both bodily and spatial. The pumpkins had their vines twisting and knotting with each other; they were the beads chained up by their stems. While picking, we were chained

up by the pumpkins we picked. With our arms reaching towards each other, the delivery chain of our collaboration also twisted from left to right. Our chains of human bodies got entangled with the pumpkins, which typically grow into meandering chains, and these chains of the plant textured the human movement of harvesting them.

Our chains entangled with the chains of pumpkins, emplacing us into the textured spaces of the allotments. The sensory relatedness of our group collaboration, therefore, also took the 'shape' of the entangling stems of the pumpkins. [110]



Fig. 4.7 A pumpkin guarded by its stinging vines and leaves in the plot, photo taken by the author in 2018

We managed to harvest all the pumpkins by the morning tea break, but the social lives of the pumpkins continued. As the sun came out, the frost faded. Jess, Ariel, and I each fetched a stool to sit in the courtyard. Caroline found us some shoe brushes. We then spent the remaining time of the day brushing the pumpkins with buckets of soapy

[110] One who read this paragraph might think of what Marcel Mauss wrote in *Seasonal Variations of the Eskimo*. As Mauss notes, 'It is by means of this technology, a social phenomenon, that Eskimo social life becomes a veritable phenomenon of symbiosis that forces the group to live like the animals they hunt (Mauss [1904-5]2004:55).' My ethnographic accounts in this and the next section (i.e. harvesting pumpkins and picking apples) resonant the spatial dimension discussed in the Maussian social morphology. However, I am also aware of the significant difference in the analytical scales and thus do not include the Maussian theory in the current discussion.

warm water. While brushing, we remained aware not to knock off any long stem on the top of each pumpkin. ‘It’s like bathing babies!’ Jess commented. I laughed and Ariel smiled.

The pumpkins were in different varieties, many of which could not be found in supermarkets. Jason went into the office for a while and came out with a piece of laminated paper listing all the common names of the pumpkins we harvested. He also put a photo next to each name. By putting this paper in the shop, Jason explained, the customers would know which type of pumpkin they were purchasing.

Ariel, Jess, and I looked at the pumpkins’ names. Caroline joined us from the office. Jess identified some ‘Goosebumps’ and said they might be the most ‘Halloweenie’ pumpkins thanks to their orange and warty skins. I found my favourite ones were called the ‘Turk’s turban’. They took the shape of a hat and were mottled in shades of orange, green, and white.

I also found the name of the heavy pumpkin which looked like a car wheel. It was called ‘musquee de provence’. Caroline commented that it looked like ‘Cinderella’s carriage’. Ariel and Jess smiled as they recognised the pumpkin which took us great effort to move to a wheelbarrow.

After we brushed off the soil left on the pumpkins, their colours looked more shiny and vivid in the sun. Jack, Kit, and Jason joined us again to move all the pumpkins into the shop. We took a while to mix and match the pumpkins of different types and colours to make sure that they presented nicely and were attractive. Caroline then placed some delicata squashes among the large pumpkins to increase the contrast in sizes. The

careful display of the pumpkins for sale presented the Restore ethos that Chapter 3 introduced. I shall revisit the ethos in section 4.4 when reviewing the gardening techniques practised in recovery group.



Figs. 4.8 & 4.9 Pumpkins and squashes harvested from the plots and displayed for sales in the shop of the Elder Stubbs recovery group, photo taken by the author in the autumn of 2018

When members and volunteers who worked on the following days walked into the shop, they talked about the stunning look of the pumpkins with excitement. Evans and Bob found the paper with introductions to each pumpkin and used it to identify the names of the pumpkins. Laura exclaimed that it was now the autumn time of the year, while Nate and Kathy weighed and sold the pumpkins to the walk-in customers. The pumpkins sold out quickly and the majority was gone before Christmas. When we talked about the sales of the pumpkins in the afternoon group meetings, there was a sense of achievement among the workmates.

In summary, in the group collaboration to harvest pumpkins from the frost, people formed chains to deliver the pumpkins, which grew in chains, out of the plots. The stinging pain caused by the pumpkin hairs reminded the workmates to move more carefully and be more aware of their surroundings. The intense sensory experience also stimulated the gardeners to collaborate with heightened attentiveness when they delivered the heavy pumpkins from the plots. By stretching arms to others across the plot, we formed twisting chains which took the shape of the pumpkins' entangling stems. The spatial-bodily relatedness empotted and emplaced us into the allotments' landscape. After carefully picking and brushing the pumpkins, the groupmates were fascinated by the pumpkins' different shapes and colours. The quick sales of the pumpkins then intensified the sense of achievement.

Clustering under the apple tree

At the Elder Stubbs, we picked apples throughout the autumn months. The task remained on the whiteboard without being wiped off in the meeting by the end of the day. In this way, members who worked on any weekday would have the opportunity to participate in the task.

The group picked apples from two orchards. [111] There was a small orchard at the end of the vegetable plots on the main site. It had around twenty apple trees, and the trees were donated by people who helped set up the recovery group in the 1990s. There was also a large orchard on the other side of the allotment. This orchard was owned by the Elder Stubbs Charity. Members and staff at Restore called the larger orchard by the street name next to it, 'the Bhandari Close'.

We formed small groups of four to seven people to pick apples. Everyone in the group would bring a wheelbarrow. While picking, we put the apples from the same tree into the same wheelbarrows. The local juice-makers at Tiddly Pommes then fetched the apples from the allotments to make apple juice in single blends for Restore to sell in its cafés and shops. [112]

One morning in September, a group of service members, staff, and volunteers set off to pick apples from the Bhandari Close. To make sure that we all picked from the same tree at the same time, we kept close to each other. Jason, Jack, and Kit picked

[111] See Fig. 4.3 in Section 4.2 for the locations of the two orchards on a map.
[112] Tiddly Pommes was a micro-entrepreneurship which collected apples picked in the Oxford area and turned them into bottled apple juice for local sale. The small enterprise made single-blended juice and labelled each bottle with the apple's cultivar name, such as 'Jester', 'Annie Elizabeth', and 'Russet'. Priced four pounds per bottle (750ml), the single-blended apple juice was very popular among the regular customers of Restore's shops and cafes. For more information, see: https://www.tiddlypommes.co.uk/

from the branches. George and Ariel checked on the apples that had fallen on the ground. Nate and I did a bit of both.

While picking, we were in the shade of the large tree, as were the fallen apples on the ground. The apples grew in clusters, and we picked them by gathering ourselves in a cluster as well. None of us spoke a word for a while, yet George hummed cheerfully. There was a sense of closeness between groupmates as we clustered around the apples, one next to the other.

We formed chains with the pumpkins we harvested and we clustered under the apple trees while picking apples. The relatedness between the groupmates took the shape of the patterns how the plants grew themselves in the orchards and the plots. The textures of the plants shaped human movements, generating an isomorphic connectedness.

Since the focus of my research lay on the therapeutic efficacies generated by the Restore members' motor intentionality, bodily movements, and sensory engagements, my analysis of the human-plant relations is asymmetrical. The effective sensory relatedness I aim to explore in fieldwork, therefore, was more of a meshwork rather than a network as Tim Ingold compares in his well-known fable, 'When ANT meets SPIDER'. Ingold proposes to explore a phenomenological lifeworld which allows consistent movement and becoming of the 'lines of lives' (or 'lifelines'). The lifelines could be people, plants, animals, or any other living organisms. The encounters and interactions between these living organisms, therefore, can be regarded as the binding together, knots-tying, and enmeshment of the lifelines. The world full of moving

lifelines then becomes an organic meshwork. When we worked in groups at the allotments, every workmate was a 'spider' with its own web attending to the movement and vibration in the world (Ingold 2011:94). By moving through the allotments' textured space while orienting to other workmates and the plants, the service members became open to others and the world, which I propose was intrinsically efficacious.

The other time when we set off to pick apples in a group of six, Jim, a member in his fifties, talked about 'his mania' on our way to the orchard. 'It's not easy to be bipolar, you know,' he walked in front of me but looked back and said, 'I did not sleep the whole night.'

As we arrived at the Bhandari close, we noticed some baskets loaded with apples by the gate. Kit said Jason had asked him to bring these apples back to the main site. We then started shifting the apples into our wheelbarrows, except for Jim. 'Wow, wow. Look at these!' Jim stood aside watching us, 'Therapeutic, huh?'

Jess sensed the irony in Jim's tone. She replied that the weather was nice. 'Yes! It's sunny. You know what I like to do on a sunny day?' Jim said, 'I would pour myself a cup of coffee and read papers under the sun.' Jess said it sounded great but we still had some work to do before the tea break. Jim, however, did not seem to be in favour of her proposal and started talking about the intense relationship he had with his son. Finally, when we noticed that the apples were mixed in two varieties, Jim joined us to separate the apples into two wheelbarrows.

As we finished shifting apples from the baskets into the wheelbarrows, Jim asked again whether we could head back for a break. Jack pointed out that the group still had

another three empty wheelbarrows to load. 'Ah! Work! Work! Work!' Jim became upset. However, when the rest of us headed towards the apple trees. Jim followed us.

When we started picking, Jim announced that he would just stand there, enjoying the sun, and watching us work. Ariel frowned and Jess sighed. Jack then pointed out that it had just been fifteen minutes since the group arrived at the orchard; there would be another half an hour until the tea break. Jim complained more loudly, but this time nobody replied. The rest of us started to pick the apples from the branches and collected the fallen ones from the ground. While picking, Kit, Jess, Jack, and I gave the apples a taste. We reached an agreement that the apples from the tree we selected were sweet enough for juicing. A couple of minutes later, Jim picked an apple to taste as well. He then started picking apples from the tree with us.

In this example, the group work to pick apples significantly transformed a member's 'doings'. In the beginning, Jim was talking excessively. Although he signed up for the task, he refused to work when the group arrived in the orchard. Although Jess and Jack, the two volunteers, tried to invite Jim to work, the conversations made Jim more upset. However, when the rest of the group became unimpressed and started tasting and picking apples, Jim joined the group doing the work with others. As he immersed himself in the flow of the work, he ceased talking about his illness and his family crisis.

The moment of therapeutic efficacy in the above excerpt may have different interpretations depending on the analytical frameworks of different disciplines. [113]

[113] For instance, Jim's participation in the work might be arguably explained as an example of conformity in social psychology (Martin and Hewstone 2003:313-4).

However, from the angle of sensory medical anthropology, I suggest that the relaxed rhythm of apple-picking and the tasting of sweet apples contributed to the above therapeutic process, which might have made the work more interesting and enjoyable for Jim to participate in.

The other morning when we were picking apples at the Bhandari close, the workmates exchanged views about the different taste of the apples. I said the Jester apples tasted juicier and were crunchier than the ones called Russet, although they were less sweet. The two apples contrasted significantly in their looks. The Russets had a yellow, coarse skin, while the skin of Jesters was in a mix of green and red, and much smoother to the touch. It was thus easy for us to tell the difference while picking.

Nate, who had been quiet for a while, announced that the 'Duchess's Favourite' was his favourite apple. Jack agreed that they were indeed a charming type of apples with a nice name. These apples were the smallest in size but looked very attractive with their rosy-red colour. I found the 'Duchess's Favourite' tasted more acidic than all others but had a unique flowery aroma.

Listening to us exchanging views, Jason pointed out to Kit that the apples were much healthier than the peanut butter sandwich he packed for lunch. Jason was a recovery worker who co-worked with Kit for his three-month reviews and completions of the Recovery Stars at Restore. He was concerned that Kit never ate the lunch meals that were always freshly and healthily cooked at the recovery group but would rather stick to his sandwich. Kit replied to Jason's concern with a smile. He then had another bite of the apple in his hand. Kit seemed to agree that the apple improved his diet for

the day as he finished the whole fruit while picking.

As we returned to the recovery group's building complex for the morning tea break, I noticed that Ariel, who shook her head when invited to taste the apples in the orchard, picked up a Jester from the wheelbarrow. She took the apple to the kitchen and gave it a rinse under the running water before having a taste. I then asked George why he did not taste the apples while we were in the orchard. George opened his mouth, pointed at his teeth, and asked if I could chop up an apple into slices for him. As I agreed cheerfully, he drew out a caramel wafer from his pocket and put it in my hands. Eventually, almost everyone in the group tasted the apples we picked, which somehow enhanced and prolonged the sense of pleasant togetherness in this gardening group work.

In summary, apply-picking was one of the most popular tasks at the Elder Stubbs. And the work generated elated moments of therapeutic efficacy. When people formed in large groups to pick apples from the same tree, they stayed close to each other, generating a sense of closeness. The process of browsing and picking the apples also prompted the gardeners to find the relaxing rhythm of their work. As the above example shows, this luring rhythm of work might draw some members who were less well at the time into the collaboration. Moreover, the tasting of the apples enhanced the bodily-felt togetherness and shaped the healthy eating habit of the gardeners.

Dispersing for weeding

The gardening work to pick pumpkins and apples brought people together. Weeding, by contrast, was organised far more loosely and laxly. The word 'weed' was a loose, all-inclusive classification. When I asked Tray, a member who was experienced in gardening, what weed was, Tray said weed could be any plant we did not need in our plots – just like the word 'pest' which could be any animal unwelcomed to the allotments.

With the help of Caroline and Tray, I managed to identify some 'common weeds' occurring in the Elder Stubbs allotments. The stinging nettles once gave my hands 'an electric shock' when I tried to pull them off from the plots. Tray who witnessed the incident suggested I look for some dock leaves to rub in my hands, which could offer instant relief to the stinging pain. He also explained that the dock leaves often grew next to the nettles.

When Ariel, Ronald, and I were doing edging, Caroline noted that the clumps of grass growing inside the plots were called the 'couch'. She said we could remove the coach grass from their roots with a hoe, but use a pair of edging shears to trim the ones growing on the boundaries of the plots.

Caroline also introduced that the plants with small and round leaves attaching to the soil were chickweed and the taller ones with white flowers growing like a tree's crown were hemlock. The roots of hemlock, which looked very much like carrots, were highly poisonous, and the milky juice in its stem would also irritate the skin. 'Overall, the work of weeding is all about identification.' Caroline summarised.

Although the weed plants listed above were very different in size, shape, and colour, they were all classified as weeds. We as gardeners had to do weeding because we did not want other plants to take away the nutrients in the soil for the flowers and vegetables we grew. However, Caroline also reminded us not to overdo the work. ‘Just weed inside the plots and leave those beyond the place alone.’ She explained that this was for an ecological purpose because the butterflies loved laying their eggs on the ‘weed’ plants.

The weeds scattered everywhere in the plots, so people scattered themselves in different plots to remove them. Chat and small talk became difficult to maintain in this task. Whether people were still closely related to each other or not became negotiable, yet the workmates still paid attention to each other’s work to distinguish the different areas they were respectively responsible for. They needed to intentionally look in different directions and coordinate their bodily movements to weed on the different pieces of land.

Overall, among members at the Elder Stubbs, weeding was far less popular than picking apples. The task of weeding was like a ‘filler’ on the whiteboard. When the other tasks were completed, one could still do some weeding. However, many guys enjoyed riding on the lawnmower, a more interesting way to do the weeding. I often saw Tray driving around the ride-on mowers in the small orchard. With a pair of earmuffs on his head, he looked pleasant and often waved to the other workmates working in the plots nearby.

There were also a couple of members who chose to sign up for weeding. Ronald,

for instance, often went for edging after lunch. Jason was concerned about Ronald's choice of work and thought he was avoiding responsibilities and opportunities to 'be social'. However, Ronald explained that weeding enabled him to spend some time alone in an open space, which made him feel relaxed and peaceful. I also saw Susana signing up for weeding when others went for apply-picking and woodwork, although she did not explain her preference.

In summary, weeding was a less popular work at the Elder Stubbs. It demanded the workmates to scatter into different plots much like the weed plants they intended to remove. The learning to identify the weeds, however, educated an attentiveness to the different colours, sizes, and shapes of the plants. A few members also seemed to be benefited from the solitude and peacefulness in the work of weeding.

Summary of this section

This section discussed the group collaboration at the Elder Stubbs. Taking place in small groups of two to seven people, moving through the textured spaces, the gardening work had rhythms that coordinated and mutually attuned their movements. The rhythms of the work brought members of the recovery group into gardening collaboration and prompted them to become attentive to the other workmates, the plants, and the tools, in manifold ways.

The gardening groupwork reviewed in this section also generated a diversity of sensory experiences which contributed to the therapeutic process. The refreshing smell of the carrots made a quiet member smile and open herself up to small talk. The stinging pain inflicted by the pumpkins' hairy stems reminded us to be more aware of our

surroundings and to move more carefully in the plots. Finally, the sweet taste of apples intensified the sense of togetherness and joy.

Noticeably, the therapeutic sensory experiences generated through our group collaboration also related us to the ways how the plants themselves grew in the allotments. When harvesting pumpkins, we formed chains that entangled with the pumpkins' twisting stems. When picking apples by cultivars, we clustered with each other under an apple tree as we picked the apples. When doing the weeding, we dispersed into different plots to look for the weed plants, which came out in various places at the allotments. The spatial-bodily relatedness with the workmates and the plants, connecting with each other through isomorphic texturing, I suggest, emplaced and empotted us into the allotments' landscape that was thriving on its diversity.

4.4 The attentive learning of gardening techniques

This section looks at people's learning and practice of gardening techniques. I argue that the body techniques practised at the Elder Stubbs recovery group embodied Restore's ethos to be a 'store' that sells products with high quality and aesthetic values. To support this argument, I present ethnographic details about the body techniques to harvest fruits and arrange flowers. I then look at how members taught or learnt the different gardening techniques and discuss the diverse ways they might have benefited from the process.

The body techniques of picking

As Mauss notes in 'Techniques of the body', to learn and practice the body techniques, one needs to 'adapt the body to its use' (Mauss [1934]1973:86). Nick Crossley elaborates on the reflective and embodied features of the Maussian body techniques. He engages his experience in Thai boxing (Muay Thai) to demonstrate that the body techniques are 'both technical and bodily' (Crossley 2007:88). Being 'technical' means that the techniques must be learnt, either intuitively or by imitation and repetition. Being 'bodily' then enabled the techniques to embody the principles of the sport, which is to train the body to be quick, energetic, and powerful. The education process, Crossley emphasises, makes explicit the principles embodied in the techniques of boxing.

The gardening techniques, alongside the Restore ethos they embodied, also needed to be learnt. With learning and practice, people became attuned to the plants and the

tools in specific ways. The learning process then educated one's attention and opened oneself to a diversity of relations with one's workmates and customers.

Picking raspberries to make jam

One September morning, Caroline stood in front of the raspberry bushes and taught us how to browse for the raspberries. She bent down to look behind the leaves and stood up on her toes to look at the bushes from above. 'It's like playing hide-and-seek with the plant.' She commented.

We also learnt how to judge the quality of a raspberry by its colour. Caroline picked a round berry in ruby red and presented it in front of our eyes. Raspberries like this one, she said, would be juicy and sweet. They would make nice jam for sale in the shop. She then pointed to a tiny one in pinkish white, and then to a blackened one which looked shrunken and dry. These raspberries, Caroline advised, were either 'not ready' or 'over' and should be left on the branches.

I spotted a raspberry in a ruby red, but my fingers smashed it when I tried to pull it off from the branch. 'You may use both hands.' Tray advised while smiling at me. He then used his left hand to hold the stem and his right hand to grasp the berry and gave the fruit a gentle tug. The berry dropped in his palm and the white core remained on the stem.

'If it does not come off easily,' Tray added, 'leave it on the stem as it would not be ready.' Tray also told me not to worry when the fruits were only slightly squashed. Afterall, he explained, the raspberries would be made into jam.

Caroline and Tray taught me how to pick raspberries. To browse for the small

berries in the bushes, we bent our torsos and stretched our necks. Our feet stood on the toes and our eyes glanced over the plant. Specifically, the techniques for raspberry picking emphasised the use of one's eyes and hands. The learning of such techniques evidently educated an attentiveness to quality, since we needed to pick the fresh raspberries rather than the ripened ones for jam-making.

As we returned to the kitchen with buckets of raspberries, Rowland guided us to wash the fruits under the running water. While washing, we double-checked if there were still any rotten or blackened ones. Since there was no time to make jam on the day, we put the raspberries into freezer bags and tucked the bags into the freezer. The jam-making could then be a task for people to do on the following days, or even one to two months after. Rowland explained that frozen raspberries were easier to cook because they softened quickly. The arrangement to freeze the raspberries also saved us time and allowed us to harvest the fruits and vegetables in season. When winter came and there was less gardening work to do outdoors, jam-making became a nice task to do for members who worked in the kitchens.

Picking apples for juicing

One morning in the orchard, Jason showed us the techniques to pick apples. He put his hand under an apple and gave it a slight twist. 'If it drops in your hand, put it in the wheelbarrow. Otherwise, just leave it on the branch.' Jason said we could also pick the apples that had fallen on the ground, but should avoid the rotten ones, so they would not 'turn the apple juice into cider'. We smiled and started picking.

The apple trees at the orchard had name tags hanging on their trunks indicating the

cultivars. Jason reminded us to pick one tree after another and put the apples from the same tree in the same wheelbarrow. In this way, the local juice-makers could make apple juice in single blends for Restore to sell in its recovery group shops. Jack, Ariel, and I checked with Jason if the apples we picked were ok. Jason then explained that a slight bruise or a cut would be fine for juicing, as we only needed to sort out a basket of nice-looking ones for sale by the allotment's entrance.

Like raspberry picking, there were body techniques for picking apples. The hand mattered in the process as it initiated a slight twist on the fruit. If an apple was ready, it dropped into one's hand. As gardeners, we learnt with our bodies a simple technique to check on the apples, during which our hand became the 'intercorporeal hinge' that guided us in orientation to the plants. The practice of the techniques, therefore, was an effective process that cultivate a gardener's sensory engagement with other workmates and the plants.

The quality of the apples also mattered as we picked them for sale and for juicing. The single-blended apple juice sold at Restore was produced locally in small batches. On each bottle of apple juice, there was a label presenting the cultivar name with a couple of lines describing the taste of the juice. It was like a description that the sommeliers wrote for wines, which made the juice very popular among the regular customers who came from the nearby, middle-class neighbourhoods, although the juice was priced higher than the ones sold in the supermarket. [114]

[114] In 2019, the Elder Stubbs berry jam was priced at £3.75/jar, while the apple juice was £4/bottle. The jam lasted 12 months, while the apple juice was pasteurised and could last at room temperature for two years.



Fig. 4.10 Raspberry jam, marmalade, and apple juice made by Restore's Elder Stubbs recovery group and displayed for sale at the South Park Winter Warmer, photo taken by the author in November 2019



Fig. 4.11 The flower seedlings, jam, and apple juice for sale at the entrance of the Elder Stubbs allotments, photo by the author in the spring of 2019

Flower picking and arrangement

In summer, we grew a wide range of flowers at the Elder Stubbs. Members and staff arranged the flowers in bunches and buckets. They placed the small bunches by the front gate of the allotments for sale to residents of nearby neighbourhoods who visited Florence Park. The group also sold flowers in buckets. These buckets of flowers were ordered by the local pubs and cafes in East Oxford. The owners of these pubs and cafés used the flowers to decorate their dining areas. Either arranged in bunches or in buckets, the flowers should look colourful, uplifting, and fresh. Unlike raspberries and apples, the flowers were sold directly to the customers. We thus needed to be more careful while picking flowers.

One morning in September, Evans, a new member, put down his name to pick flowers. With a pair of secateurs in hand, he went straight to the plot by the road and quickly cut off three chrysanthemums, all in yellow. Caroline stopped him. 'Pick different colours,' She suggested, 'and the stems are a bit short – they should be taller than the bucket'. Ariel, Evans, and I nodded.

'Here's another trick to sort out the flowers.' Holding the three chrysanthemums with her left hand, Caroline used her right hand to strip off all the leaves on the stems into the plot. 'It's quicker than using the secateurs,' She explained, 'and if you strip the leaves into the plots, you don't need to clear the paths.' Caroline also reminded us to put the buckets of flowers in the shade of the building to avoid the sunlight at noon time.

The techniques of flower picking embodied an orientation to quality and efficiency most evidently. We stripped off the leaves on the stems so the flowers could last longer

than a week. We also paid attention to the aesthetics of flower arranging to make sure that each bunch or bucket would have a mix of colours and varieties. The aesthetics that I discuss here are grounded in 'deepened engagements in the environment'. It arose from an attention to the life processes of the plants (Laplante 2015: 241).

Many members enjoyed flower-picking and arrangement, possibly due to the aesthetics of the work. To them, the aesthetic process of flower-picking might also be therapeutic as it promoted the body's orientation to being-in-the-world. [115] Ariel and Eve, for instance, always put down their names for the task. While working, they carefully attended to the flowers they picked, matching them in different colours and smelling from their petals. Never did I see them picking flowers in a rush. Once when Eve was attracted by the 'dramatic look' of Amaranth, she asked Caroline to say more about this type of flower. Ariel was usually quiet, but she sometimes took a few seconds to look at the flowers in her hands.

In summary, this subsection reviews the body techniques to harvest berries and apples and to pick flowers. I suggest that the gardening techniques people practised in the recovery group embodied Restore's ethos to make and grow high-quality produce for sale. The process to learn the techniques then educated an attentiveness to the plants.

[115] See also Chapter 3 for the interrelations between aesthetics and rehabilitation as embedded in the designs of craftwork pieces that people made in the workshops of Restore in the 1980s.



Fig. 4.12 Cut flower in bunches, displayed for sale by the entrance of the Elder Stubbs allotments, photo taken by the author in October 2018



Fig. 4.13 Cut flowers sold by the Elder Stubbs recovery group in a bucket (priced £10) to the Magdalen's Arms, a popular Michelin Bib Gourmand pub in East Oxford,
photo taken by the author in October 2019

Members as tutors and learners

At the Elder Stubbs, members learnt and practised gardening techniques in different ways. Different people had different bodily conditions which would affect the ways they worked and the therapeutic efficacies they benefited from the gardening process. How the learning and practice became therapeutic thus largely varied by the individual.

Some members were experienced gardeners who offered help and advice to others. Tray showed me how to pick raspberries with both hands and taught Kit how to use a ride-on lawnmower. However, when Tray's membership at Restore was about to terminate, he suddenly became unwell and stopped coming to the allotments for a couple of weeks. Eve was also a good gardener. I saw her showing new members how to do 'plugging' in the polytunnel. Since Eve had woodwork skills, she would answer questions from others when they encountered problems making a bird box or a bug hotel. After working at the Elder Stubbs for around two years, Eve signed up for the Transition Training to become a volunteer at Restore. [116]

Ariel did not teach others the gardening techniques but she was always ready to collaborate. Many staff and members liked working with her. More importantly, Ariel seemed to enjoy the pleasant work with the plants as she would spend time taking a careful look at the flowers she picked, the centipedes climbing out of the soil, or the bumble bees flying around the cornflowers. After working at the Elder Stubbs for roughly one and a half years, Ariel started a traineeship in catering in a downtown Café.

[116] See Chapter 5 for the discussion of Transition Training and Chapter 6 for the discussion of members' moving on and out of their recovery groups.

She seemed to have no problem 'moving on' from the Elder Stubbs.

Some members, however, encountered difficulties learning some specific gardening techniques. Luke, a member in his late fifties, found plugging 'challenging' because he could not see the roots of the seedlings. He explained to me that his eyes were not very good so he had to wear a pair of sunglasses even inside the polytunnel. After I suggested Luke fill the small pots with compost while I separate the seedlings from their entangling roots, he looked relieved. As our collaboration proceeded, he joined the chats with others around the table, looking much more relaxed. [117]

George in his early sixties encountered difficulties when he picked raspberries. His hands were consistently shivering and he was wearing a pair of glasses with very thick lenses. The raspberries that George picked were either too ripened or too raw. Many berries were squeezed by his fingers and the red juice stained his white jacket. After working for a while, George went behind a clump of bamboo to have a cigarette.

However, when people were setting off to pick apples in the orchard, George joined their group at once. He hummed with me when we walked to the orchard. As we started picking, George mixed up the two different varieties of apples. However, he no longer made the mistake after Jason pointed out to him that we needed to pick the same variety of apples. Throughout the work, he continued picking with a cheerful humming.

The apples were much larger than raspberries, which made them easier for George to hold with his hands and to check their colours with his eyes. He also seemed to enjoy

[117] This example reflects what Peter Agulnik, the co-founder of Restore noted as a principle of Restore, that 'Any individual might not have the capacity to make a whole object, but together by different people doing different parts of a constructive work, you can create a whole.' (see Chapter 3)

the sense of togetherness when we picked apples in a group. This example shows that the great diversity of the plants we grew at the Elder Stubbs contributed to the therapeutic effectiveness of the gardening group work. With such great diversity, people with different bodily conditions could find some tasks that they enjoyed doing.

There might be other members who hardly found the gardening work at the Elder Stubbs helpful for improving their well-being. These members, however, usually left the recovery group within a month or simply just did not show up after the 'taster day'. Due to the lack of consistent contact with these members, I was not able to investigate the reasons why they stopped coming to the recovery groups. However, a review of former staff's narratives in Chapter 3 has indicated that the reasons might be a lack of interest in gardening or the declining health conditions of the individuals.

In summary, the gardening work at the Elder Stubbs became therapeutic to different members in different ways. Some members seemed to enjoy being the tutors for the gardening techniques. They might thus be benefited from the increasing self-esteem and the career transition to become a Restore volunteer. Some were more indulged in the affective encounters with the plants and animals. Some members might not be able to master all the techniques of gardening, but they were also benefited from the sense of togetherness in group collaboration, and the exercise of body during the processes of learning and practising the gardening techniques might also contributed to a better sleep at night.

4.5 Conclusion

This chapter presents ethnographic accounts of the gardening work at the Elder Stubbs recovery group of Restore. I focus on people's bodily 'doings' central to an approach of sensory medical anthropology. Precisely, I look at how people moved through the allotments' textured spaces when they collaborated in small groups. And I argue that, through group collaboration, members made and participated in the rhythms of the work and thus become related to others. I also look at how members learnt and practised the embodied gardening techniques to attend to the quality of the products. I argue that learning gardening techniques educated one's attention to the plants and tools while cultivating a caring awareness of one's regular customers.

With the above ethnographic accounts, I propose that the recovery group work at the Elder Stubbs could be efficacious to its members. Firstly, gardening was pleasant to do for those who were interested. The pleasantness was evident even when people did not talk about their feelings but rather immersed themselves in a comfortable silence. The process of the work often enacted pleasant sensory experiences, such as the vibrant colours of the crops, the aromas of flowers and herbs, and the sweet taste of apples. These sensory experiences in one's encounters with plants then intensified the pleasantness.

Secondly, the gardening work engendered learning processes for the body. This learning process was important to members who wanted to master new skills for personal development or future careers. It promoted the body's movements through space and cultivated the body's sensory engagements with its surroundings. The

learning processes, therefore, enskilled the body and opened the body to a remarkable diversity of sensory-social relatedness.

Lastly, the gardening work at the Elder Stubbs was highly social because most tasks were conducted in groups. Members who found the gardening techniques challenging to master could thus contribute to the group collaboration. They could then be benefited from the rhythms of the work which exercised their body and cultivated sensory-social relatedness with others. To these members, it was important to maintain the social connectedness they had at the Elder Stubbs, since they were more emplaced and empotted to the allotment community and became less lonely through such empotment. The weekly participation in the recovery group work has become a stabilising part of their life. It would thus be problematic to push these members to move on and out of Restore in two years. I shall elaborate on the problem in the next two chapters.

Chapter 5. Caring through crafting:

Transitioning to volunteering roles at the Orchard

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On my first day working at the Orchard, Sage proposed to show me around the place. [118] We began at the shop by the entrance to the building. The room was small but bright, illuminated by large, glass-panelled windows. The shop was one of Restore's many stores in the recovery groups which displayed all sorts of craftwork the members and staff had made for sale. We had a look at the greeting cards on a rotating stand, some stuffed toys on the wooden shelves, and jewellery handmade with a diversity of

[118] At the Elder Stubbs and the Orchard, members like Sage would propose to show the newcomers around the recovery group, while the induction in the Garden Café was organised by the staff in a very structured and formal way to emphasise food hygiene and safety.

materials such as stone, metal, and wood.

Given my experience at the Elder Stubbs (see Chapter 4), I identified some woodwork pieces made for use in the garden. There were a couple of seed dibbers, some bird boxes, hedgehog houses, and bug hotels. Sage then had me look at some pieces for the kitchen, such as spoons, spatulas, honey dippers, salad bowls, bread bins, and artisan-style cheese boards.

After showing me around, Sage picked up a wooden plate to show me its details. 'The oil used for this one,' her fingers slowly slipped over the edge of the plate, 'are different from those for the gardening stuff and the toys.' While she spoke, I noted the touch of her fingers and saw that the surface of the woodwork was matt. Sage put the plate on her palm and lifted it close to my eyes 'Because it is for food. We use vegetable oil-finish on the wooden crafts for food.'

Having been made and handled with care, the plate presented itself with fascinating details. As Sage lifted the plate to our eyes, I saw that the vegetable oil applied to preserve its surface had been absorbed by the wood. The treatment gave the plate a natural, rustic look. It was a brief yet intense appreciative encounter between Sage and myself focused on the sensory qualities of the things for sale at the place. We looked at the plate's matt surface with our eyes, sensed its smoothness with our hands, and this created an atmosphere of intense awareness of each other's presence.

I then took the plate, held it with both of my hands while feeling its surface, and said the plate was very nice. Sage smiled and told me she had made it.



Fig. 5.1 The shop at the Orchard, photo posted on Restore's Twitter in 2021

When I tried to make sense of the above ethnographic encounter recorded in my fieldwork diary, it resonated with Tim Ingold's discussion of the ecology of materials. Drawing on Martin Heidegger, Ingold proposed a 'radical distinction' between thing and object (Ingold 2012:436). He defined the 'thing' as 'a gathering of materials in movement—a particular knotting together of the matter-flow' (ibid.). By contrast, the 'object' favoured by the material culturists is complete and ready-made, setting itself up against any bodily perception and forbidding further movement (ibid. 439).

According to the Ingoldian ecology of materials, a 'thing' can be a pot, a body, or a person. The wooden plate, Sage, and I in this way were all moving *things* in our own trails. By encountering, sensing, and responding to each other, our bodily movements and sensory engagements intertwined and knotted to a meshwork that gave the recovery group's lifeworld a material aspect. [119]

[119] See also Chapter 4 for discussion of meshwork.

The above ethnographic encounter could also be read as a process of empotment. As explained in Chapter 1, a 'pot' occurring in a therapeutic encounter can be seen as a thing in the Ingoldian ecology of materials. Sage and I oriented our bodies to sense the wooden plate. We looked and touched on the plate while talking about the careful approach to preserving its surface. We also imagined that one day the plate would be used to serve its owner some nurturing food in future. The plate that Sage made, therefore, was not only a line of life moving through the processes of making, selling, and being consumed. It was also a pluripotent 'pot' that embodied Sage's craftwork skills, a helpful assistant for her introduction to the work at the Orchard. Sage's careful handling of the plate showed how she cared about the craftwork pieces she made. Her patience to let me take time to look at the things displayed in the shop and inviting me to have a touch and feel of the plate, also showed how – through this gesture of engendering mutual attentiveness – she invited a new person into the group with light-touch care.

Before we left the shop, Sage mentioned that her place at the Orchard was closing because she had been a member of this recovery group for four years. Although the membership at Restore should be no more than two years, people could apply for extensions when they were dealing with significant changes in life, such as marriage, divorce, pregnancy, house-moving, or change of carers. An extension was usually three to six months each time. [120]

When I asked Sage if she had any plans for life after her membership terminated,

[120] For instance, George who was a member at the Elder Stubbs managed to have several extensions before he 'moved on' from Restore (see Chapters 4 and 7).

she said she was unsure but was considering ‘volunteering’. Sage also said that she would like to talk with me about her Restore journey since I had invited all members at the Orchard to do so during the morning group meeting.

We then left the shop and entered the meeting room. Another woman just arrived in the room. Putting her handbag on the table, she called out Sage’s name and introduced herself to me as a new member called Iris.

‘Yeah, she is new.’ Sage confirmed. She then looked at Iris and said, ‘Maybe you can take my place.’ ‘Oh, that would be pressure,’ Iris smiled, ‘because you’ve done such great work.’

I was never able to organise an interview with Sage due to the pandemic. Seven months after I left the Orchard, Sage and I saw each other again when we attended the refresher course of Mental Health First Aid (MHFA) online. Sage participated in the course from an empty office at the Orchard; I joined from my home in China. Although it was only a virtual meeting, we recognised each other. I then knew that Sage was taking an essential step in her Transition Training to become a volunteer at Restore.

In this chapter, I look at some service members’ work at the Orchard. I note that craftwork was intrinsically different from gardening and catering because it was organised through individual projects rather than group collaborations. Nevertheless, many members at the Orchard were willing to care for their workmates by helping them with their craftwork projects. I propose that the offering of care through craftwork made these members competent for the volunteering work at Restore, and I suggest that the current regulations could be more flexible and supportive for such members to become

in-house volunteers for Restore.

This chapter has six sections. In section 5.1, I discuss the dilemmas that the members encountered when they applied for the Transition Training to become volunteers at Restore. Sections 5.2 to 5.5 then present my ethnographic study of the members' work at the Orchard to propose more flexible and supportive management regarding the volunteer transition at Restore.

Specifically, section 5.2 is an introduction to my fieldwork method in this recovery group. Section 5.3 looks at the geographical and historical context of Banbury, the town in North Oxfordshire where the Orchard was located. In Section 5.4, I discuss the spatial arrangements at the Orchard and suggest that the spaces in the small building had significantly textured the members' bodily movements, as well as their sensory, emotional, and social experiences. Finally, in Section 5.5, I propose some essential criteria that contributed to a member's successful transition to volunteering roles at Restore, which were the mastery of the work and the adoption of one's skills and techniques to help and care for others with their craftwork projects. The chapter ends with a conclusion.

5.1 Transition Training and its dilemmas

The Volunteer Transition Training at Restore enabled members to continue working in a recovery group after their two-year membership terminated. The transition also enabled them a new role as an in-house volunteer rather than a service user. It was thus a very popular pathway to 'move on' among members at the Orchard. In 2020, four members from the Elder Stubbs and one from the Garden Café signed up for the training, while the Orchard collected the names of more than ten members.

To be eligible for the volunteer transition training, a member should have obtained competent skills and techniques for the recovery group work. The member should also demonstrate willingness and effort to help others at work. The group coordinator and recovery workers would announce the opportunity to do the volunteer transition training in the group meetings. They also screened the candidate list if too many people applied. If they received no applications from members, they invited members whom they found suitable for the training. [121]

Members who did the transition training should complete all the free but essential courses that Restore organised for its new volunteers (introduced in Chapter 4). Besides, there were several regulations for the members who were set to embark on the volunteering work at Restore. And it was these regulations that generated dilemmas.

According to the regulation, all members who wanted to become a volunteer at Restore should take a three-month break from the charity before they started working

[121] See an example in Chapter 6 when Sarah, a recovery worker in the Garden Café, who invited Sean, one of the Café's best baristas, to do the Transition Training.

as a volunteer. Besides, they should not volunteer in the recovery group where they used to work as a member.

Service members at the Orchard, however, were waived from the second regulation because the Orchard was the only recovery group in North Oxfordshire. People in the Orchard would need to spend one to two hours on public transport to work in any of the four recovery groups in Oxford City, and commuting time would be doubled if they wanted to work in the fifth group in Didcot, which was in South Oxfordshire.

Given the sparsity of recovery groups in North Oxfordshire, Restore's management committee decided in 2020 that members at the Orchard could remain working in the Orchard after transitioning from the status of a member to a volunteer at Restore. This possibility was granted, however, on condition that they would work on different weekdays from those on which they had worked as members, and they should start volunteering only after taking a three-month break.

Many Restore staff said to me that they were convinced of the necessity of the regulations. Endorsing the OMHP outcome, they were concerned that the volunteer transition training would not be a valid pathway for members to 'move on' without the above regulations. As the Prologue introduced, the OMHP monitored the 'destination' of service members who were 'discharged' from Restore, so it would be questionable if the destination remained the same as the place where one used to work as a service user.

Interestingly, however, on an occasion of recruiting members wishing to become

volunteers, after Jen, the coordinator of the Orchard, made clear the above regulations in the group meeting, many members looked disappointed. Two members who went to attend the induction course in Oxford also told their workmates at the Orchard that the process to transition into volunteering roles was a bit more complex than they expected.

I was not able to talk to everyone who signed up for the training on the occasion. However, I only saw Jen from the Orchard showing up at the MHFA course online, and it was a compulsory course for volunteers at Restore. This might indicate that some members who put down their names on the sign-up form had quitted the volunteer transition training despite that it was a very attractive opportunity to 'move on' when their membership terminated.

My question, however, is whether the members' motivation to work consistently at the Orchard was in any case against a therapeutic purpose, as the OMHP's measure of 'discharges' assumed. I also question whether the current regulations for the Volunteer Transition Training at Restore could be more flexible and supportive. This chapter, therefore, aims to look beyond the existing regulations to explore the underlying criterion embedded in the therapeutic process of the recovery group work at the Orchard which might contribute to the members' successful transitions to volunteering roles at Restore.

5.2 Participant learning at the Orchard

The Orchard was Restore's only recovery group in North Oxfordshire. It was in the town centre of Banbury. Members at the Orchard did woodwork and craftwork. There was also a patio with some shelves outside the recovery group building for people to grow plants in small pots.

The Orchard had around sixty-five members when I did fieldwork in this group in 2020. It was the largest recovery group I visited in Restore. Ten to fifteen members came to the Orchard every day, while the record number of a 'peak day' was twenty-four. [122] To fit every member's name into a one-page, A4 paper, the register of the Orchard was written in a much smaller font than the registers used in the Elder Stubbs and the Garden Café.

Although the Orchard had the largest number of members, it had the smallest number of full-time staff. Both the Elder Stubbs and the Garden Café had one group coordinator and two recovery workers, while the Orchard had only one group coordinator, Jen, during my fieldwork between 27 January and 10 March 2020. [123]

While Restore was recruiting another two full-time recovery workers for the Orchard, the locum workers and volunteers took up responsibilities for running the craftwork activities in the recovery group. There were two part-time locums, Billy and Kate, who worked in the group for one to two days a week. The Orchard also had a few volunteers. Eva and Miranda worked almost every day. David only worked on Mondays

[122] By contrast, the Elder Stubbs had around ten members, while the Garden Café had no more than six members working on each day (see Chapters 4 and 6).
[123] See the discussion of my dual role in fieldwork in Chapter 4.

and Blair was the volunteer on Fridays. Like other recovery groups, the Orchard had an employment coach, Evelyn. [124]

Since the Orchard was temporarily understaffed, it opened with reduced hours. The recovery group opened at 9 am and closed at 1 pm, which was around two and a half hours before the other recovery groups of Restore closed. This meant that people at the Orchard would not cook lunch on site, although members could bake cake and biscuits for the morning tea break. Instead, members and staff could also take home the culinary materials delivered by the Food Bank, including some vegetables, fruits, bread, and pastries.

Overall, I spent thirteen days volunteering and doing research at the Orchard. It was a very short time. Due to the COVID-19 pandemic, the fieldwork ended six months earlier than scheduled. [125] My fieldwork diary recorded the names of twenty-four members whom I worked and chatted with during these days. Ten were men and fourteen were women. Three members, including Sage, expressed an interest to talk about their time working at Restore. However, due to the abrupt termination of my fieldwork, I did not have a chance to organise an interview with any of these members. The discussion in this chapter, therefore, relies on the small talk people had with me and others at work.

During the thirteen days at the Orchard, I spent six days with members in the craftwork room for small handcraft, six days in the woodwork room, and one day for a

[124] See Chapter 1 for the introduction of Employment Coaching at Restore, and Chapter 6 for the discussion of moving on to employment.
[125] My original plan was to visit all six recovery groups of Restore, as Chapter 1 introduced.

creative writing course organised in the craftwork room. I was a novice to most work at the Orchard. While the lack of skills made me a less competent volunteer, I was taken good care of by members and volunteers at the Orchard, who were keen on helping me make progress in my first few projects in craftwork and woodwork.

My fieldwork method in this recovery group, therefore, took on what Yishan Wang (2021) refers to as the 'participant learning', or what Elisabeth Hsu (2006) calls, the 'participant experience'. Instead of simply observing and taking notes on people's recovery group work from afar, I learnt the woodwork skills and techniques from the service members at the Orchard. By adapting my own body to learn the woodwork techniques to a degree that I could perform some tasks independently by myself, I became part of the group and thus tended to experience the rhythm of the work and the intercorporeal relatedness with others. However, adopting the method of participant learning and experience does not mean that I have chosen a method that is completely different from participant observation. On the contrary, participant experience only 'went a step further' (Hsu 2006:149) by highlighting the fieldwork as an intersubjective and a reflexive process. I shall demonstrate the nuance with ethnographic details in Section 5.5

5.3 Locating the Orchard in Banbury

This section introduces Banbury, the historical town in North Oxfordshire where the Orchard Recovery Group of Restore was located. Following Desjarlais and Throop's proposal of critical phenomenology, I argue that the understanding of the Orchard members' everyday experiences of craftwork should not be separated from the historical, political, and economic forces that contextualised the recovery group's lifeworld (Desjarlais and Throops 2007:25). [126] With my own experience of vising the Orchard, I imagined how members and staff of the Orchard commuted to the recovery group by moving through the historic landscape of the town. I then discuss the provision of health and social care in the area.

How people travelled to the Orchard

Hearing me say 'I like Banbury' at the tea break, Kay raised her eyebrows, looking a bit surprised. 'Then you must have heard of this.' She started singing. Jess who sat next to her put down the coffee cup to join her:

Ride a cock-horse to Banbury Cross,
To see a fine lady upon a white horse;
Rings on her fingers and bells on her toes,
She shall have music wherever she goes.

'It's actually quite near – the fine lady and her horse.' Kay said with amusement, 'We could go for a look at her anytime.' Jess laughed and agreed, 'It would be a nice short walk.'

[126] See the review of critical phenomenology in Chapter 1.

The song ‘Ride the Cock-Horse’ was a famous nursery rhyme that made Banbury a well-known town in the English-speaking world. The earliest printed record of this nursery rhyme can be traced back to 1784. The fine lady in the song related to many women figures in the Old English World, including Queen Elizabeth I and Lady Godiva.

The ‘fine lady’ that Kay and Jess planned to visit was a statue at the Banbury Cross. Cast in bronze and mounted on a plinth of local Hornton stone, the statue was put up by the people of Banbury in 1859 to celebrate the marriage of Queen Victoria’s eldest daughter. [127] The Banbury Cross where the fine lady stood was a famous landmark in town. Since the statue was only 160 metres away from the Orchard, many members and staff would go past it on their way to the recovery group.



Fig. 5.2 The Fine Lady Statue at the Banbury Cross, Google Street View, November 2020

On weekday mornings, people came to the Orchard by different means of transportation. Jen, the group coordinator, lived on the outskirts of Banbury and had a

[127] For more details about the Banbury Cross and the fine lady statue, see: https://www.banbury.gov.uk/Fine_Lady_Statue_16402.aspx

car. Billy and Kate, the two locum workers, also drove their cars to work. They lived respectively in Oxford and Bicester. Eva and Miranda, the two volunteers who worked in the group almost every day, said they lived somewhere 'near Banbury'. Miranda came to the Orchard on foot; Eva said she would ride her bike when the weather was fine and take the bus when it was wet. Blair, the volunteer on Fridays, had just moved to live in the UK and rented a flat within walking distance from the recovery group. David who volunteered on Mondays took the train, as I did, but I did not know the exact town he travelled from.

Some members from outside Banbury drove in by car as well. There was a large car park by the Orchard's building complex which could accommodate their vehicles. Noticeably, being able to drive as a mental health service user would indicate that the person's diagnosis was comparatively 'mild to moderate', according to the Driver and Vehicle Licensing Agency (DVLA). [128]



Fig. 5.3 The carpark by the Orchard, Google Street View, April 2021

[128] See the registration on the website of the Driver and Vehicle Licensing Agency: https://www.gov.uk/guidance/psychiatric-disorders-assessing-fitness-to-drive

Members who did not drive cars took buses and trains. Not many came on foot because most members lived outside Banbury. Among the twenty-four members I met in the Orchard, only Linda was a Banbury local. Other members, by contrast, had been referred by medical practices in Bicester, Chipping Norton, or other towns and villages located in the north and the west of Oxfordshire.

John, for instance, said he lived in a village near Chipping Norton in North Oxfordshire. He explained that due to the problems with his feet, he preferred driving in his car rather than taking any public transport. John described that the village he came from was 'very small and quiet'. He often felt lonely living there. Banbury, by contrast, was 'noisy, crowded', and the town offered many intriguing activities and events, including, he said, the craftwork at Restore. John concluded that he enjoyed commuting in his car between the two places.

According to Google Maps, almost all driving routes from outside Banbury took A361 to reach the Orchard, a main road that went by the Banbury Cross in the southwest of the town. People on public transport came from the opposite direction and were thus exposed to a mixture of modern and historical landmarks in the east. Walking out of the train station, there was an ancient stone bridge on the River Cherwell with its earliest reference traced back to 1393 (Hitchcox 1992: 54). Once across the bridge, there was the orange, three-storey building of the Banbury Health Centre. Some letters of the centre's name were missing. Interestingly, members in the Orchard rarely mentioned this GP practice, probably because they registered in the practices in the villages and towns where they lived in.



Fig. 5.4 The Banbury Health Centre on Bridge Street, photo taken by the author in January 2020

Going further down town to the west, one walked past the central bus station. The Restore members who came to Banbury from surrounding villages by bus might get off there. The street was a commercial area since Victorian times. [129] People from the Orchard sometimes purchased the materials for doing craftwork from a chain store called Wilko on this street.

Bridge Street ended at the Banbury Town Hall, a Gothic Revival building that was constructed in 1854. To visit the Orchard, one took the High Street on the lefthand side of the Town Hall and turned left onto the Calthrop Street before the High Street ended at the Banbury Cross. The walk took only seven minutes, but the route was a 'microcosm' of buildings from different periods, including the late medieval house of

[129] As the Banbury Historical Society's journal, *Cake and Cockhorse*, records, Bridge Street was the main east-west artery out of the town since the mid-19th century. It listed many small businesses and retailers including 'skilled craftsmen like carpenters and masons, lawyers and insurance men' (Hitchcox 1992: 62).

No. 85-87 and the Georgian façade of the Lloyds Bank (Kaye 1962:31). It is thus understandable that many members at the Orchard praised Banbury as a 'beautiful, historical' town. However, the political economy of health in Banbury was far less easy to praise, which I shall explain in the next subsection.

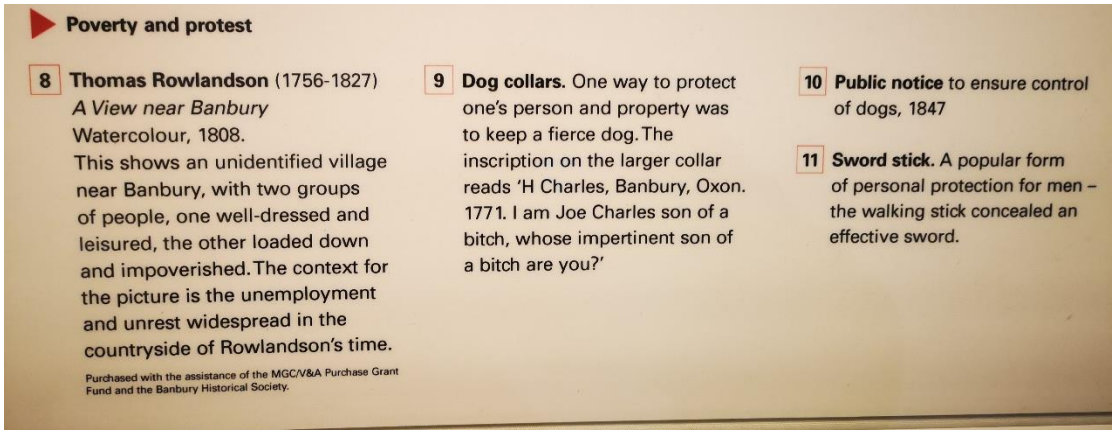
Health and social care in Banbury

On my first day in Banbury, I visited The Banbury Museum. One section of the museum exhibition, titled 'A dirty, ill-built town', caught my attention with its relevance to health. The section presented photographs of some 'most insanitary dwellings' constructed in Banbury between the 18th and 19th centuries. Besides these photographs, there was a piece of introductory notes which recorded the plagues taking place in the same period. The introductory notes were:

> **Health and Housing**
> **1795:** Banbury was described as a 'dirty ill-built town'. Despite growing prosperity it remained, like most towns, an unhealthy place. The population, including Neithrop, trebled from 3,810 in 1801 to 11,700 in 1871
> **1831:** outbreak of 'Banbury Fever'. The inhabitants, 'particularly the lower orders', were warned to guard against cholera
> **1832** and **1833:** outbreak of typhus
> **1845:** outbreak of smallpox
> **1846:** deaths in Calthorpe Lane were blamed on 'the stench arising from the stagnant water and filth accumulating in the drains'
> **1849:** Enquiry into public health in Banbury found conditions 'perhaps as extreme…as re to be found in the filthiest and most crowded towns in England'
>
> (Banbury Museum and Gallery, 2020)

Alongside the problems in public health, there was violence and poverty. The museum exhibition highlighted how the Banbury residents in the 19th century carried

a ‘sword stick’ or kept a fierce dog to protect their ‘person and property’ (see sidenotes 9 and 11 in the figure below). Besides, there were watercolour paintings depicting the conflicts between people from different social classes.



Poverty and protest

8 **Thomas Rowlandson** (1756-1827)
A View near Banbury
Watercolour, 1808.
This shows an unidentified village near Banbury, with two groups of people, one well-dressed and leisured, the other loaded down and impoverished. The context for the picture is the unemployment and unrest widespread in the countryside of Rowlandson's time.

Purchased with the assistance of the MGC/V&A Purchase Grant Fund and the Banbury Historical Society.

9 **Dog collars.** One way to protect one's person and property was to keep a fierce dog. The inscription on the larger collar reads 'H Charles, Banbury, Oxon. 1771. I am Joe Charles son of a bitch, whose impertinent son of a bitch are you?'

10 **Public notice** to ensure control of dogs, 1847

11 **Sword stick.** A popular form of personal protection for men – the walking stick concealed an effective sword.

Fig.5.5 Sidenotes for the items in the Banbury Museum, photo taken by the author in January 2020

The social and economic conditions did not seem to have improved enormously in the current century. After the town was flooded over the Easter weekend in 1998, residents in the affected areas suffered adverse and long-term impacts in health and housing (Tapsell and Tunstall 2008). [130] The survey of the Office for Health Improvement and Disparities (OHID) in 2019 also recognised that some areas in and around the town of Banbury were among the 20% most deprived areas in England. [131] Besides, the Banbury Health and Wellbeing Profile, published in 2019, identified 8 out

[130] Health geographers Tapsell and Tunstall (2008) found that most Banbury residents in the flooded areas had no flood insurance. They experienced injuries, infections, shocks, fatigue, nightmares, and low mood after the disaster. Many also felt stressed, anxious, insecure, and isolated. One respondent of their research even said, as they quote, that ‘I wish I’d never heard of Banbury.’

[131] The 20% most deprived areas were Banbury Cross and Neithrop, Banbury Grimsby & Hightown, and Banbury Ruscote. The Banbury town centre, including where the Orchard was located, was allocated in the Banbury Cross and Neithrop ward.

See the link to the report that contains information about the levels of deprivation in these areas: https://insight.oxfordshire.gov.uk/cms/system/files/documents/Cherwell_JSNA_2021.pdf
See also Chapter 6 for an introduction to the indices that the OHID used to measure the levels of deprivation.

of 27 public health indicators which were worse than the England average in Banbury, including male life expectancy, emergency hospital admissions, deaths from all causes, and hospital stays for self-harm. [132]

The deprivation was visible when one walked down the streets in central Banbury. The missing letters on the NHS building somewhat indicated the underfunded healthcare of the area. During the daytime, the benches on the street were often occupied by the homeless. I encountered twice a middle-aged woman asking me for money and saw her wandering in the town centre almost every morning.

Linda, the only member who was a Banbury local at the Orchard, said she knew the woman in person. She then said that the woman was not homeless but lived in a flat near where she lived. Linda believed that the woman was 'richer than all of us at the Orchard' because she received money from her mother every week. 'If you look at her carefully,' Linda explained, 'you will find her wearing a different piece of nice clothes every day!'

Although there were some exaggerations in Linda's comment, there were also some truths in her perspective on the members' economic status. Jen recalled that there were a couple of members who hardly did any craftwork but just showed up in the building before lunchtime. The lunch at the Orchard seemed to be the only meal they had in a day – or even in many days. I was not able to meet these members during the time of my fieldwork, possibly because the group was open at reduced hours and no longer catered lunch.

[132] See the link for the original data: https://insight.oxfordshire.gov.uk/cms/banbury-jsna-profile

In summary, this section reviewed the social, historical, and economic fabrics that textured Banbury's medical landscape. The deprivation of the area was visible, the moment one stepped out of the train station, and moved through the town centre to arrive at the building complex of the Orchard. As the next section will show, the deprivation that affected general health and social care in the area also limited the space and resources that the local authorities made available for the Orchard.

5.4 A small building and its workspace

This section looks at the workspace that people made use of when they did craftwork at the Orchard. After a brief review of how Restore found the small building for this recovery group in 2010, I present ethnographic accounts of the Orchard members' movements through the building spaces and their comments on the place. The section ends with a proposal for a larger, more illuminated, and better-ventilated place for the Orchard.

Setting up the Orchard

In June 2010, the Oxfordshire County Council and the Primary Care Trust commissioned Restore to set up a new recovery group in Banbury, because the two local authorities acknowledged the lack of mental health services in North Oxfordshire. The recovery group was first located in the Orchard Way Shopping Centre in the north-western end of the town. It was 20 minutes' walk away from the town centre and was 'very small and hard to get to' for the recovery group staff and members (Annual Report

of Restore, 2010-11). The Cherwell District Council provided these spaces however only for a short term, so Restore needed to find a more permanent site for the Orchard.

In March 2011, Neil Wild, the founder of the Wild Property Consultancy, helped Restore to find a more permanent place in the current location of the Orchard. It was a small building on Calthorpe Street in Banbury town centre. The building was a showroom owned by the Barker Family. The landlord generously allowed Restore to change the use of this property. In this way, a showroom became the site of the Orchard up to the time of my fieldwork.

Besides the help from Wild Property Consulting and the Barker Family, The Banbury Charities Organisation donated £1,700 for the Orchard to purchase tools and materials for organising craftwork. [133] The organisation also put Restore in touch with Sapa Profiles, an aluminium manufacturing company. Since Sapa was closing its business in Banbury, it donated all its office furniture and equipment to the Orchard. The setting up of the Orchard, in this way, combined local efforts with the limited funding and resources provided by the statutory funders, which at the time was the Cherwell District Council, the Oxfordshire County Council, and the Primary Care Trust.

In the diagram below, I demonstrate the different rooms in the Orchard's building complex. Most members spent most of their time of the day in either the craftwork room or the woodwork room. Besides, there was a shop at the entrance, a meeting room, two offices, and some facilities, including a small 'quiet room' for people to make

[133] Banbury Charities is a partnership of eight registered charities. See information about this group at: https://banburycharities.co.uk/

phone calls or have private conversations.

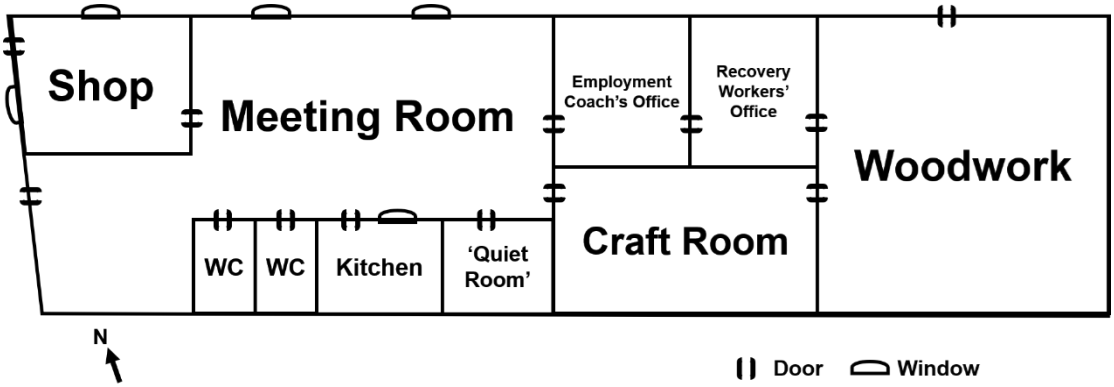


Fig. 5.6 The different rooms in the building of the Orchard, diagram made by the author

Although the building in the town centre was larger than the original place at the Orchard Way Shopping Centre, it was still very small in comparison to the buildings used by Restore's Elder Stubbs and Garden Café recovery groups in Oxford. As the figure below demonstrates, the Orchard, with the largest number of members, had a building that was not quite the same size as the Garden Café, which had the smallest number of members.

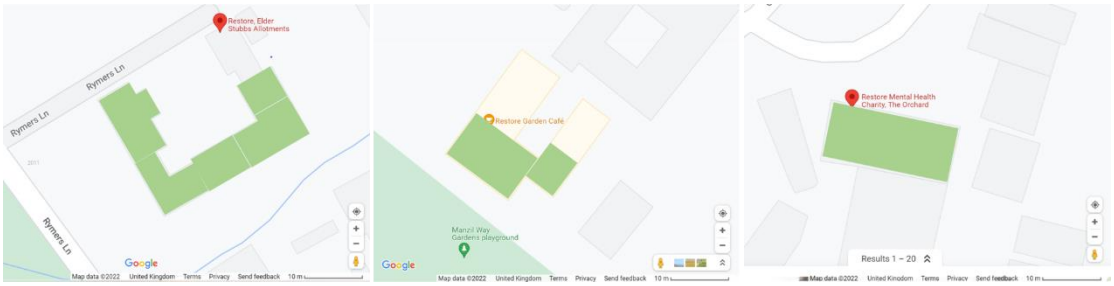


Fig. 5.7 Comparing the buildings at the Elder Stubbs, the Garden Café, and the Orchard, diagram made by the author from Google Maps in 2022

Moreover, the building used by the Orchard had fewer windows than the ones in the two recovery groups in Oxford. The buildings at the Elder Stubbs and the Garden Café had at least one window in each room. The building used by the Orchard, by contrast, only had windows in the meeting room and the shop. The rooms where

members did craftwork had no windows at all. [134] As will become evident below, the building size and the number of windows directly affected the members' sensory experiences. I shall elaborate on this in the next subsection.



Fig. 5.8 Outside the building complex of the Orchard, photo taken by the author in January 2020 [135]

The choice of rooms for craftwork

After catching up with Iris in the meeting room on our tour through the premises of the Orchard, Sage and I walked from there into the craftwork room to see the activities taking place there. The door between the two rooms was left open throughout the day, with air and sound flowing through in between. We passed the kitchen on our

[134] This was probably because that the buildings at the Elder Stubbs and the Garden Café were designed and constructed solely by Restore with funding and grants that the charity obtained in the 1980s and 90s (see Chapter 3), while the building used by the Orchard was converted from a showroom, as introduced.

[135] The group repainted the exteriors of the building in October 2021. See photo after the work: https://twitter.com/oxrestore/status/1446499123407036478?s=20&t=WeNmG2kgcCW5a8IRQ-omOw

way and said ‘hi’ to Katherine who was baking by the serving window. We helped her break two eggs into the pudding mix and heard a burst of laughter in the craftwork room. When Sage and I eventually entered the craftwork room and joined the chat, we were surrounded by the warm smell of the bread pudding coming from the kitchen.

There were around eight people in the craftwork room, one was a man and the others were women. Karen was making a wreath with scrap fabrics she had selected from a large box. She chose specifically the blue ones and the green ones to create a balance of colours. Morrison was stuffing a toy koala with cotton. Jane was on a sewing machine making a pink apron. May was needle-seaming a tiny puffy doll for a key chain. Amy was selecting beads from a tin to make a bracelet. Seeing Sage with me on our tour, Amy gagged with Sage. Karen asked me how long I had been in the UK, and Morrison was curious about how I found life in Oxford.

I found the temperature in the craftwork room slightly higher than in the other rooms in the building. It was potentially due to the density of people working in this room. Since the craftwork room had no windows, it also felt dimmer than the shop and meeting room.

In the following weeks when I worked in the craftwork room, I found that members worked in this room differently. Some members, such as Linda and Jess, seemed to like the sense of togetherness of working with others in a small and dark room. They tended to stay in the craftwork room for most of the day, making craftwork pieces while holding conversations about their weekend plans, family life, and relationships.

As Tuan Yi-Fu noted, the comparative smallness and largeness of spaces do not always indicate people's sense of crowding and spaciousness, because one's perception of the space is strongly influenced by culture and experience (Tuan 1977: 55). The people in a room can crowd us out but also enlarge our world. Tuan emphasised that when people work together 'for a common cause', they do not deprive each other of space but enlarge it by giving each other support (ibid. 64). In other words, the ways in which people participated in the craftwork activities at the Orchard would affect their perceptions of their surroundings.

Following Tuan's observation, members working in the same building of the Orchard might experience the building's spaces differently because everyone was at the centre of his or her world and had a sufficiently different body schema to differentiate with nuance the circumambient space one experienced (Tuan 1977:41). Some members, as stated, enjoyed the sense of company which was intensified by the crowding of people. Others, however, disliked working in the craftwork room precisely because of its crowdedness. Rebecca, for instance, commented that the room was 'too dark and depressing' as it reminded her of the abuse she experienced in childhood. She said she would have a panic attack if she stayed in the craftwork room for too long.

Katherine also found that the aisles in the craftwork room were too narrow for her to move about with ease. Once when she dropped a box of fabrics on the floor, she had to ask me for help because bending down and picking the fabrics up was difficult for her. I found the narrow aisles in the craftwork room inconvenient as well. When someone took a sewing machine or spent some time selecting the card paper from the

shelves, others had to wait until she returned to her seat to pass the aisle between the shelves and the tables.

Members who did not enjoy being in the craftwork room worked in the meeting room instead. The meeting room was one of the only two rooms in the building that had windows (the other was the shop). Members who chose to stay in the meeting room expressed their preference for the 'brightness' of the room. They said that the air was also fresher in the meeting room.

Jen, the group coordinator, was aware of the members' preferences. She let people choose the place they preferred. However, when Jen was on annual leave, a new locum staff came down from Oxford to supervise the Orchard. A dispute broke out among the group after the staff asked everyone in the meeting room to work in the craftwork room. Eventually, Sage, the volunteer-to-be, stood out and explained to the locum staff the reasons why people needed to work in different rooms. She also walked out of the building to look for members who left after the dispute and invited them to continue working in the meeting room.

In summary, members worked at different places in the building complex of the Orchard. Some members did not mind working in a small, windowless room and seemed to enjoy the feeling of closeness and sense of company. Some members, however, preferred working in the large meeting room with access to natural sunlight and fresh air. Regardless of the members' different preferences, the size of the Orchard building was in general considered as too small for a large recovery group of sixty members. There should also be windows in the craftwork room. My ethnographic

observation related in this subsection, therefore, could be read as hints that these aspects need to be improved. Overall, precarity can be 'placed' in the service users' access to healthcare facilities, as Natassia Brenman (2020) argued. The building spaces of the Orchard were immediately sensible and affective to the body through their materiality.

However, my aim in this chapter is not merely to point out the existing problems in the building spaces. I also wish to highlight another story, one that emphasises the intertwined spatial-bodily relations generated by people's regular commute and the spatial layout that textured members' participation in the recovery group work. I shall elaborate on this story in the sections ahead.

Working around the tables

In the craftwork room, people sat in a circle around the tables, enclosed by tall shelves behind them by the walls. These shelves stocked all sorts of materials and tools, such as sewing machines and paper cutters; boxes of beads and stones; drawers of crayons, needles, and pencils; piles of card papers and magazines; and rolls of wires, strings, and laces.

Members who fetched the materials to work in the meeting room also sat in a circle, and generally there was a large space between one person and another. In both the craftwork room and the meeting room, people put their projects on the table in front of them. While working and talking, they saw not only their own projects but also the ongoing work of the others.

Similarly, people in the woodwork room gathered around the workbenches in the centre of the room. Like in the craftwork room, the central working area in the

woodwork room was surrounded by shelves, tools, and in this context, many types of woodwork machinery. The hand tools were stored in a large cabinet on the wall. On the long tables by the walls, there was a pillar drill, a chop saw, a scroll saw, a lathe, a biscuit joiner, a few jig saws, and some cordless hand drills. In the corner by the emergency exit, there was a large bandsaw and a sanding station. I learnt about the names of these pieces of machinery at the safety induction with Eva but did not manage to try out all of them.

The woodwork room had no windows either. Members and staff who worked in this room sometimes opened the emergency exit to increase ventilation. The woodwork room was larger than the craftwork room. The distances between the workbenches and the surrounding pieces of machinery were also wider than the aisles in the craftwork room. While working, most woodworkers stood by workbenches rather than sitting down because they often needed to bend down, step backwards, and walk between the workbenches and the surrounding pieces of machines.

Like the tables in the craftwork room, the workbench became a platform that the woodworkers shared with the others. When the woodworkers used clamps (see Fig. 5.9 below) to clamp their woodwork pieces in the making on the workbench, they became textured to the workspace of the woodwork room. One could see the other people's ongoing projects clamping around the workbenches, while others could see her piece as well. The intercorporeal relation among the workmates was intensified by their mutual awareness and their spatial texturing around the workbenches. When I was carving out a cooking spoon, Eva was gluing together a hedgehog house next to me.

Benedict was sawing some bamboo sticks opposite us. He was making a bug hotel in the shape of a pagoda. By working around the workbenches, people became attentive to not only their own projects but also other people and their craftwork pieces.

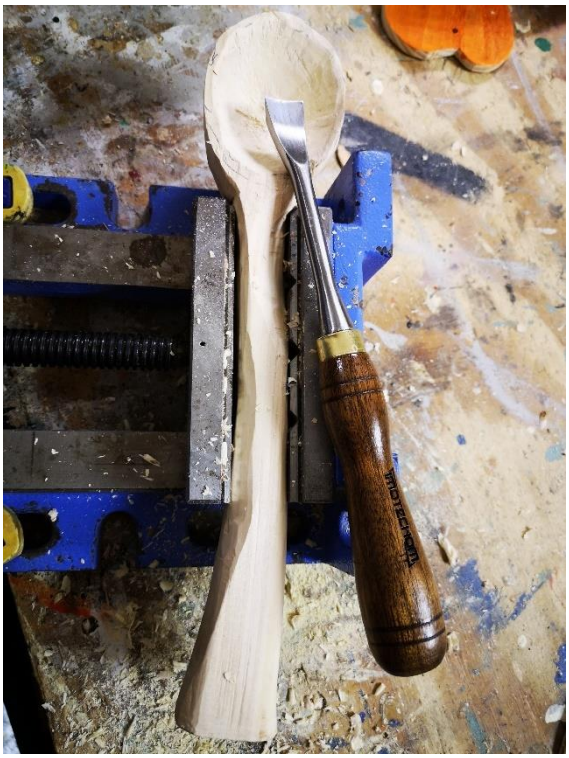


Fig. 5.9 A wooden spoon clamped on the workbench, photo taken by the author in March 2020

Moreover, when people worked in a circle in the woodwork room, the craftwork room, or the meeting room, they all looked towards the centre of the room and were oriented towards the same area of space as were the others. The air, body heat, sounds of laughter, and words of small talk flowed above the table, giving rise to a palpable sense of togetherness. This sense of togetherness sometimes prompted a lively atmosphere. Most importantly, the sensory experience of working around the table generated synchronicities, which could induce therapeutic efficacy by heightening one's orientation to other people and things. (Hsu 2005) When Adam turned on the radio at 10.30 am in the woodwork room to do the pop music quiz on the BBC

programme, 'Pop Master', other woodworkers around the table joined him as if they were having a pub quiz. [136] One morning, Ken Bruce the broadcaster played the song, *Yesterday Once More*, and asked which band had performed it ('The Carpenters'). Everyone laughed.

This sense of togetherness and proximity at work also cultivated friendship and companionship among members. Karen and Celine often sat alongside each other in the craftwork room. And they often hung around together in Banbury town centre in the afternoon. I bumped into them twice when they were shopping for groceries on the High Street. Jess and John who pulled each other's legs across the craftwork room tables both signed up for the Tai Chi and Wellbeing class at the Recovery College. [137] When I met them in the class, Jess referred to us three as 'the Restore gang'. She also helped John at an occasion when he felt unwell and needed a break during the class.

In summary, when people worked around the tables in the craftwork room, the meeting room, and the woodwork room, they became related to each other through the small talk and the mutual presentation of their ongoing projects. Considering that people came together from villages and towns near Banbury (as Section 5.3 discussed), the long-distance commute turned into close interpersonal exchanges at work, a process to bring everyone close together through their orientation and movement in space. This process of gathering under the same roof to work around the table, I propose, emplaced and empotted the members into the communal workspace of the Orchard.

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[136] See the link to the programme: https://www.bbc.co.uk/programmes/p06q6h18/episodes/downloads

[137] Restore's Recovery College courses in Banbury took place at the Banbury Wellbeing Hub of the Oxfordshire Mind, which was only ten minutes' walk away from the Orchard and was on the Britannia Road near the (Banbury-)Oxford canal. See the introduction to the Recovery College in Chapter 1.

5.5 Caring through crafting

This section proposes two criteria that substantially contributed to a service member's transition to training for volunteering roles at Restore. The first criterion draws on one's mastery of the skills and techniques for the work. In the context of the Orchard, the criterion may lead to a caring, empathetic engagement with one's own craftwork project. The second criterion is the willingness to care for others by helping them with their ongoing projects. As the ethnographic examples below will demonstrate, to offer appropriate care for others in the group also demanded sensitive attentiveness and flexible practice.

I argue that a successful transition into volunteering roles, substantiated by the above two criteria regarding one's ability to care, should be regarded as a valid way of 'moving on' which did not require one to move out of Restore. Moreover, making one's own project and offering help to others promoted one's sensory engagement with the people, things, and tools. The process of making, therefore, is also a process of generating therapeutic sensory relatedness. Such bodily-felt processes would alleviate the problem of orientation as experienced in mental illness, that the body-self was close from any motor skill, sensory engagement, or perception with others (review in Chapter 1). In this way, a member's becoming of a caring volunteer at Restore should therefore be treated as evidence of therapeutic efficacy.

In the co-edited volume, *Care in Practice*, Mol, Moser, and Pols highlight the ontological significance of care. They propose an 'adaptive tinkering' of care, which they define as a practical modality of attentive experimentation (Mol, Moser, and Pols

2010:13). They describe that good care is like 'persistent tinkering in a world full of complex ambivalence and shifting tensions' (ibid. 14). Such 'persistent tinkering' then embeds the caring practice in the responsive and reflexive processes of trying out, adapting, and making subtle adjustments. In other words, it made the provision of care more coherent and flexible.

Mol, Moser, and Pols specify their discussion of the 'tinkering of care' to 'farming, health care and care for people who are old or who cope with disabilities' (ibid. 8). They especially note that the craftsmen's care for their projects or the gardeners' care for the plants were not within their range of study. However, their framing of the 'tinkering of care' highlight a situation-based and practice-oriented understanding, which is highly informative to my ethnographic analysis of the caring practices that transform a member into volunteering roles at the Orchard.

As Mol and colleagues argue, the 'tinkering of care' does not produce general principles but offers 'local solutions to specific problems' (ibid. 13). At the Orchard, indeed, one's practice of care was closely entangled with the ongoing craftwork projects. By helping a workmate to solve the practical problems encountered in craftwork, one offered care to the workmate.

Since the existing literature on the 'tinkering of care' does not include the caring practice in craftwork, as Mol and colleagues acknowledged, a sensory medical anthropological approach has us researchers look precisely at this hands-on activity organised for therapeutic purposes. I propose that sensory medical anthropology may contribute a novel way to the examining of the *things* occurring in caring encounters,

thereby effecting an empotment of the people ‘tinkering’ with these things.

As the ethnographic details in this section will demonstrate, the practical advice and hands-on engagement with ongoing craftwork offered a volunteer-to-be some legitimate means to care for their workmates. To care, therefore, was not only about attending to people who mattered, but also to pay attention to the *things* that mattered to these people. By caring through crafting, one placed oneself in a triadic relation between carer and cared for and an indirect relationship from person to ‘pot’ (craftwork) to person rather than in a person-to-person encounter, which can be experienced as quite threatening by some people. The craftwork as the third player in a caring encounter then helped a volunteer-to-be not to be experienced as directly over-interfering into his or her workmate’s personal space or privacy. The indirect relatedness to another person, through direct involvement with the ‘pot’ as a third player, allowed for the maintenance of protective boundaries.

The therapeutic process of restoring a table

At the Orchard, members, locums, and volunteers each had their own projects. The wooden plate, for instance, was Sage’s project. As our tour ended in the woodwork room, Sage asked me to think about which craftwork I wanted to make as my first project in the group. She also reassured me that she would love to help if I needed her guidance for craftwork.

In line with Restore’s ethos, the things that people made were displayed for sale in the shop at the building entrance, as already said. Besides, the woodworkers also received orders to make bird boxes, bug hotels, and sometimes more special

commissions such as to restore a vegetable storage rack or a dining table. [138] Those items went directly to the customers without being first on display in the shop.

The ownership of projects stood out as a major difference between the work at the Orchard and the work in the other two recovery groups. Neither in the Garden Café nor at the Elder Stubbs allotments was there a clear boundary between one's own work and the work of the others, because things were always made, grown, and sold through group collaborations (see Chapters 4 and 6). People also seemed to have different ways of communication when they did different types of work. The gardeners at the Elder Stubbs often worked in comfortable silence. The Garden Café's baristas and chefs were entangled in frequent exchanges of words during the peak hours, but the conversations were mainly about the customers' food orders. At the Orchard, people enjoyed chatting while sitting around the tables and they spoke about all sorts of topics when they each worked on their own ongoing projects. By the end of the day, when the whole group gathered in the meeting room, they each presented the progress of their projects one after another.

One morning, Bertrand came for a chat when we were in the woodwork room. Bertrand was a tall, thin man in his middle age. He said he lived with his partner 'near Banbury'. At the group meetings, Bertrand was usually very quiet and often looked serious. However, once entering the woodwork room, he became very chatty and passionate about both his own project and the projects of others. I was not sure if

[138] During the very brief time of my fieldwork, I rarely saw any walk-in customers. Rather, the visitors to the building were often people who needed changes to pay for their parking fees. However, my fieldwork time was too short for anyone to form a conclusion that the Orchard had fewer customers than the other recovery groups of Restore. Nor was I able to tell if the number of customers had affected the therapeutic effectiveness of the recovery group work.

Bertrand was even interested in the volunteer transition training since he did not put down his name on the list. However, Bertrand was one of the best woodworkers at the Orchard. Other members would always ask him for help and advice when they encountered problems in their projects.

'Of course, the work here is therapeutic.' Bertrand started the conversation with a confirmative answer to my research question that I introduced in the morning group meeting. 'However, it works differently on different people.' Bertrand then explained that 'the ladies in the craftwork room' might be benefited more from chatting and offering companionship to each other, but it was the exact woodwork project that 'worked' on him. Bertrand explained that, by concentrating on woodwork, he was able to take a break from 'other dark things in life', the things consistently bothering him that he did not want to go into details or even recall for himself. Although the relief generated by his project was merely temporal, he considered it essential and meaningful.

Bertrand then pointed to an old dining table in the corner of the room. His project at the time was to restore the table. Bertrand explained that the table was originally broken and had been disposed of. However, it was made from very fine wood and the design was old-fashioned. He then walked back to the corner to show me the detail of the table: it had leaves dropping on its sides which could be folded up to serve a larger group of people. It was a flexible piece of furniture because it could be used as a small, square table or a large, round one.

Bertrand recalled that when the table was delivered to the Orchard, the hinges for the leaves were broken. On the day we had our conversation, Bertrand had just fixed

the hinges. He seemed pleased about the work and was excited to show me the outcome. I praised the table's flexibility and Bertrand announced that the next step was to completely sand down and polish the wood. 'One day,' he said with aspiration, 'it might be purchased by someone, and have another life at a new home.' He seemed to have internalised Restore's ethos to be a community store.

After our chat, Bertrand picked up a piece of sandpaper and spent the rest of the day hand-polishing every corner of the table. He started from the surface in the centre and polished from there in the centre to the leaves on the sides. He then reached for the four legs. With high concentration, he did not miss any gaps or edges. And by the end of the day, his hands and sleeves were covered with wood dust. At the afternoon group meeting, Bertrand was cheerful when he provided an update about his project.

In *The Pursuit of Pleasurable Work*, Trevor Marchand discusses the craftsman's empathetic engagement with the materials and tools. As Marchand notes, a master woodworker can 'feel for the timber and for the tool-in-hand' (Marchand 2021:245). The body's empathic engagement, Marchand specifies, is developed in everyday practices.

Bertrand was a woodworker who empathetically engaged with the tools and materials. At another occasion when he demonstrated to me the ways to chop a stick of bamboo into short pieces, the bamboo split into halves while sawing. Benedict stopped the work at once and said, 'It does not like it.' He then carefully adjusted the blade of the handsaw and performed the sawing technique again. While sawing, he explained that 'The tool would do its work'. The empathic engagement with tools and materials,

I argue, was not merely a psychological projection, but also a practice of caring. It was a craftsman's care for the things he engaged with in an ongoing project.

Marchand also notes that a sense of 'deep satisfaction' may derive from the process of finishing a woodwork project from start to finish (ibid. 239). This sense of satisfaction was not only about the complement of the project. It was also about the pleasurable process of working with the wood which 'stimulates and heightens the senses of sight, touch and smell' (ibid. 210). When Bertrand was sanding and polishing the fine wood surface of the dining table, he praised it for its density and hardness. And when Eva was chiselling a spoon, she praised the natural curvy patterns of the olive wood.

However, two weeks after the careful work of sanding down the table, Bertrand encountered a problem. The wood finish he applied on the table made the surface hazy and cloudy. Being extraordinarily quiet, Bertrand bent down to examine the surface and frowned, looking clouded by the problem. It was a breathtaking moment for most of us present in the woodwork room. I remained quiet, while David the volunteer came along to help. David and Bertrand reflected on the work done in the previous weeks to check if the wood finish was applied when the surface was still wet, or if an unsuitable product had been chosen for this type of wood. They then came to the decision to wipe off the finish with alcohol and try out another type.

In the following week, Bertrand wiped down the polish with great effort. As the cloudy hue on the table surface gradually disappeared, he became relieved and was no longer frowning. I did not manage to see the last step of his restoration work due to the

unexpected termination of my fieldwork. However, the most critical challenge seemed to have been resolved. As the cloudy hue disappeared from the surface of the table, the cloud on Bertrand's face also disappeared when he updated us about the work on the table in the afternoon meeting.

Trevor Marchand described problem-solving in woodwork as a multi-sensory process. With the eyes scanning around and the body bending down, different visual perspectives were achieved to examine the problem. Although the detective work may delay production, it often progresses learning (Marchand 2021:235).

From the lens of sensory medical anthropology, I argue that problem-solving in woodwork can also be a therapeutic process. Besides the deep satisfaction and increase in confidence one might obtain after completing the project, the restoration of a dining table also prompted the body to become active in its sensory engagement with the work. The fixing of hinges allowed free movement of the dropping leaves, which prompted Bertrand to aspire for the table's new life. After sanding, the surface became smooth; and after washing off the wood dust caused by sanding, the hands also regained their smoothness. When the surface was covered with unexpected clouds, the person's eyebrows curled, and the mood became somewhat clouded. However, when the milky layer was washed off, the wood and the person both appeared to breathe easier.

The restoration of the wooden table, I suggest, simultaneously generated a betterment in the well-being of the woodworker. To a certain extent, it allowed Bertrand an escape from the dark moments in his life, as the work demanded high concentration and careful bodily engagement. It requested him to be fully present in the here and now.

The empathetic process of restoring the table was not merely achieved by psychological imagination, because Bertrand cared for the table with his bodily conduct. Overall, it was the craftsman body's sensory engagement and careful movements that generated the changes demanded for the completion of his project. And Bertrand, as a member of Restore, also benefited from the therapeutic process in a bodily fashion.

In summary, this subsection looks at Bertrand's project to restore a dining table. As one of the best woodworkers at the Orchard, Bertrand demonstrated mastery in woodworking knowledge and in bodily skills to solve the problems he encountered during the process. He had an empathetic bodily engagement with the wood and his tools, which made him care about the future of the table he fixed, polished, and restored.

The quality of being a skilful woodworker, I propose, is essential for volunteering at the Orchard. Moreover, the caring and empathic engagement with one's craftwork project had therapeutic indications. Bertrand said that the concentration and bodily engagement during the work could temporarily divert him from the darker moments in his life. With a sensory medical anthropological interpretation, I argue that the efficacy was generated through the effortful and empathetic body that resonated with the craftwork.

Caring for others through craftwork

Although members and volunteers at the Orchard each focused on their own craftwork projects, they also collaborated. Not everyone was a skilful craftwork person when he joined the recovery group. When a novice encountered a problem at work, he could ask for advice from others who had more experience in the work.

People who went for small handcrafts could use handbooks on the shelves in the craftwork room to learn knitting, sewing, drawing, and toy-making. They could also ask for advice from their workmates in the craftworks who had more hands-on experience in the work. Besides, Jen would occasionally invite local professional craftsmen and craftswomen to give classes on origami or basketry. The classes took place very frequently so even I had a chance to attend a clothes-dyeing class during the very short time of my fieldwork.

In comparison, the woodwork skills were much more complicated to learn due to the many hand tools and pieces of machinery used. Many members in the woodwork room, therefore, did not have a goal to become professional carpenters. What mattered more to them was to make high-quality products for the customers who had commissioned their work or for sale in the shop.

The volunteers I met at the Orchard were all very skilful in craftwork. [139] Besides, they were also very observant and had the social skills to care for the members' ongoing projects. When there was no one came to them for help, they could spot the person in

[139] Regarding the other volunteers' competency in craftwork, my volunteering role was somewhat illegitimate since I had no skills in woodwork at all. Members at the Orchard noticed the difference when they saw me working in the woodwork room. However, they also seemed to accept the difference and perhaps treated me more as an anthropology researcher rather than a volunteer.

need of some additional support and approach the person without making him or her uncomfortable.

David, for instance, often started a conversation by saying, ‘Hey, what are you up to?’ When Morrison explained to David that he wanted to make a toy trailer but could not understand the first few steps in the handbook, David listened patiently to his plan and read the handbook with him. After knowing Morrison’s concern regarding the wheels of the toy trailer, David reassured him, ‘We can make one with spinning wheels!’ David then discussed with Morrison the first few steps in the handbook. After watching Morrison getting started and making sure he was ‘on the right track’, David went to his side of the workbench to continue making a birdbox.

Regarding the above interactions, David as a volunteer noticed that Morrison was getting stuck with the handbook. He approached Morrison with a casual catch-up. The caring support that David offered adapted to the specific craftwork problem that Morrison needed to solve. The help, therefore, could be regarded as a practice of 'tinkering care' tailored to the situation.

Similarly, Joanna once heard me complaining that the circles I drew were not round enough. She then drew out from her pocket some circle-shaped models which she cut from card papers. Putting all the card-paper circles on the table between us, Joanna invited me to pick any circle that may help with my design. Later when a locum worker came down from Oxford, Joanna introduced herself to him that she used to be a member at the Orchard ‘many years ago’. She had completed the Transition Training and worked as a volunteer for another five years in the recovery group.

Like David, Joanna was observant and would reach out to someone who needed technical support. She had skills in small handcrafts. I often saw other members asking her for advice and comment about their work. Joanna also knew many members for a longer time than did most volunteers. Like Jen, Joanna was aware of different members' preferences of the workspace or knew the types of small handcraft they enjoyed doing.

I also saw members who signed up for the volunteer transition training in 2020 offer help to others. Sage, my guide to the Orchard's building complex, proposed to help me explore what I wanted to do as my first project when we finished the tour on-site (see above). Richard, another member who put down his name for volunteering, also helped Jane solve the problem with the hinges of her toy box. Jane thanked him in the afternoon group meeting. As one of the best woodworkers on Friday, Richard also collaborated with Andrew to make a nice bug hotel commissioned by Lesley, Restore's CEO in 2020. They delivered the bug hotel to the charity's Manzil Way headquarter when they participated in the induction course for new volunteers.

Some members did not put down their names for volunteering but helped their workmates with their projects nevertheless. Bertrand, for instance, was a skilful woodworker who was always willing to discuss with people about their projects. When I said I wanted to learn sawing, Bertrand came to see how I was doing. After watching me saw, he asked if he could offer some tips. With my consent, Bertrand pointed out that many beginners tended to see woodwork as a heavy task and thus pressed hard on the tools and the materials. However, if the technique was right, 'the saw will do the work'. He then fetched the junior hacksaw from my hand to examine if its blade was

‘aligned’. He also adjusted the clamp I fixed on the workbench to make sure that the plywood would not move back and forth as I sawed.

With all the preparation work done, Bertrand started explaining the technique of sawing. ‘Once placing the saw on the wood, you should use your thumb to fix its position.’ He bent down a little bit closer to the workbench, using the hacksaw to cut quickly into the plywood. Taking a pause to stand up, he then began sawing along the pencil-line I had drawn on the wood. ‘If you do not saw in an even line, the cut on the wood would be uneven.’ He explained while sawing. ‘And if you press the saw heavily down to the wood, it will get stuck and split.’ After sawing off an edge from the plywood, Bertrand stood straight, handed the hacksaw back into my hands, and concluded, ‘As long as you *drag* the saw back and forth, it will do its work.’

I then got my hands on the hacksaw while Bertrand returned to work on the dining table. After a few attempts, the work felt less strenuous, and the hacksaw in my hands moved much more easily and smoothly in the plywood. Just when I felt that my movement became what Bertrand meant by ‘dragging’, I heard his comment from the corner of the room, ‘That *sounds* about right now.’ As Trevor Marchand noted, the sounds and auditory senses were often adopted to monitor a woodworker’s performance and progress (Marchand 2021:211). In the tutorial, Bertrand noticed my improvement by listening to the sound of my sawing. And as I noticed in the following days, the piercing and crackling sounds of the wood often indicated that someone had encountered a problem in his work, while the tuneful and rhythmic burking, clerking, and dirking were often taken as good signs.



Fig.5.10 The author's first 'project', made with the help from Bertrand, photo taken in February 2020

In the above examples of craftwork collaboration, people who offered technical help to others' projects also practised a tinkering way to care. The question that the helpers asked focused on the specific problems one encountered in craftwork. Nothing personal was inflicted and the strategy targeted right to a solution for the problems.

Notably, one's caring through crafting included a third player in the process, which was the ongoing craftwork project. Both the owner and the helper attended to the craftwork piece in making, which I argue to be the 'pot' that afforded the two (human) participants' attention and bodily perception. Both workers were thus 'empotted' within this triadic relation to care for the piece of craftwork. Their eyes looked at the same plank of wood and their ears listened to the sounds of the hand tools.

Moreover, the craftwork as 'pots' did not only afford people's sensory engagements. It also generated uncertainties for the caring practice to 'tinker'. The wood might not 'like' the tool and the tool might not like it being used with the wrong techniques. A 'pot' was always embedded in an ongoing process of changes. It was this

openness to changes, I argue, that enabled the tinkering of care and the correlating therapeutic efficacies to happen. As Marchand notes, 'skilled handwork lends practitioners a vital sense of agency to make, undo, repair and transform their world, and the world of others, in immediate, practical, hands-on ways' (Marchand 2021:215). The craftworkers' sensory engagements with the project and with each other opened the possibility for them to transform each other's life worlds. It was an indirect way for one to offer care to another. Nevertheless, the two workmates in collaboration experienced together the worry when the problems occurred. They also shared the joy with each other when a project was beautifully completed.

The work and care around the projects also maintained a protective interpersonal boundary for members and volunteers. To work as a Restore volunteer, one needed to follow the regulations and keep boundaries with members. The boundary-keeping was necessary because one might risk one's own wellbeing by interfering too much into others' personal lives. For volunteers and volunteers-to-be at the Orchard, the focus on one's craftwork project offered a legitimate way to provide care and support with reduced risk of breaching the protective boundary.

For instance, when Jen noticed Karina sitting still by the table without talking to others or working, she could ask about her ongoing project other than asking directly if something was wrong in her personal life. The other time when Linda was becoming a bit too open about her private life in the craftwork room, Eva called out the phrase, 'fluffy bunny', which was a sign to suggest the group change a topic. Eva thereupon instantly asked Jess about her progress in sewing.

In summary, this section proposes two criteria that can substantiate a member's transition to volunteering roles at the Orchard. One's own mastery of craftwork skills and techniques, as the first criterion, enabled the member to cultivate attentive and empathetic relatedness with his or her craftwork materials and tools and thus to make high-quality products for sale in the shop or for commissions. The second criterion, which was to use one's skills to help others with their projects, then enabled one to offer adaptive care that focused on solving the problems that others encountered in craftwork. This focus on the ongoing craftwork project, I propose, offered a safe platform with protective boundaries for one to care for others.

5.6 Conclusion

This chapter looks at people's craftwork at the Orchard, Restore's only recovery group in North Oxfordshire. I looked at the spatial arrangements of the Orchard's building complex and proposed that the textured spaces of the building were conducive to therapeutic encounters. Specifically, I noticed the nuances in people's experiences of the workspace. While some members preferred the small craftwork room with the company of a crowd of workmates, some preferred the larger space and natural light in the meeting room. Some preferred sitting by the table doing small handcrafts, and some preferred standing by the workbenches to do sawing, drilling, and sanding for woodwork. In either room, people worked in circles around the table, attending to their own ongoing projects while being aware of the chats or the work of others.

A close examination of people's attendance to the craftwork projects of themselves and others revealed the therapeutic processes generated in craftwork. Either to care for one's own work or the work of others, the person became empathetically oriented to other people, the craftwork materials, and tools. The body became open to the world, adapting itself to the complex situations generated by the ongoing craftwork, and making attempts to solve the technical problems encountered. It was a therapeutic process that generated bodily concentration and sensory relatedness with others. As Bertrand explicitly noted, the woodwork projects at the Orchard diverted him from the darker moments in life. Either for a short while or for longer, they were perceived to be highly effective.

Besides presenting ethnographic accounts of members' work at the Orchard, I discuss a matter regarding treatment evaluation, which was experienced as a practical matter of the volunteer transition training for the members. I propose that the members who had the skills for the work at the Orchard and who were willing to help others with their craftwork projects should be encouraged to become volunteers at Restore. The OMHP measures should acknowledge the volunteer transition as a service outcome, although the betterment was not achieved through 'discharge' but as a promotion of one's career. Some former members who transformed into volunteers at Restore were later employed by the charity as part-time and full-time staff in its offices and recovery groups. Some even got promoted to more senior posts. Such a career pathway, I propose, is worth to be popularised. And the current regulations regarding the members' volunteer transition training should be more supportive and flexible.

The study in this chapter, however, was also limited by the very short time of fieldwork. Since I only spent thirteen days working at the Orchard, I could not witness the complete processes of most members' craftwork projects. To thicken the discussion in this chapter, I worked with my notes from a visit to the Banbury Museum and several empirical materials about the provision of health and social care in Banbury. The examination of space in sections 5.3 and 5.4, therefore, should also be read as a proposal for the local authorities to provide more statutory funding and better facilities and resources for Restore's mental health recovery group in one of the most deprived areas in the country.

Chapter 6. Employment, emplotment, or empotment?

Becoming a host in the Garden Café

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6.6 Conclusion

It was a Thursday morning in January 2020. Everyone attending the morning meeting of the recovery group was attracted by the stunning view of the garden. The warm sunshine touched the lawn and the bushes. Everything was plated by the golden sunlight, from the wooden tables by the flower bed to the high hedges at the end of the curving pathways.

Sarah, a recovery worker in the Garden Café, started the group meeting with a

slightly unusual question. She asked, 'If, without considering the cost, you were to spend this sunny day elsewhere, where would you go?'

Sean said he would go bowling. He was our cash-till master who remembered the price of everything. Ben the barista who often worked by the counter with Sean said he would watch a live football match. Joseph – also keen on sports – hummed in agreement. He wanted to go rock climbing in Derby.

Sarah laughed cheerfully and said she would go photograph Joseph climbing. Besides working in the recovery group, Sarah was an amateur photographer who was about to open a course at the Recovery College [140] with Alex, a member of the Garden Café who was also keen on photography.

Greta who became a recovery worker in 2019 said she wanted to visit a cat café in London. Then it was my turn. I said I wished to explore a walking pathway by the River Thames which I discovered on the train to Banbury. Sean was interested and asked me which train stopped by this riverside pathway.

Our discussion in the morning meeting intrigued me because the 'what if', or the subjunctive mode in people's speech, contains some degree of reality, a sense of practicality. People talked as if they were genuinely planning for the day. They engaged with their hobbies and interests and thought through different possible routes to reach their destinations.

Medical Anthropological studies of illness narratives reveal the close connection between the subjunctive mode and healing. As Good and colleagues note in their study

[140] See an introduction to the Recovery College in Chapter 1.

of the epilepsy narratives in Turkey, the ‘subjunctivizing tactics’ allow the sufferers and their families to justify their attempts to continue seeking care while maintaining hope for positive outcomes (Good et al. 1994: 837). In other words, one needs to be wanting to be better so as to be healed. Similarly, the Garden Café members’ imaginative plans for a sunny day out also set up an attitude of being open to life. It might work as a prompt for one to leave one’s house and become explorative to others and the world.



Fig. 6.1 The indoor seating area of the Garden Café. The place was for customers during the Café’s opening hours, while recovery group members and staff also used the tables and chairs for their morning and afternoon meetings. A photo taken by the author in June 2023

Members of the Garden Café, however, did not only make plans for a sunny day. When Restore set up this recovery group in 2008, one of the purposes was to support more of its members into paid jobs. Meanwhile, many gardening and craftwork groups

of Restore had been filled up and encountered difficulties to accept new members. Although the existing members at the time had not yet been asked to 'move on' within two years, they were encouraged to explore opportunities outside the charity with the support of Restore's employment coaches.[141] The setting up of the Garden Café thus had a mission to offer more 'practical skills' that fitted into the demand of the job market.[142]

After Restore became part of the Oxfordshire Mental Health Partnership (OMHP) in 2014, the 'discharge rate' and 'employment rate' of its service users became fundamental measures of its service outcome. The OMHP also monitored the average waiting days for new members to be allocated to a recovery group (see Prologue). Since then, the Garden Café was expected to support more Restore members 'move on' into paid jobs.

When I worked at the Elder Stubbs and the Orchard, people told me that the Garden Café was a 'more formal' and more 'employment-oriented' group in Restore. They also found that catering was 'more work and customer focused' compared to gardening and craftwork. Many members began working in the Garden Café after their membership in a gardening or craftwork group terminated. Among the thirteen

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[141] See the introduction to employment coaching at Restore in Chapter 1.

[142] As the Office for National Statistics (ONS) records, there were 387,000 people employed as kitchen and catering assistants in the UK in 2008. Besides, there were 260,000 people who worked as chefs and cooks and 156,000 as restaurant and catering managers.

In contrast to the large numbers of people employed in the field of catering, there were only 152,000 people employed as gardeners and 24,000 worked in horticultural trades.

The jobs in craftwork and woodwork were even fewer. In 2008, only 45,000 people had an occupation in furniture making or other types of woodwork. Only 19,000 people had an occupation in handicraft. See the link to the original dataset: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/employmentbyoccupationemp04

members whom I met in the Garden Café between 2019 and 2020, eight used to work in another recovery group in Restore.

The statutory funder regards the members' 'moving on' to employment as the most important outcome of Restore's service. However, the members I met in the Garden Café had more diverse reasons to work in this recovery group. As this chapter will demonstrate, the café work was 'therapeutic', but not necessarily due to its dedication to helping them find a paid job outside Restore.

Sue Estroff in her ethnography of a community mental health programme in the USA found very few clients worked or enjoyed having a paid job. They demonstrated 'overwhelming reluctance, fear, anxiety, distaste, lack of skill and experience, and inertia regarding work' (Estroff 1981:147). Estroff argued that the problem was in the hostile reality of community life which constructed and enhanced people's psychiatric patienthood. Coping with the pressures of employment was a challenge. Furthermore, the financial support for the unemployed clients perpetuated their ill health conditions by being an attractive source of income. Since the financial support required proof and evidence for people's disabilities and deficits, it made its recipient present themselves as ill as possible.

I was not able to obtain the details about Restore members' wages and incomes as did Estroff, due to my role as a volunteer and the very short time for fieldwork. The social economic conditions of my research participants might also be different from the mental health clients who worked with Estroff. However, I share Estroff's view that employment may not be the most valued goal that any mental health service user should

strive for.

At Restore, many members said they felt ‘better’ because they were able to work continuously in the Garden Café, serving as a valued host of the place. To these members, working in the Garden Café mattered more than finding a paid job outside Restore. This chapter takes these members’ experiences and insights seriously. I argue that the work in the Garden Café became efficacious by enabling the members to become a host of the place. By becoming hosts of the Garden Café, the members became emplaced and empotted themselves into a friendly, mutually-supportive community that they catered for and belonged to.

In Section 6.1, I look at the stories of former members of the Garden Café who had worked in this recovery group between 2008 and 2018. The stories of the former members reveal how they emplotted themselves into the different roles in the Garden Café, such as the chef, the barista, and the cashier. They also show that finding a paid job outside Restore was not always a desirable goal for every member who had worked in the Garden Café before.

Section 6.2 introduces my fieldwork in the Garden Café, precisely how I did participant observation in this recovery group. Then in section 6.3, I locate the Garden Café in East Oxford. I also discuss the spatial arrangements inside the Garden Café which made the place a ‘community café’.

Section 6.4 looks at the Garden Café members’ work in the kitchen and by the counter. I propose that by learning the catering skills and techniques to collaborate in a ‘front space, back space’ rhythm, the members empot themselves into the communal

place of the Garden Café. The catering work, I suggest, induced a process for them to become the hosts of this community café.

Finally, Section 6.5 reviews ten Garden Café members' attitudes toward employment and their work in the Garden Café. It discusses the different reasons for these members to work in the Garden Café to show that employment may not be suitable for everyone's journey towards recovery and better health. Instead, I propose that most members valued more about becoming a skilful worker and a good host for the Garden Café.

6.1 Is employment always desirable? Stories of former members

This section looks at the stories of four members who worked in the Garden Café between 2008 and 2018. It shares the same goals with the ethnographic analysis in the next few sections. The first goal is to find out about the members' experiences of the work in the Garden Café, and how they found it 'therapeutic'. The second goal, as stated, is to explore people's diverse attitudes towards employment. [143]

In *Healing dramas and clinical plots*, Cheryl Mattingly argues against a 'naïve realist' position, which would be to regard narrative as a simple imitation of action and experience (Mattingly 1998:25). Instead, Mattingly sees narratives and experiences as deeply intertwined. Experience has in it 'the seeds of narrative' and narratives offer meaningful structure to life (ibid. 45). Mattingly's argument indicates that the Restore members' experiences of working in their recovery groups have narrative structures. It also means that the stories people told have truth values in relation to their therapeutic experiences.

To reveal the ways how one works out a structure through narrative, Mattingly emphasises the process of emplotment. Drawing on Paul Ricoeur, Mattingly defines emplotment as the operation that draws a configuration of actions, experiences, and events out of a simple, chronological succession (Ricoeur 1984:65, in Mattingly

[143] The reason why I did not discuss the former members' stories of working at the Elder Stubbs was that the primary focus of Chapter 4 was the intercorporeal and interspecies relatedness emerging in the gardening group work. Members at the Elder Stubbs worked in comfortable silence. Their bodily doings of the work, especially their mutual attentiveness in group collaboration, sensory engagements with the plants, and the practice of gardening techniques, had already revealed a vibrant lifeworld where therapeutic sensory relatedness occurred.

The Orchard recovery group discussed in Chapter 5 hardly had any of its former members' stories recorded in Restore's archives. This was probably because the Orchard was a new recovery group of Restore which was just opened in 2010.

1998:46). This section, therefore, looks at how the former Garden Café members emplotted themselves into the stories of becoming a skilful catering worker and how such processes of emplotment revealed their diverse experiences of the therapeutic effectiveness of the recovery group work.

Story No.1 from Lucy who worked in the Garden Café before 2014 [144]

I am now working in the new Garden Café, which I enjoy very much. What I do in there was to make the coffees for customers, clean the Café ready for the next day and train the supervisors on the coffee machine. I am also working in the kitchen making the sandwiches, cakes etc. I do the washing up in the dishwasher, which I like very much. Before you can work in the Café you have to do a Level 2 food hygiene course, which I passed.

…

At Restore I have learnt a lot. It has helped my mental health, my confidence, my self-esteem. I also learnt practical customer skills, meeting new people and how to run a café. I am hopefully going to a first aid course soon at Restore to help me in case someone has an accident. I hope to carry on at Restore and working in the Café because I would not know what to do without them. The Supervisors, Workers and everyone else are brilliant to work with and to talk with when you have a problem.

Lucy told her story before 2014 then the Oxfordshire Mental Health Partnership became the biggest statutory funder of Restore. Members at the time were not pressured to move on and out of their recovery groups in two years. Neither was employment considered the most valued outcome.

Lucy in her story talked about a variety of work she conducted at the different places of the Garden Café. She said she 'liked the work very much' and found the learning process had improved her health and wellbeing. She also talked about her hopes, which was to do the Mental Health First Aid (MHFA) courses and continue

[144] The stories in this section came from the archives of Restore, which I obtained through remote access from Dr Jonathan Leach during the pandemic. I choose not to record these members' personal information or the exact year they worked in the Garden Café to prevent them from being identified.

working at Restore.

Lucy's story, in my view, construed a therapeutic process that combined therapeutic emplotment (Mattingly 1998) and empotment (Hsu 2022). On the one hand, her narrative of the work emplotted her into the role of a good café worker who even passed the Level 2 course in food hygiene. The diversity of tasks she completed, alongside the encounters with people she found friendly to be with, took shape in a narrative structure.

On the other hand, the telling of the story was an illocutionary act (Austin 1962: 98-100). By talking about how she benefited from working in the Café, Lucy expressed her strong wish to carry on working in this recovery group. This illocutionary act made Lucy's narrative part of an empotting process that was configured by her bodily 'doings'. Evidently, Lucy's expression of her strong wish to continue working in the Café showed that she had emplaced and empotted herself into the Garden Café. Her health status improved the more as she learnt to become a valued barista and chef for this community café.

Story No.2 from Jason who worked in the Garden Café before 2014
I was unemployed for the best part of a year and it was a real struggle. Restore helped me a lot. I stared coming to the café and worked behind the counter and in the kitchen and met some nice, interesting people. It kept my mind occupied and gave me additional work experience. One of Restore's coaches gave me support, including help to apply jobs online. I had a few knock-backs but she encouraged me to keep going. Now I have two part-time jobs. Without places like Restore, I dread to think what would happen.

Jason also talked about the exact work he did in the Garden Café. Like Lucy, he enjoyed meeting people and found the catering work improved his health by keeping his mind 'occupied'. However, unlike Lucy who wanted to stay in Restore and continue

learning new skills, Jason wanted to find a paid job. In this way, Jason's story, alongside the Restore journeys of the three male members I interviewed (see section 6.5), shows that employment could be an important goal to some Restore members.

Noticeably, Jason mentioned that he had a few 'knock-backs' but his employment coach at Restore encouraged him to 'keep going'. Although my positionality as a volunteer did not allow me to sit in any member's employment coaching sessions in fieldwork, I estimate that the coaching at Restore had a similar structure as occupational therapy. As Mattingly notes, the therapeutic efficacy of occupational therapy depends upon the patient and therapist finding some way to 'actively construe and connect clinical actions into a larger, cumulative process – making a larger story out of a series of on-going actions' (ibid. 83). In other words, the therapist has a narrative task to emplot the clinical actions within the therapeutic encounter. The purpose is to create a significant therapeutic experience for a patient. [145] As applied to Jason's story, the actions that Jason took to overcome the 'knock-backs' might have also been emplotted by his interaction with the employment coach to fulfil the story of getting employed.

[145] One example is about the tour that Donna, an occupational therapist, gave to Steven, a patient who was in rehabilitation from a brainstem contusion due to a car accident. Throughout the session of occupational therapy, Donna consistently emplotted the actions of Steven and of herself by defining them as part of a therapeutic story, a story to help Steven become emotionally ready to be presentable to others and that motivated him to connect to the public world of the hospital (Mattingly 1998:86-9).

Story No.3 from Jane who worked in the Garden Café after 2014
I referred myself to Restore after leaving my job, which was a traumatic time for me. Within a couple of weeks, I was able to start at Restore.

I'd seen the sign on Cowley Road before, but had no idea that there was such a wonderful haven hiding behind that gate! There is still a lot of stigma about mental health, but once you pass under that sign it's all forgotten. Everyone you come into contact with, the staff, the volunteers and the other members, have all had some experience of what it's like to struggle with mental health issues. They don't judge you.

It took me a while to find my niche, but I was able to try lots of different things, and everyone was so understanding, friendly and helpful. Now I work in the café, serving customers and making coffees. I like to be kept busy. At Restore I've been able to get into a routine that's helped me feel able to work again. After leaving work I felt I would never be able to work again, but now I'm working part-time. I feel I have the space to figure out what I really want to do next.

Story No.4 from Victor who worked in the Garden Café after 2014
Everyone at Restore is eager to help and very supportive, and it's great to feel I can put my expertise and skills to good use.

I've always lived a vibrant life full of people and activity. I've run my own businesses and worked as a consultant. All my life I struggled with bi-polar disorder, even though I was only officially diagnosed 2 years ago. The struggle to cope got harder and I realised that I was also struggling with depression. I've always been a very gregarious and outgoing person, and when I withdrew due to my depression I realised I was getting stuck in a vicious cycle. I wasn't going out, I couldn't motivate myself, but being isolated and inactive was making it worse, not better.

Now I work in the café at Restore. I have a routine and I'm meeting new people every day. It keeps me motivated and active. I love the interaction and it's great to know that your input is useful and helpful to the community.

The third and the fourth story share a similarity in their narrative structures. Both stories were told as part of the longer life story of the narrators. I have found this type of narrative very common among the stories that Restore collected from its former members. Alongside their employment coaches and supervisors, the members tended to call their stories 'The Restore Journey', a therapeutic excursion to achieve a better state of health.

The story of Jane was an example. Jane's previous job caused a 'traumatic time' in her life while becoming a member in the Garden Café gave her time and space to 'find her niche'. The work in the Café then altered her attitude towards employment. She was working 'part-time' again, feeling positive and ready to explore new opportunities for the future.

The plot of the above 'Restore journey' structure Jane's experience of the work at Restore. The narrative flows with a sense of coherency and continuity, which helps the readers to identify the transformative stages in a therapeutic process. It also highlighted the significant individuals, events, or practices that contributed to the therapeutic process. For instance, Jane's story highlights how the work in the Café had offered her a 'routine' to navigate the time in a day or a week. The story also emphasised the connections that Jane had with the friendly people they met at Restore.

The daily routines and supportive social networks were also mentioned in the story of Victor. As Mattingly reviews in her discussion of the entanglements between therapeutic plots and life plots, the narrative is a way to conceive how the self is socially constructed (Mattingly 1998:104). Both Jane and Victor in their narratives expressed an increase in self-confidence and a more optimistic perspective towards the future. This transformation of self-perception through supportive social networks and the maintenance of the weekly routine thus echoes Mattingly's discussion of how narrative reveals the self as socially-constructed.

However, there is a danger for the above coherent structure to be misused to push members to 'move on' and out of Restore. If people's 'Restore journeys' were only

some timed stages in their lives, these journeys would be deemed to have a clear beginning and an ending to feed on the coherency of the plot. Mattingly explicitly addresses the problem on this aspect of narrative. She questions the coherent self, or the self-continuity, which was often taken for granted in the analyses of illness narratives (Mattingly 1998:107). Instead, Mattingly argues that the narrative's organisation of events does not only allow the self to be revealed in terms of sameness, continuity, or coherency. It also reveals the self in terms of discontinuity and instability (ibid. 119). Overall, one's life experiences can be messy, because that's how the realities often tend to be, but the narrative's role should not be restricted to ordering the messiness. Rather, it provides a temporal structure which reveals both enduring routines and the uncertainties.

The nuance in Mattingly's discussion of the discontinued and unstable self is especially applicable for analysing the story of Victor. The story reveals a conflict between Victor's two selves. On the one hand, there is 'the professional Victor' who had a vibrant life and a glooming career promoted by his competent skills and expertise. On the other hand, however, there is 'the ill Victor' who was frustrated, defeated, and stuck in a vicious circle that closed himself off from others and the world. The work in the Café offered Victor a precious but temporal mediation between the two conflicting selves. He was able to offer his skills and expertise to the group, being valued for such input, while having his ill conditions understood and supported by others at Restore.

Both Jane and Victor spoke of employment, but each story has its own nuance. Jane's attitude towards employment was altered by her experience of working in the

Garden Café, yet her story was open-ended and paused on an optimistic sense of ongoingness. It was thus not definite that Jane would 'figure out' to leave Restore for employment. Victor did not mention any plan of leaving the Café either. He rather enjoyed being a valued member of the Garden Café. Both Jane and Victor were happy about working 'part-time', which was more flexible than working on a full-time job.

In summary, this section looked at the stories of four members who worked in the Garden Café between 2008 and 2018. As the stories told, the catering work in the Garden Café undoubtedly 'worked' on these former members. It gave them structures of the day and routinised their weekly schedules. The relations with the Café supervisors, workmates, and customers were also supportive. All stories contained a plot of the narrator becoming a helpful workmate in the Garden Café.

Most importantly, the stories revealed the diversity and the nuances in people's attitudes towards employment. Some members were keen on finding a paid job outside Restore; some preferred not to leave the charity but rather wish to continue working in the Garden Café and learning new skills from the courses available. No one, however, was definite about leaving Restore. Having part-time jobs while continuing the work in the Garden Café seemed to be ideal for most members.

6.2 Participant observation in the Garden Café

The Garden Café focuses on catering. Meanwhile, customers could purchase from the café's counter garden produce from the Elder Stubbs and craftwork made at the Beehive recovery group. [146] The Café opened to the public between 10 am – 3 pm from Monday to Friday, while the recovery group work took place between 9 am – 3.45 pm.

The Garden Café had only around twenty-five members, which made it to the smallest recovery group of my fieldwork. Every day there were four to six members at work. As Sarah commented, the workspace in the Café would be 'too crowded' if more than six members were working on a single day. Vice versa, it would be 'too empty' if there were only two to three members.

Overall, I conducted fieldwork in the Garden Café for three months and volunteered in this group for a total of five months. [147] Of the thirteen members whom I met in this group, ten agreed to be my research participants, which meant that I could write about their catering work in my thesis. Six members worked in the Café for one day a week and four twice a week. Only one participant was a woman and she was one of the only three women who regularly worked in the Café during the time of my fieldwork.

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[146] As Chapter 1 introduced, the Beehive was a recovery group doing craftwork and gardening at Restore's Manzil Way headquarters.

[147] I was volunteering in the Garden Café for one day each week between 20th September and 15th November 2019. My application for the ethics clearance (CUREC2) was still in process during this period, so I could only volunteer in the group without doing any research (the limitation also applied to my volunteering work and fieldwork at the Elder Stubbs, as Chapter 4 explained).

The fieldwork covered by ethic clearance commenced on 6th December. I then worked in the Café for three days a week until 21st January 2020 and for one day a week until 11 March 2020.

The staff and volunteers, by contrast, were all women. Like the Elder Stubbs, the Café had three full-time staff, including one group coordinator (Katrin) and two recovery workers (Sarah and Greta). Besides, there was a part-time locum worker (Emily) and an employment coach (Laura).

Every weekday there was one volunteer, or none, working in the Garden Café. Katrin and Sarah explained that due to the small size of the workspace, the Café could accept no more than one volunteer for each day. I was thus able to volunteer on the three weekdays without other volunteers on the post.

Since the Garden Café has less than ten people working each day, the organisation of group meetings was more flexible than in the other two recovery groups I worked at. Besides making announcements of charity special events and training opportunities, which took place in every recovery group, people in the Garden Café discussed a diversity of topics in the morning and afternoon meetings, such as the new year goals, things one did in the previous weekend, or the imagined plan for a sunny day, as the ethnographic vignette at the beginning of this chapter demonstrates. The topics were usually proposed by Katrin, the group coordinator. And since the group was small, everyone would be invited to talk. This made the group meetings an important session of the day, as people were talking about their experiences. [148]

[148] The group meetings at the Elder Stubbs and the Orchard, by contrast, were usually too large to discuss other topics than work. The meetings at the Elder Stubbs often compromised ten to fifteen people. And people in this group focused on the allocation and completion of gardening tasks and other sorts of work in the woodwork shed and the kitchen. While the two members who 'did' the diary and the board talked through the tasks one after another, others replied or chipped in with comments (see Chapter 4). At the Orchard, everyone had their own ongoing project. They took turns to talk about the progress they made in the afternoon meetings. However, since the group often had more than fifteen people each day, the presentation of everyone was limited to two to three sentences (see Chapter 5).

My fieldwork method in the Garden Café was participant observation.[149] However, I did not write fieldnotes when I volunteered in this recovery group because the catering work in the Garden Café was fast in pace and demanded quick responses and high concentration. Instead, I typed down key words on my phone during the 30-min lunch break and wrote dairy after I returned to my own place in the evening.

After the first couple of weeks doing fieldwork and volunteering in the Garden Café, I found a convenient 'spot' to work at, which was by the sink in the back kitchen. While most members preferred learning cooking or doing customer service by the counter, I did the washing-ups. However, the task enabled me to work in the kitchen, paying attention to what the members and staff in this room were making and cooking, listening to and joining in the small talk. It also allowed me to walk to the seating areas at the front to pick up crockeries and cutleries and have a look at my workmates by the counter. Doing the washing-ups also made me a good workmate, since I picked up the least popular task in the group. However, when it came to the peak hours, I also went to the front to help take orders from the queuing customers.

In the Garden Café, four members, all men, responded to my invitation for interviews. I was able to interview three members, while the interview with the fourth member was cancelled due to the COVID-19 pandemic. My volunteer role limited the types of questions I could ask (explained in Chapter 4), so I found the information I collected through this method not sufficient to present any holistic or nuanced account of members' experiences of working at Restore. I thus focused my discussion on

[149] Since I had experience in cooking, I did not do participant learning in this recovery group as I did when I learnt woodwork skills and techniques at the Orchard (See Chapter 5).

people's bodily conduct when they collaborated as a team in the Café, as I did in the other two recovery groups. Besides, I analysed the stories of former members who had worked in the Garden Café between 2008 and 2015, as section 6.1 has presented.

I did not take many photos during my fieldwork in this group, mainly due to the fast pace of the work. For ethical reasons, I took no photos of members or staff in any recovery group of Restore. However, when I was able to attend an event at Restore's Manzil Way headquarters in 2023, I took the chance to take a few more photos of the Garden Café's spaces to help with the discussion in this chapter.

6.3 The Garden Café as a 'community café'

This section introduces the Garden Café as a 'community café'. It begins with a very brief review of the social demographics of East Oxford, the area where the Garden Café is located. The review shows that the two main sites of Restore, where I conducted fieldwork between 2018-20, are among middle-class neighbourhoods in Oxford. In combination with the socio-demographic data, I present my experience of the Cowley Road to elaborate on the material and sensory dimensions of the area around the Garden Café. Lastly, there is a review of the spatial arrangements inside the Garden Café, which made the place into a 'community café'.

The socio-demographic characteristics of East Oxford

To present a brief overview of the area where the Garden Café is located, I look at the socio-demographic characteristics of East Oxford. The socio-demographic characteristics of the area indicate that the Café is surrounded by middle-class neighbourhoods. Moreover, since the Elder Stubbs recovery group is only twenty minutes' walk away from the Garden Café, the area I review in this section should also cover the areas around the Elder Stubbs. Overall, these two recovery groups have customers from the same neighbourhoods in East Oxford.

The City of Oxford had twenty-four wards until 2020. The ones on the eastern side of the Holywell Ward are commonly recognised as the area of East Oxford. The headquarters of Restore, where the Garden Café is located, is in the St. Clement's Ward; the Elder Stubbs allotments, where the Elder Stubbs recovery group is located, is in the

Temple Cowley Ward adjacent to the St. Clement's. Both the Temple Cowley and the St. Clement's Wards are in the centre of East Oxford.



Fig. 6.2 A map of Oxford City wards until May 2021, Oxford City Council, modified by the author to highlight the Garden Café and the Elder Stubbs

The two wards where the Garden Café and the Elder Stubbs are located, alongside the four wards next to them (i.e. St. Mary's, Churchill, Donnington, and Cowley), are middle-class neighbourhoods. This finding is based on the Index of Multiple Deprivation (IMD) of the six wards in 2019. As The Oxford City Council and District Data Service (OSCI) introduces, the IMD is a complex index showing the 'levels of

deprivation' in different geographical areas. The IMD grouped the population in England into ten deciles according to seven domains, which were 1) income, 2) employment, 3) education, 4) health, 5) barriers to housing and services, 6) living environment, and 7) crime. The 'Most deprived 10%' in the 10th column below, for instance, referred to the population living in the neighbourhoods ranked among the most 10% deprived in England. (OSCI 2021:16)

Table 6.1 The IMD of Six East Oxford Wards in 2019 (Oxford City Council) [150]

Least dep. 10%	Least 10-20%	Least 20-30%	Least 30-40%	Least 40-50%	Most 40-50%	Most 30-40%	Most 20-30%	Most 10-20%	Most dep. 10%
Temple Cowley (Elder Stubbs allotments)									
0	**2160**	0	0	**2704**	0	**1531**	0	0	0
St. Clement's (Garden Café and Restore headquarters)									
0	0	0	0	**3258**	**1267**	**186**	**1446**	0	0
St. Mary's									
0	0	**1134**	**1564**	**1609**	**1782**	0	0	0	0
Donnington									
0	0	**2392**	0	**925**	0	**3464**	0	0	0
Cowley									
0	0	**1684**	0	**3887**	0	**900**	0	0	0
Churchill									
0	0	**0**	**2242**	**1656**	0	0	**3731**	0	0
Oxford City									
21704	18859	17663	19814	25655	9353	11120	12698	16210	1506
Oxfordshire									
173357	142450	96113	90820	67218	33695	31370	18677	27172	1506

As the table above demonstrates, most people living in central East Oxford are between the 'least 20-30%' and the 'most 20-30%' deprived population in England. The

[150] Data sources: Local authority profiles:
https://www.oxford.gov.uk/downloads/download/819/local_authority_reports
Small area (ward) profiles:
https://www.oxford.gov.uk/downloads/download/1228/ward_profiles_-_may_2021_onwards

range is roughly in the middle groups of the IMD deciles. The numbers indicate that the two recovery groups of Restore are surrounded by middle-class neighbourhoods. Some residents in these neighbourhoods became regular customers of the Garden Café, as I shall describe in Section 6.4. [151]

Locating the Garden Café on Cowley Road

The review of ward profiles presents the socio-demographic characteristics of East Oxford, the area where the Garden Café was located. In this subsection, I present an account of the area based on my fieldwork experience. And my description emphasises the sensory and material dimensions of the textured spaces around the Garden Café.

The Restore Garden Café stood at the intersection of Cowley Road and Manzil Way Street in East Oxford. The Cowley Road began from the east end of Oxford High Street: it was one of the three arteries radiating from a roundabout called the Plain, one of the busiest roundabouts in Oxford.

Following the road numbering system in the UK, the Iffley Road in the south (A4158) and the Headington Road in the north (A420) were the two A-roads which function as the main through-routes in East Oxford. The Cowley Road (B480) in-between was a B-road built to a lower physical standard but has no less traffic: until April 2021, the Oxford Bus Company had four bus routes using Iffley Road, ten routes on Headington Road, and eight on Cowley Road. [152]

[151] Apart from the social-economic backgrounds, the population in central East Oxford was also diverse. The six wards had residents from a diversity of ethnic groups, including a large Pakistani community. I summarise the demographic details on ethnic diversity in Appendix 1.

[152] See the link to the bus routes: https://www.oxfordkey.co.uk/site/uploads/images/originals/1540.pdf

If taking an eight-minute walk from the Plain to the Garden Café in 2020, one could go past various restaurants, shops, and groceries. These businesses huddled closely with each other on Cowley Road, presenting a great diversity of choices for food and groceries. There were forty or more restaurants offering food from all over the world, such as Spanish tapas, Greek falafel, or Turkish grill; there was a Jamaican restaurant, some African takeaways, an Indian fine dining establishment, a Pakistani fried chicken shop, some Chinese stir-fry and noodle bars, a couple of Japanese sushi restaurants, and so on. There were also two bakeries, two ice-cream shops, a local butcher, three pubs, four cocktail bars, and more than ten small groceries selling regionally-specified fruits, vegetables, meat, spices, sauces, snacks, and even house decorations.

Besides shops and sit-in places for food and drink, there were other small and large businesses, many of which were local and independent shops. From the Plain to the Garden Café, there were five barbers and hairdressers, four bicycle shops, three video game stores, two vintage clothing shops, two furniture stores, two cell phone repair shops, two sex toy shops, two housing agents, two interior designer's offices, a shirt-painting shop, a music instrument store, a watchmaker, an O2 academy, a vaporizer store, a liquor shop, a tattoo studio, a bookmarker, a pawnbroker, a money shop, some cash points, a Ladbrokes, a stationary shop, a dry-cleaner, a self-service laundry with coin-operated machines, a Thai spa, and a florist.

Various charities and religious groups mingled among these small and large businesses. There were the charity shops of OXFAM, Age UK, Helen & Douglas, and

Barnardo's. The Cowley Road Methodist Church was next to a popular pub called the Big Society. The East Oxford Community Centre was facing Sainsbury's, and its adult learning centre was behind the carpark of Tesco.

The diverse business and charitable organisations differed from each other in their layouts. They attracted a diversity of visitors. When walking on the road, one might hear people talking in different languages: salesmen whom I took for Filipinos making phone calls in languages I could not identify, Brazilian students dining out in groups, and middle-aged female customers bargaining in Spanish.

The Cowley Road also had all kinds of residential buildings. The first floors of some shops were holiday homes. A couple of houses were student accommodations owned by the Oxford Colleges. The mental health housings provided by Mind and Response were also on Cowley Road or within walking distance. [153] Some Restore members at the Elder Stubbs and the Garden Café lived in these supported accommodations. I bumped into people from Restore several times when I was walking on Cowley Road. They said they were on their way to shop for groceries, meet friends in a Café, or attend a local event.

[153] Response was originally named the Group Homes Organisation, and was founded at the old Littlemore Hospital (see Chapter 3). Mind is a nationwide mental health charity with a regional branch in Oxfordshire. Both charities were in the Oxfordshire Mental Health Partnership (OMHP) with Restore (See Prologue about the partnership). Link to Response: https://www.response.org.uk/
Link to Oxfordshire Mind: https://www.oxfordshiremind.org.uk/



Fig. 6.3 The Garden Café on Google Maps, the screen-shot was taken by the author on 26 June 2021

The Garden Café was not situated on Cowley Road. A large lawn known as the Manzil Way Garden served as a buffer zone in between. The lawn was the first green space one would encounter if entering East Oxford from The Plain. The line of dense settlements on the left-hand side of the road paused for a moment at the lawn. The first thing one would see behind the lawn would be the large, four-storey building of the East Oxford Health Centre. The headquarters of Restore, alongside the Garden Café, was on the other side of Manzil Way Street, hidden behind a clump of shrubs and trees.



Fig. 6.4 The Garden Café's entrance among the high hedges, a photo taken by the author in June 2023

Among the 55 reviews posted by the Garden Café visitors on Trip Advisor between November 2012 and April 2021, thirteen described the place as 'an oasis.' Similar idioms and metaphors included 'a great find', 'a perfect retreat', and 'the hidden gem of the Cowley Road'. Understandably, the Garden Café was a wonderful discovery to these customers, because it was not instantly visible from Cowley Road. To find the Café, one had to take one's time and pause on one's way along the busy, bustling road. One had to walk onto the pathway that cut across the lawn without being distracted by the children's playground and remain sharp-eyed enough to identify the Café's signboard by its wooden gate amidst the high hedges. The Garden Café, therefore, was an oasis for its visitors to pause and relax before they would leave for other places in the city. Two quotes from Tuan Yi-Fu explicitly demonstrate the process:

> If we think of space as that which allows movement, then place is pause; each pause in movement makes it possible for location to be transformed into place. (Tuan 2001:6)

> Place is a pause in movement. Animals, including human beings, pause at a locality because it satisfies certain biological needs. The pause makes it possible for a locality to become a center of felt value. (Tuan 2001: 138)

Tuan elicits the relations between the body's movement and space. Initially, people paused at the Café for food and drink, but they also paused in the landscape they moved through before making the discovery. Once one entered the gate on the hedge, the lush vegetation in the garden took the visitors away from the busy and bustling atmosphere on Cowley Road. In summer, one would find colourful tulips, pansies, and sunflowers; and in winter, there was still plenty of greenery on the garden's bushes and trees. The members from another recovery group known as the Beehive, which, like the Garden Café, was also located at Restore's Manzil Way headquarters, took good care of the plants in all seasons.

By the gate, there were two curving pathways. The one on the left passed a gazebo with tables and chairs providing shady outdoor seats in the hot weather. The other, on the right, was slightly shorter and went via a little arch bridge to the patio at the Garden Café's front door. The Café's one-storey building had wooden walls, generating a natural, organic feel. Through the large windows, one could see purple bunting hanging from the ceiling, while the lighting inside was mild and soft.

Of the 55 reviews of the Garden Café on Trip Advisor, 31 mentioned the beautiful garden. The table below provides a list of some most common adjectives the visitors

used to describe the atmospheres in the Garden Café:

Table 6.2 Adjectives used to describe the Garden Café on Trip Advisor *
*Out of 55 reviews posted between November 2012 – April 2021

Adjectives	Number of reviews
Friendly	22
Lovely	20
Beautiful	15
Relaxing	11
Calm	9
Quite	7
Tranquil	7
Peaceful	5

The Garden Café's calm, relaxing atmosphere was prone to generating therapeutic effects on the recovery group members. As Robert Desjarlais notes in *Shelter Blues*, there is a symbiotic relation between a place and the people who inhabit it (Desjarlais 1997: 87). While the building for the shelter he worked in, as 'a crazy place to put crazy people', enhanced the clients' sensory disorientation with its brutal design and unfinished reality, the Garden Café's natural environment and peaceful atmosphere, by contrast, was likely to induce relaxing and soothing experiences.

During the annual planning meeting in 2019, the service members who worked in the Garden Café were invited to write down a word or a phrase to describe the place. One member wrote 'serenity'; another said 'less pressure'; many nodded when someone proposed the word 'safe'. Although being a relaxing and safe place in contrast to the busy, bustling road outside, it would be wrong to conceptualise the Café as a sanctuary, closed off from the rest of the world. As the next subsection and Section 6.4 will show, members who worked in the Garden Café would visit different places on

Cowley Road to purchase culinary materials while working. They also interacted with the customers from different backgrounds. The Café, therefore, was an oasis where the anxiety-reductive experience could be generated.



Fig. 6.5 The entrance to the Garden Café, a photo posted on Restore's Twitter account in August 2021

Moving across the front and the back 'stages'

Most customers visited the Garden Café via its front door. They went through a small gate on the hedge, walked across the garden, and entered the building. By contrast, the staff and members came to the place in the morning via the charity's main entrance by Manzil Way Street. They walked past the charity's office area and entered a 'team room' where they could store their bags in the lockers and put on an apron. The members then went into the Café through its back door by the counter.

Simon Sinclair (1997) in *Making Doctors* describes the frontstage and backstage habitus in a London medical school. Different stages were opened to or excluded from different groups. Some stages were official and some were unofficial. [154] As I found in fieldwork, Restore's Manzil Way headquarter also had different stages. There were a few frontstage areas (marked in green in Fig. 6.6). Some were official as they were accessible to all visitors (e.g. the counter); some were less official because they were only accessible to the Garden Café workers (e.g. the kitchen). In any frontstage area, a worker should wear an apron. They should tie up their long hair and wash their hands frequently, especially before processing or delivering the food. Moreover, one did not check one's cell phone when working at the frontstage.

The Garden Café workers adopted a different conduct in different stages. Members who worked by the counter could speak with each other but the conversations were often interrupted when they saw new customers enter the room. It would also be inappropriate for them to eat or drink in front of the customers.

[154] For instance, according to Sinclair, a clinical ward was an official frontstage made accessible to medical students, their teachers, and patients from the public. In this official frontstage, teaching by means of humiliation was common, which indicates some degrees of the medical hierarchies.

By contrast, the Middlesex Hospital Dramatic Society (referred to by the medical students as the 'Manic Depressives' or the 'MD') was an unofficial frontstage. The public was excluded from the Society's Clubhouse where the performance took place and the audiences were mainly students themselves. The MD was where the preclinical students acquire 'the unofficial learning of official dramatic roles' (Sinclair 1997:116), in which they played the roles of generic consultants and patients as rehearsals for their future clinic work.

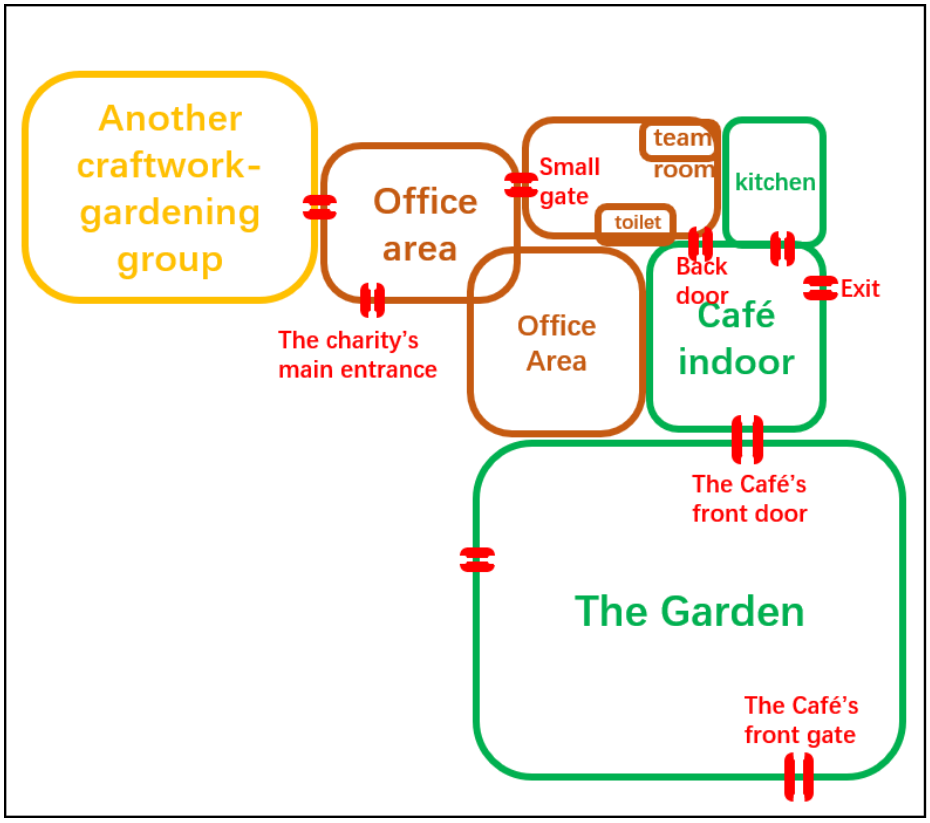


Fig. 6.6 Layout of Restore's Manzil Way Headquarters. A diagram made by the author, the frontstage areas are in green, while the backstage areas in brown

By contrast, the kitchen as a less official frontstage was a more suitable place for small talk. The chats in the kitchen would go uninterrupted alongside food preparation. Workers could eat and drink in the kitchen. When a special dish or a newly baked cake was made, people gathered in the kitchen to have a taste. The 'tasters' were often in small slices and were put on a plate displayed by the serving window for everyone to sample. On some occasions, the workers also had a nibble when hungry, especially when they were working during lunchtime.

Most backstage areas, on the other hand, were behind the Café's backdoor (i.e. the brown areas in Fig. 6.6). Some were more official (e.g. the team room) than others (e.g. the toilets). There was no need to wear an apron in any backstage area and anyone wearing an apron would have to take it off before using the toilet. Most members took

lunch breaks in the team room. A few preferred the two meeting rooms next to the team room. While eating, they played with their cell phones or chatted with workmates.

Besides the rooms by the corridors behind the back door, there was another backstage area: the small patio with a couple of chairs outside the emergency exit by the counter. This patio was the place where some members took their cigarette breaks. A couple of smokers liked to chat with each other on the patio and they preferred a strong cup of coffee to go with their cigarettes.

Although I have identified front and back stages in the Garden Café, my aim is not to analyse the Garden Café space from a bird-eye view. The boundaries between the different front and stages were not rigid, and the space of the Café was textured by the bodily movement and sensory engagement of the members, staff, and customers. When new customers came by the cash till and asked 'Where is the toilet?', members who worked at the front would tell them to go through the back door by the counter and the toilets were on the left-hand side of the corridor (see Fig. 6.6). The door one should pass to access the toilets marked the boundary between the major 'frontstage' and 'backstage' areas. The toilets were shared by the customers, the Café workers, and Restore's administrative and executive staff who worked in their offices in the same building.

When I brought up the toilet's unique location to Katrin, the Garden Café's group coordinator, she explained, 'Because we are not Starbucks or Costa. We are a community café.' Unlike most commercial cafes with 'Staff Only' restrooms that were usually locked to the public, the toilets of Garden Café were open to everyone. This

unique set-up of a ‘community café’ showed the ethos of the place: people who came to the Café were treated as if they were part of the same community.

Moreover, the Café’s backdoor was also used by some ‘regulars’ to take a shortcut to the counter. These regular customers were the charity’s staff and a couple of members who worked in the Beehive, the craftwork group that shared the same site with the Garden Café. Besides benefiting from the shortcut, these members and staff also enjoyed a 25% off discount on all food and drinks.

The unrigid spatial boundary between the commercial area of the Garden Café and the offices in the headquarters of Restore challenged the distinctions between people coming from the ‘outside’ of a mental health institution and those who worked ‘inside’. Whether visiting the Café through the front gate or the back door, people who used the same toilets came to the same counter for the same food and service.

Notably, the building where the Garden Café was originally located had been constructed for the gardening group on this site. It was used as a workshop and a shop until 2008. Since the building was used for different purposes in different years, its layout and stages became co-productions of people’s daily activities and the life of Restore as a charitable organisation. These changes in space, as I argue, are matched by people’s flexible adjustments and quick responses to ‘make good use’ of the resources (discussed in Chapter 3), which made the charity spaces resilient to unpredictable changes and open to diverse possibilities.

In summary, the interior spaces of the Garden Café had several formal, informal, front, and back stages. While people followed different bodily conduct in different

stages to do catering, the boundaries between the stages were not always rigid. The customers' access to the toilets in the backstage near the office differentiated the Garden Café from the commercial cafes. The regular customers who came from inside the Restore building also blurred the boundary between the outsider and the insider of the Garden Café community. These boundary-blurring movements and practice prove that the Garden Café was 'a community café', as Katrin, the group coordinator emphasised.

Summary of the section

This section introduced the Garden Café's location by the Cowley Road in East Oxford and its flexible spatial arrangement as a 'community café'. By looking at the socio-demographic characteristics of the area, I argue that the Garden Café was in the middle-class neighbourhoods in Oxford whose residents became regular customers of Restore's cafés and shops. The adjacent green space and high hedges around the Garden Café made the place an oasis in the busy, noisy area in East Oxford. The customers said they felt tranquil and relaxed when they visited the Café, while the recovery group members also spoke of feeling safe. Most importantly, the porous boundaries between the Café's frontstage and its backstage, signified by the customers' free access to the toilets in the charity's office area, made the Café a community place that challenged the common segregation of a mental health organisation between the insiders and outsiders.

6.4 Empotting into the Garden Café through teamwork

This section looks at the catering work in the Garden Café. Unlike gardening or craftwork, the catering work in the Garden Café was fast-paced and demanded concentration, quick responses, and collaboration. I note that the service members became empotted into the communal spaces of the Garden Café by learning the skills in cooking and catering and collaborating through teamwork. These processes of empotment transformed the service members into skilful chefs, bakers, baristas, and cashiers for the Garden Café.

I propose that the processes of becoming a host of such a community café are intrinsically therapeutic. By working on the catering team with attention and care, members became oriented to people and things that textured the Café's spaces. They also cultivated a vital and productive relatedness to the work and the place while making themselves a valued and dignified worker to others. This dimension of getting better by becoming a host of the place, I propose, is as important as 'moving on' to employment, and should not be confused with the bias that people would become pathologically 'attached' to a place of they are not pushed to move on elsewhere.

In this section, I first look at the timetable that structured a member's day working in this recovery group. Then, I look at the members' work in the kitchen and by the counter. I argue that the work on both sides entailed the learning of catering skills and techniques, which educated one's sensory attentiveness to a broad range of culinary materials. Lastly, I discuss the 'front space, back space' rhythm of people's group collaboration to process the orders during peak hours.

The daily routine

Like all recovery groups in Restore, the Garden Café had a time table which structured the major activities in a day. Here, I present the timetable as it was on Restore's website.

> Members arrive between 9:00am and 9:15am. Our Breakfast Club is a time to socialise with each other.
> At 9:30am we have our morning team meeting to plan the day and decide who is doing what. There are usually two people at the till, serving customers tea, coffee and cakes. The rest of the team is in the kitchen.
> At 10:00am the café opens to the public. The kitchen team will begin prep work for lunches.
> At 12 noon the kitchen is open for hot meals. We serve a variety of ethical and organic dishes and snacks.
> At 2:00pm the kitchen closes and we start clearing everything away.
> At 3:00pm the café closes and we have our end of day team meeting to discuss what happened during the day and how everyone found it.
> All members leave around 3:45pm.
>
> 'A Typical Day' in the Garden Café', Restore Website [155]

What my fieldwork observation could add to this timetable was that on each day there were some busy hours (the 'peaks'). There was a 'morning peak' at around 10.30 am when groups of regular customers came in for coffee and tea. Then there was a 'lunch peak' between 11.30 am and 1.30 pm. To work in these peak hours, members, staff, and volunteers in the Garden Café took breaks in turns. They negotiated for each other's 10-min breaks in the morning depending on the circumstances and used a timesheet to allocate the 30-min lunch breaks.

The timesheet was a form on an A4-sized paper. The form separated the time between 12-2 pm into two sets of 30-minute timeslots. The first set of slots were for people who worked at 'the front' by the counter, and the slots in the second set were for

[155] See the link to the original text: https://www.restore.org.uk/restore/garden-cafe-recovery-group

those at ‘the back’ in the kitchen. In the morning group meeting, people passed over the form, picked their timeslots, and wrote down their choices of food for lunch. However, many members preferred to pick the slot first and decide what to eat after knowing what would be freshly cooked in the morning. When everyone had filled in the form, the timesheet would be placed by the serving window in the kitchen, so the chefs would know when to cook what for whom during the lunch peak.

The turn-taking for lunch breaks marked the major difference between the time schedule in the Garden Café and the ones at the Elder Stubbs and in the Orchard. The gardeners and woodworkers in the first two groups took all their breaks together. During the breaks, they sat down together in a large dining room with snacks, hot drinks, and portions of lunch meals. The lunch breaks in these groups were often a time for chats, jokes, and debates of ideas.

People in the Garden Café, by contrast, avoided taking breaks at the same time to navigate the morning and lunch peaks. For example, one morning at around 10:45 am, after taking orders and making drinks for twelve customers from a sports club, Sean asked Ben if he wanted to take his morning break. Ben said he was fine, and Sean said ‘I’m gonna take mine.’ He then went to the ‘team room’ in the corridor behind the Café’s backdoor. After exactly ten minutes, Sean returned, and Ben went to take his break not long after. The negotiation between Sean and Ben was very brief but effective. By being attentive to each other, the two members managed to take breaks in turns, so there would always be one of them waiting by the counter to cater for the customers. The one who took the break first returned in time, so his workmate would not be alone

at the front for too long.

Jake, a member who had worked in a gardening group before joining the Café, made an apt comparison. He found that the activities in the latter were more ‘chilled’, especially when people were working outdoors in the plots. There was ‘less time pressure’, so one could ‘actually talk to people’ and ‘be sociable’. He had made a couple of friends in the gardening group and they maintained their contacts even after he ‘moved on’ to work in the Café.

In comparison, Jake found that the Garden Café was more ‘work and customer focused’. To him, the Café had a rather straightforward goal to help people find a paid job. He learnt a lot of practical skills in catering, such as how to use the coffee machine and the cash till. However, when there was a queue of customers waiting, he sometimes ‘had to rush’ and felt ‘a bit pressured’. Thankfully, Sean, his teammate by the counter, was an experienced barista who was friendly, collaborative, and helpful, so they could always navigate elegantly through such moments of heightened pressure.

In summary, the daily routine in the Garden Café recovery group was significantly different from the routines in the gardening and craftwork groups of Restore. To navigate the peak hours, workmates in the Garden Café took turns for breaks. This arrangement made the structure of the recovery group work more formal and more customer-oriented, as some members perceived it. However, by negotiating and taking breaks in turns, the members also became caring and attentive to each other and the customers, which could be regarded as therapeutic as they were open and related to the Garden Café’s shared lifeworld.

Learning to make fresh, nourishing food on the menu

Most meals at the Garden Café were freshly handmade in the kitchen. They were quality-rich and high in nutrition values. The free-range farm eggs and golden label ham came from The Alder's, a local butcher right opposite the Manzil Way on the other side of Cowley Road. The coffee beans were premier fairtrade espresso, a blend of Arabica and Robusta supplied by the Oxford Coffee Company on the High Street. [156] For several times a week, the staff ordered condiments, flour, oil, and teabags from Sainsbury's. The Oxford Food Bank [157] was another important provider, which in this case was free of charge. However, the team only used the freshest fruits and vegetables from the Food Bank.

Anthropological research has offered many insights into the social lives of things, and medical anthropologists have discussed the social lives of medicines. Sjaak van der Geest, for instance, found how a purgative produced by a company in Detroit ('Alophen') became the most popular contraceptive among the youth in a rural town in Ghana, which revealed the prevalent and sometimes dangerous use of foreign-produced medicines beyond the acknowledgement and control of medical professionals (Whyte, van der Geest and Hardon 2002:164). In this example, the social life of a pharmaceutical drug connected its producers to its users on two different continents and thereby related them into the commercial and medical exchange. The food materials at

[156] See the website of The Oxford Coffee Company: https://oxfordcoffee.co.uk/

[157] The Oxford Food Bank (name changed to the Oxford Food Hub in 2020) is a local charity in Oxfordshire. It collects surplus food from wholesalers, supermarkets, restaurants, and others, and redistributes it for free to community organisations across the county. It also delivered vegetables, pasta, rice, bread, dessert, and other culinary materials to the Elder Stubbs recovery group every once to twice a week for use in the cooking of lunch meals.
See the website of the organisation on: https://oxfordfoodhub.org/

the Garden Café also had their social lives. Coming from multiple sources, they related the Café members to the providers of culinary materials in Oxford.

For instance, when the Food Bank's big van arrived in the morning, almost everyone (except for those who waited by the counter) took a stroll to the car park with empty plastic baskets. People then filled their baskets with pears, apples, clementines, oranges, carrots, onions, tomatoes, heads of broccoli, cauliflowers, packs of leafy salad, and other fruits and vegetables. On the way back to the kitchen, the groupmates glanced at the baskets in each other's hands while commenting on the quality of the fruits and vegetables. 'We could make more banana bread now.' Greta, the recovery worker, proposed. 'And broccoli stilton soup.' Joseph, a new member who was excited by the diversity and the freshness of culinary materials, added.

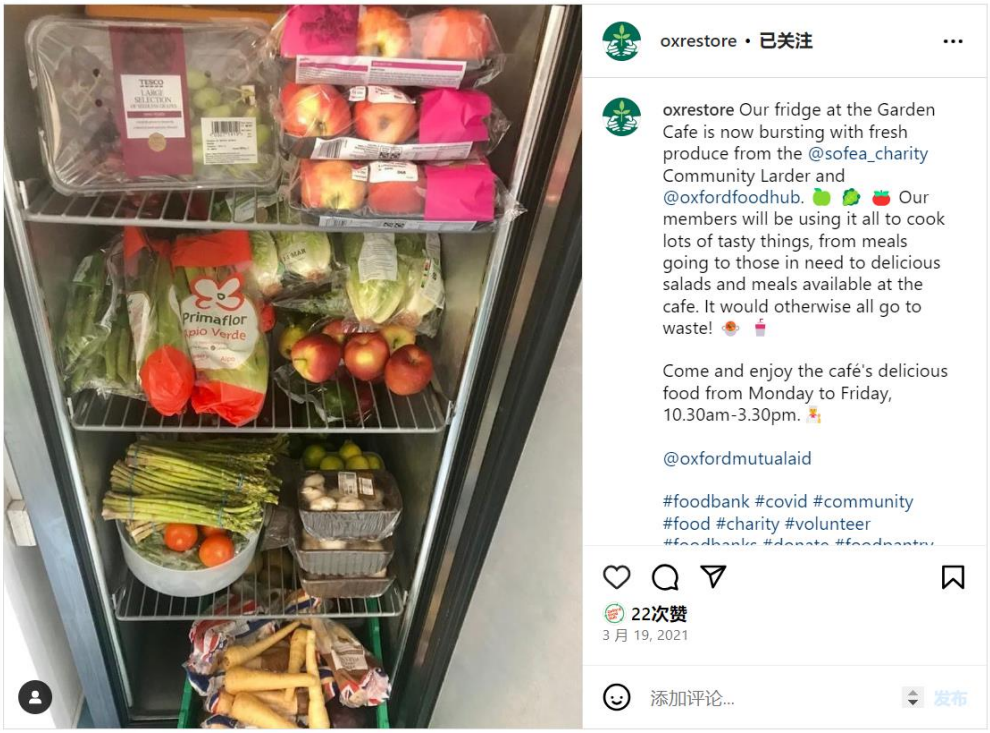


Fig. 6.7 The fridge in the Garden Café's kitchen, filled with a diversity of culinary materials, a photo posted on Restore's Instagram on 19 March 2021

There were also short ‘trips’ to Alder’s, the local butcher whose shop was opposite the Café on the other side of Cowley Road. Members who undertook the purchasing task would walk across the lawn and the Cowley Road to fetch a tray of eggs or some packets of ham with an invoice from ‘Andy the Governor’, the owner of the butchers. Sometimes when the kitchen was running out of an ingredient (e.g., olive oil, bell peppers, lemons), the staff would also suggest one or two members draw a £10 note from the cash till and walk to the nearby groceries or supermarkets to make an emergency purchase. This offered opportunities for service members to practice social skills while relating them to a diversity of people outside Restore.

After getting the culinary materials from their diverse sources, the Garden Café workers sorted them out and washed them up in the kitchen. These materials were then mixed and matched with each other and were turned into the handmade lunches on the menu (see Appendix 2). The food and drinks on the menu were healthy and tasty. Almost every lunch meal combined a large portion of fresh vegetables with plant or animal proteins, easily digestible carbs, and good fats.

The healthy food, while nurturing the Café’s customers, also brought genuine health benefits to the members and staff who made them. Workers at the Garden Café had the same coffees for their morning staff drinks and the same meals for lunches. The toasted sandwich (‘toastie’) with salad and crisps, for instance, was a popular dish among the members: many members, such as Joseph and Eric liked their toasties filled with ham and cheese; Edward who was a vegetarian would then choose the filling of mozzarella, pesto, and sundried tomato. When the weather was cold and wet, many

turned to vegetable soup and they preferred a small mug of boiling hot soup with a slice of quiche or a savoury pastry just out from the oven.

The Garden Café's extensive menu demonstrated not only the great variety of healthy food available for the customers and café workers to consume. Most importantly, the menu enacted skills and practice. Members needed to make efforts to memorise the prices. They should also be able to match the customers' different dietary requirements to a suitable type of food and drinks on the menu – some customers might be vegetarian, and some might need plant milk for their coffees. The complex work with the menu thus cultivated a careful attentiveness to the demands of one's customers, during which a service member at Restore might learn to become oriented to different things and people. Learning to work in the Café, therefore, was a challenging yet rewarding process that generated therapeutic efficacies.

In summary, members' cooking and preparation work in the Garden Café dealt with a variety of culinary materials. The process to obtain these culinary materials then related the café workers to different people who worked in the local shops and charities. The social lives of the culinary material, however, did not only play a critical part in generating social relatedness between people. It also afforded the workers' attentions and sensory engagements in the process of making and selling the food and drinks on the Café's menu, as I shall elaborate on in the examples below.

Handling raw materials

Members who worked in the kitchen needed to sort out the culinary materials from the Food Bank. They actively engaged their senses when handling and processing these raw materials. When Edward asked Sarah if the tomato in his hands was fresh enough to put in a salad. Sarah advised him to 'have a touch'. Touch was an important sensory modality when we selected the vegetables and fruits in the kitchen. The hardness of cucumbers and onions indicated a sign of freshness, and so did the firmness of the tomato skins. Many of us found bananas 'tricky'. Some bananas with blackened skins were perfectly ripe inside and would be very suitable for baking. We thus often peeled off the banana skins to have a look and touch on the inside before deciding whether we should use them or 'chuck' them.

By practising the ways to select raw materials, an attentive relation between the body and the things was generated. This temporal relation between one's body and the culinary materials highlights one's awareness of the freshness and quality of food, which was the source of vitality. The vegetables and fruits engaged in this relational process thus afforded a Café worker's bodily perception. Their materiality generated diverse sensory experiences which demanded the worker to make proper responses and decisions: the rotten and dried parts of the vegetable should be peeled off and disposed of in the compose box, while the fresh ones should be put in the fridges or at the bottom layers of the working tables. By paying attention to the different qualities of the culinary materials and making quick decisions while moving between the bins, the tables, and the fridges, the efforts empotted the service members into the workspace of the kitchen.

The selection of raw materials also took place between people. On many occasions, members handed over the items to each other to share ideas and exchange views. They would have a touch or a smell before offering the advice. After testing the onions with her fingers, Greta the recovery worker suggested Michael slice them up for the Greek salads. Joseph, a member who had worked in the Café for a year, advised Ellen on his first day that the not-so-good broccoli would be better sorted out and boiled up in a soup.

Learning to cook

To make the healthy, nutritious food on the menu, the group used two files of recipes. The files were loose-leaf and laminated by pages. On each page, there were recipes with step-by-step guidance to make a tomato soup, a vegetable quiche, or a dozen of Viennese whirls.

The recipe files could be very helpful when one needed to make a cake, a quiche, or any other food needing many steps to cook, but the knowledge of cooking did not only lie in the recipes. As Tim Ingold argues, the instructions in a cookbook cannot be simply converted into one's bodily conduct (Ingold 2001: 137). To learn the art of cookery, one needs to move one's body to copy the activities of skilful cooks. The novice 'watches, feels, or listens to the movements of the expert' and repeats the work by attentively engaging his own bodily movements with 'rhythmic adjustment of perception and action' (Ingold 2001: 141). In other words, it was the education of attention, rather than the transmission of representations, that mattered to the learning

process for cooking.

Drawing on Merleau-Ponty (1964) and Bourdieu (1977), Ingold defines the novice's copying of the practices of skilled cooks as 'a mixture of imitation and improvisation' (Ingold 2001:141). He understands imitation and improvisation as the two sides of the same coin: while imitation reflects the fact that copying takes place under guidance, improvisation shows the novices' own discovery of the knowledge. Overall, the two are 'the situated and attentive engagement that is fundamental to becoming a skilled practitioner' (ibid.). Ingold's framing of learning to cook can be found in the everyday work in the Garden Café, which I shall demonstrate with an example.

One morning, Sarah picked up a handy paring knife to perform the techniques of chopping to Ellen who claimed to have done hardly any kitchen work before joining the Café. With Ellen standing aside and watching, Sarah used her left hand to hold a cucumber from its longer end and chopped off some cubes with the paring knife in her right hand. She then picked up a cube and advised Ellen to finish chopping the remaining cucumbers, tomatoes, and feta cheese into similar sizes. She also reminded him to use different colours of chopping boards for different culinary materials.

During the demonstration, Ellen stood aside in silence – but in a similar body posture for concentration. When the paring knife was passed on to his hand, Ellen started practising, trying to imitate the chop by adjusting his hands and bodily posture. When he managed to find his way on the track, Sarah, the recovery worker, left his working table to pick up another cooking task.

When the mixing bowl was filled with cheese and vegetables, Ellen came to Sarah again to ask about the 'right' amount of seasoning to put in his Greek salad mix. Sarah advised him to simply go for a try by adding a little salt, pepper, and olive oil. She also advised him to 'have a taste' before deciding to put more. 'Overall,' Sarah explained, 'less was better than more'. The customers could always add more salt or pepper from the seasoning jars on their tables. However, it would be from Ellen's own attempts of tasting and testing that he eventually worked out the proper amount of seasoning for the Greek salad he was making.

The process to work out the 'right' amount of ingredients can be conceived as an embodied process of learning. To sample was to guarantee the good taste of the food. The person who conducted the sampling did not do it for himself but for his customers and workmates who would probably select the dish for lunch. The attempt to sample, as I argue, cultivated a member's awareness and concern for the people he cared for. And through this awareness and concern for others, a caring relation was cultivated, which could be regarded as therapeutic and meaningful to some members who had been isolated after being discharged from acute care in mental hospitals and were closed off to others when they were unwell.

In summary, members in the kitchen made use of a variety of culinary materials to learn cooking. The process to make the fresh, nourishing food on the menu demanded one to not only consult the recipes but also to imitate the movement of a skilful worker and to improvise by sampling the taste of a dish. The bodily practice of learning to become a chef or a baker in the kitchen, therefore, educated one's caring awareness for

one's customers and workmates, which should thus be regarded as efficacious.



Fig. 6.8 The fresh salad made in the Garden Café, a photo on Restore's Twitter in September 2021

Attending to a diversity of customers

In the kitchen, people learnt cooking by attending to the fresh, nourishing culinary materials and imitating the movement of a skilful worker. The work at 'the front' by the counter, by contrast, engendered more direct interactions with different customers. The work on this side also provided opportunities for people to learn catering skills, such as the ways to use the coffee machines and cash till.

As Sarah once demonstrated, one needed to touch the metal jug with one hand when steaming the milk. The temperature should be high enough that the hand would feel it difficult to stick to the metal jug for a long time. Only in this way, the coffees mixed with steamed milk, such as cappuccino and latte, would remain hot when handed to the customers.

Besides checking the temperature of milk, a worker at the front needed to be familiar with the coffee bean grinder and to distinguish the different sizes of portafilters and coffee cups for the single and double options. He also had to distinguish the decaf teabags and coffees and swap the cow milk to plant milk when needed. Not all skills were easy to learn. It usually took at least a week of practice to gain a preliminary.

Apart from making hot drinks, there were other tasks expecting the body to work with skill, attentiveness, and care. The cash till, for instance, was more complicated than the coffee machine for many novice workers. To process the orders and take payments, one had to memorise the correct procedure to type on its keyboard. Moreover, people who worked by the cash till should do what Katrin called ‘customer service’ by welcoming the Café visitors with friendly greetings.

Even after one mastered the skills to work on the coffee machine and the till, one needed to be sensitive and alert to other jobs while working by the counter. As Sean once reminded me, we should be frequently checking the sugar bowls and water jars and refilling them in time. When the Café was less busy, Edward taught me the ways to match up the utensils, put them into clean napkins, and folded the napkins neatly into pouches. Greta and Edward also demonstrated to me that we should walk frequently between the seating area, the counter, and the kitchen to deliver orders and pick up dishes for washing-ups.

Many members, including Joseph and Ellen, told me that they felt the work at the front was ‘more challenging’ than that in the kitchen. They found that they needed more practice to master the ways to use the coffee machine and the cash till. Since the work

by the counter was also oriented directly to the customers, any mistake or slow movement might also become evident.



Fig. 6.9 The Garden Café's counter, with a door on the side opened to a patio with a small vegetable plot and some chairs for some members to take cigarette breaks, the photo was taken by the author in June 2023, note that the food price had slightly increased due to the inflation

Moreover, the work at the 'front' was in the middle of a collaboration chain connecting the kitchen and the customers. Working at the front, therefore, required more instant responses and kinaesthetic flexibility to navigate the peak hours. However, once they mastered all the major skills to work by the counter, several members tended to prefer working on this side rather than in the kitchen, because they enjoyed catching up with regular customers. Sean and Joseph, the member who undertook the task as the cashier, also enjoyed counting coins and typing receipts to see how much the team had

made the for the day and announced the number with satisfaction during the afternoon group meeting. By making their places by the counter through enthusiastic work, they became empotted to the workspace at 'the front' as the skilful cashiers and baristas for the Garden Café's regular customers.

Most regular customers of the Garden Café came from nearby. Three social clubs met weekly in the Café: a parent-toddler group, a women's running group, and a yoga group. Each social club had fifteen to twenty members. The staff at the East Oxford Health Centre and the charity workers from Oxford Mutual Aid, and other people who worked in institutions nearby bought their lunch meals to take away. [158] Besides, a few elderly couples often came to the Café for an hour-long lunch once or twice a week. Some lady friends who had retired also came occasionally for afternoon tea. They remembered the names of the members who worked by the counter. Once after they tried the café's special pastries for the day, they asked to meet the chef by the counter to praise him for his work.

As already mentioned, the 'regulars' also comprised members and staff who worked in the Restore office and the Beehive Recovery Group, which were on the same site with the Garden Café. These regular customers who worked at Restore occasionally came to the Café for coffee and food. Some brought their family and friends, while others came alone with a book. In 2019, a few members who had already left Restore also planned to set up a social group which met weekly in the Garden Café.

[158] The Oxford Mutual Aid is a local charity collaborating with the Garden Café to provide food and other essentials to low-income families and people living with disabilities. See the link to its website: https://oxfordmutualaid.org/

Notably, the customers who did not know the members personally would not be able to tell if a worker in the Garden Café was a service user, a staff, or a volunteer. What they saw were skilful baristas and friendly cashiers at the front, efficient chefs and bakers in the kitchen, or novice trainees trying to learn some, skills in catering (as detailed in the sections below). In this way, within the spaces of Restore's garden café, the distinction between 'normies' and 'crazies', which Sue Estroff (1981) had criticised, evidently had become blurred.

Most regular customers were aware of the Garden Café's charitable feature and were very patient when the person in service was a novice. There were also customers who had been through similar mental health troubles as the charity members. Many members who worked by the counter could easily identify these customers who were 'having a bad day' and they learnt from each other and the staff how to deal with the crisis in calm, professional manners. Once, for instance, a customer exclaimed loudly by the counter that the coffee freshly made for her was 'chilling'. Without explanation, Ben instantly made a new cup and handed it hot to this customer. In the afternoon group meeting that day, Sarah checked out with Ben if he was alright after the incident. Having tasted the staff drink that Ben made for me, I knew about his barista skill. Ben confirmed that he was ok. And Greta talked about her experience working with difficult customers. Whether the encounter was nice or not, these real-life circumstances of working with different people offered a chance to exercise one's social skills with others in a formal setting.

In summary, the work by the counter demanded one to learn several technical skills, such as the skills to use the coffee machine to make different types of coffee on the menu and to take payment on the till. Besides, members at the front needed to provide customer service and move frequently between the kitchen, the counter, and the seating areas to deliver orders and food. Many members found the work by the counter more challenging than the work in the kitchen as it contained more complex social situations of dealing with different customers. However, members who mastered the skills to work on this side tended to enjoy hosting a diversity of regular customers. By mastering the skills and techniques to work as baristas and cashiers by the counter, their bodies became agile and their awareness of others increased, which could also be regarded as evidence of the therapeutic efficaciousness of the catering work.



Fig.6.10 Coffee and cake made by members and staff in the Garden Café, which were sold and served by the counter, a collage made by the author from two photos posted on Restore's twitter account in December 2020

The fast-paced collaboration between the kitchen and the counter

Every day in the morning meeting of the Garden Café, people picked a 'side' to work at. It could be either 'the front' by the counter or 'the back' in the kitchen. The workmates at the front and the ones in the back worked together to navigate the peak hours. The two sections above discussed the body techniques to work on both sides. This section here presents how members collaborated with the catering skills and body techniques to process the increasing orders during peak hours.

While workmates at the front moved frequently between the counter and the kitchen to deliver orders, drinks, and food, those in the kitchen moved swiftly among the different cooking areas to make several lunch meals at the same time. On either side, one needed to be aware of others while conducting one's own task, which generated the correspondence of collaboration. As Ingold (2022) explains, 'correspondence' was like two friends walking down the street while talking to each other at the same time. They moved through the space to reach somewhere while being attentive to what the other was saying. The 'front-space, back space' collaboration in the Garden Café generated a similar correspondence. People were in their own processes of completing a specific catering task, but at the same time, they also needed to be responsive to the 'doings' and the demands of others. [159]

When Edward walked into the kitchen from the counter to announce the new food orders, Eric and Greta nodded to him while matching the calling numbers for the lunch

[159] See the link to the recording of Ingold who talked about the example of correspondence in his book launch at the Royal Anthropological Institute on 11 March 2022: https://www.youtube.com/watch?v=3uG3tJb1aOE

meals ready for the customers. Eric then placed a toastie on the sandwich maker and put the garnish salads and crisps on a plate while waiting for the toastie to be grilled. Meanwhile, Greta was by the stove, stirring the soup in the pot while minding the slice of quiche spinning in the microwave oven. To participate in this front-back collaboration, people on both sides needed to have quick eyes, so they could concentrate on their own tasks while offering help to others. The sharp ears would also be helpful for those in the kitchen to catch the orders, and for those at the front to react quickly to the chef's call bell.

In summary, by means of the body techniques of cooking and catering, people in the Garden Café collaborated to make healthy food in the kitchen and serve hot meals and drinks to the customers. Their collaboration generated a 'front space, back space' rhythm to process the orders in food and drink during the lunch peak. The collaboration was a highly interactive process facilitated by the Café members and staff's mutual orientations, quick responses to each other, and masteries of catering skills. It thus rendered the people's body to be flexible and alert with multiple dimensions of sensory engagements, which should be regarded as an improvement in health and evidence of the efficaciousness of the catering work in this recovery group.

Summary of the section

This section looked at the service members' 'doings' of the catering work in the Garden Café. I demonstrate how members in the kitchen learnt to use a variety of fresh culinary materials from different sources to make the nurturing food on the menu. I also present how people at 'the front' by the counter learnt to use the coffee machine and the till while serving a diversity of customers. I propose that the work on both sides promote can active sensory engagement with people and a diversity of things and thus generate therapeutic efficacies in restoring one's sensory orientation to others.

Most importantly, the garden café workers' collaboration during the peak hours generated a 'front space, back space' rhythm that connected people on the team to be agile and responsive in order to process the increasing orders for the customers. While the rhythm of the teamwork further intensified the service members' orientations to others, the collaboration also empotted the members into the Garden Café's communal spaces when they moved along while corresponding to each other.

Besides the restoration of orientation and empotment, there were other dimensions of therapeutic efficacies. For instance, sense of satisfaction and achievement was also generated among the members through their teamwork to serve the regular customers and make income for Restore. Becoming a valued and dignified worker in the Café might also increase one's confidence and self-esteem. I shall further discuss in the next section some members' participation in the work in the Garden Café in relation to the multiple efficacies that took place in their Restore journeys.

6.5 What the current members valued?

It was the first group meeting after the Christmas break. Katrin, the group coordinator, was ill but she texted Sarah to propose a topic for our morning discussion. Sarah then asked in the meeting if we thought there was any difference between a dream and a goal. She also encouraged us to talk about our dreams or goals for the new year.

To kick off the discussion, Sarah looked at Joseph, who sat on her lefthand side by the table. Joseph then announced that his goal for the new year was to find a paid job. His dream was to learn driving but he did not think the dream could be achieved in a short while. [160]

Sarah then asked Ben if his goal was to find a job as well since Ben had been working closely with Laura, the employment coach for members of the Garden Café. Ben said what was more urgent to him was to change the place he lived. He was on a supported accommodation waiting list which would provide more private space than the place he lived in had at the time.

Sean who sat next to Ben then said that his new year goal was to do the Transition Training and become a volunteer at Restore. [161] Sarah looked happy when hearing this. 'So you thought about it?' She asked. 'Of course.' Sean smiled and lifted his eyebrows.

Michael was the last to speak. He pondered for a while and said he would try to keep healthy in the new year. Laura commented that this was already a big thing in life

[160] I learnt after this morning's meeting that the Driver and Vehicle Licensing Agency (DVLA) in the UK requires additional notification and psychiatric assessment for people who had mental illness to apply for a driving license. See also the discussion of people's right to drive in Chapter 5.
[161] See the discussion of the Transition Training in Chapter 5.

because keeping healthy sometimes also needed loads of effort.

The above discussion presents the Garden Café members' different dreams and goals for the new year. Not all these dreams or goals were related to the catering work in the Garden Café, yet they revealed the different sides and trajectories in each member's life. Such diversity of dreams and goals, I suggest, proves the difficulty for any single, standardised outcome to reveal the most crucial or urgent demand of each service user of a mental health organisation.

Despite the difference in people's dreams and goals, the above members of the Thursday team all turned up on time for their morning group meeting. For one to two days a week, they were the chefs, baristas, and cashiers for Restore. The group coordinators and customers tended to call them by their roles on the team and the members took the roles as their jobs and responsibilities to be good chefs or baristas. They were somewhat emplotted into these roles while being empotted into the communal spaces of the Garden Café. As the below subsections will show, some members had advanced skills in cooking and baking that would enable them to be recruited by a commercial café. However, they still preferred working at Restore rather than moving on to any full-time employment in catering. In this section, therefore, I present the Garden Café members' very diverse responses to 'moving on' and out of Restore. I propose that instead of simply counting the number of people who moved out of the Garden Café to employment, a close examination of each member's emplacement and empotment into the Café reveals another novel perspective of the therapeutic efficacies generated in this recovery group.

Not all for a paid job

Although the Café was set up to prompt employment, members whom I worked with in this recovery group were not all seeking a paid job. Among the ten members whom I worked closely with in this recovery group, only two members told me that they wanted to find a paid job by working in the Garden Café.

Joseph set his new year goal on employment, as noted. He was in his early thirties. Besides spending Thursdays working in the Garden Café, Joseph worked as a gardener at Aspire for another two days each week. [162] During our interview in 2020, Joseph said he was happy in both organisations but for the long term, he still needed a paid job. He explained that he was still young and did not want to spend the rest of his life as a mental health service user in different organisations. He also said that he wanted to make some money, so he could enjoy life a little bit afterwards. Similarly, Jake in his late twenties also talked about his plan to learn some practical skills in the Garden Café so he could find employment in catering afterwards.

Ben who was of similar age to Joseph did not mention employment as his new year's goal. However, he was having employment coaching with Laura, as Sarah noted in the morning meeting. Sarah also said that Ben told her that he was willing to gain more work experience outside Restore.

Edward did not say that he wished to find a paid job by working in the Garden Café. Never did I see him consulting the employment coach at Restore. However, he managed to find himself a part-time job in a science technology company in Oxford.

[162] Aspire is another organisation in Oxford supporting people to find employment. See the link to Aspire: https://www.aspireoxfordshire.org/

Edward had a university degree which might have helped with the job application.

Noticeably, the four members who showed interest in employment were all men below the age of forty. Other members of the Garden Café, however, had very different goals and perspectives. Sean, for instance, was not eager to find a paid job outside Restore at all. He was in his early middle age and said to have enough savings to live self-sufficiently. As Sarah and Katrin noted, the two days in the Café had significantly contributed to Sean's weekly routine. Alex who was of similar age to Sean was also interested in the work and the volunteering opportunities within Restore. However, instead of signing up for the transition training as Sean did, Alex applied for a part-time job to become a 'tutor of experience' at the Recovery College.

Eric in his late thirties was one of the best chefs and a 'star baker' for the Garden Café. Sarah and Greta used to say that with his skills, Eric could easily find a job in a commercial café. However, Eric told me one day when we were working in the kitchen that he did not want to find a catering job outside Restore. Similarly, Justin, Michael, and Nicolas were all in their forties and fifties. Employment was never a topic in our small talk. Nor did I see any of them signing up for a coaching session with Laura.

In summary, not every member in the Garden Café had a goal to find employment in catering by working in this recovery group. Instead, some members were interested in volunteering and part-time jobs within Restore. Some also simply just enjoyed working in the Café and would be glad to maintain the work on their weekly schedule. In the next subsection, I will look at these members' exact work in the Garden Café.

Becoming a host in the Garden Café

During the Garden Café's opening hours, the members worked in the kitchen and by the counter. Some had preferences; some were more flexible. Either way, they participated in the 'front-space, back-space' rhythm so the team could process the increasing orders during the peak hours.

Edward, for instance, was flexible regarding the sides. When some of his workmates wanted to work at 'the front', he went to make salads and cakes in the kitchen. When some members left before the lunch peak for medical appointments, he went to the counter at the front to help make coffee and take orders. When there were new members in the group, Edward volunteered to show them the ways to use the coffee machine and the cash till. He was often taken as a volunteer rather than a member by the customers and the only few occasions reflecting his illness was when he showed up late after the morning group meeting, telling us he did not sleep that night.

At the interview, Edward told me that in the most difficult months after he was discharged from the Warneford Hospital, the work in the Garden Café gave him a reason to get up in the morning and be out of his room for the day. He also said that he used to work part-time in a café when he was a teenager and was thus familiar with the work in both the kitchen and the front. After joining the Garden Café, he found himself enjoying the vibes and the work relations in the group.

Eric, by contrast, had a preference regarding the side. He always worked in the kitchen and Katrin called him a 'star chef' for the Thursday team. Before joining the Garden Café, Eric was a member at the Elder Stubbs. He often proposed to cook lunch

for the gardening group and always volunteered to help at seasonal events, such as the summer festivals and winter warmer. Besides making food and pastries on the menu, Eric sometimes made a special dish for the day with culinary materials available in the kitchen. He baked a Pear Tarte Tatin one afternoon with the ripe pears from the Food Bank and a piece of puff pastry left from making the mushroom rolls. Once brought out to the counter, the pear tarte tatin was sold out in an hour. The customers who liked the special dessert invited Eric to the front and asked how he made it. Eric who answered the customer's question looked a bit shy but also very proud.

As already said, Eric did not intend to seek a catering job elsewhere but rather preferred to continue working in the Garden Café. When the Café was less busy, he would come to the front in the afternoon to join the chats with his teammates. In the winter of 2019, he wrote the Christmas cards for everyone in his group and made a healthy version of the red berry meringue roulade for the Café's Christmas dinner by replacing the creamy fillings with Greek yoghurt. Although Eric did not talk about himself a lot, we could tell that he cherished the work relations he had with his teammates.

Alex was recognised by the Garden Café team as another 'star baker'. The Viennese Whirl that Alex made was a signature treat that was favoured by many regular customers. Michael also usually worked in the kitchen. The task of toastie-making was always his job because he enjoyed pilling up the different ingredients in a fixed order. However, when the front-back rhythm ran out of order due to some small accident, Michael became a bit upset and suggested we work with 'more structure'.

Justin, by contrast, always proposed to work by the counter. He was around retirement age and only worked for a half-day in the Garden Café every week. In the morning, Justin stood by the counter with a welcoming smile and greeted every visitor to the Café cheerfully. Justin could recognise many regular customers and the regulars also knew his name. While having casual catch-ups with the customers, he typed on the cash till and took payment. He worked effectively and would fetch slices of cake from the cabinet while the coffee machine was pouring shots of espressos into the cups.

However, during the morning peak when there was a queue with lots of customers waiting, Justin sometimes left the group quietly to take a break in the team room. He might have found the busy vibes difficult to cope with and thus always left the Café before the lunch peak. Despite the reduced working hours, Sarah mentioned the 'huge improvement' Justin had achieved since he first started working in the group. Although I was not able to investigate the details of any member's illness (explained in Chapter 4), I could tell, with my Mental Health First Aid training, that Justin was struggling with voices. However, he managed to cope with the voices well when hosting the regular customers with his warm greetings, funny jokes, and good barista work by the counter before the peak hours. He also looked cheerful and pleasant when catching up with the regulars who knew him by his name.

Similarly, Nicolas, Sean, and Ben also preferred working at the front. They were familiar faces to the regular customers. Besides, they were willing to teach other members the essential skills to become a cashier and a barista. Nicolas taught me the ways to use the coffee machine while Sean taught Jake how to use the till. When Joseph

who usually worked in the kitchen proposed in a morning group meeting that he wanted to learn some skills at the front, Ben became his ‘supervisor’ by the counter.

By exchanging skills, Joseph and Ben became close friends. They started by making the ‘staff drinks’ in the morning. To help Joseph practice, the rest of us intentionally ordered different types of coffee with various additional requirements such as ‘double shots’, ‘soya milk’, and ‘decaf’. In return, Joseph taught Ben gardening techniques when they tidied up a small vegetable plot by the Café’s patio. While working, Ben and Joseph chatted about football, rock climbing, and other types of sports. They also planned to watch a football match at the Oxford United Club.

In summary, members worked with different preferences of sides and tasks in the Garden Café. Their work celebrated the diversity of becoming ‘better’ by working on the team. Some became what the customers and the staff called the ‘star chef’, while some became the cashier known by every regular customer. Despite the different ways and sides that they preferred to work, the Garden Café members valued the work relations or even friendships that they had with their teammates. Some also enjoyed the occasional catch-up with regular customers who knew them by their names. These close relations needed time to cultivate and effort to maintain and they emplaced and empotted the members into the spaces of the community café where they felt safe and valued. By catering for a community place of their own, they also benefited from a sense of relatedness and belonging, which stabilized one’s weekly routine and reduced the loneliness one might experience when struggling with the illness.

6.6 Conclusion

This chapter explored the multiple efficacies of the catering work in Restore's Garden Café recovery group. The Garden Café carried a mission to promote employment among the service users, so the service of Restore could generate better outcomes for the charity's statutory funders. However, service members in this recovery group benefited from the work in different ways.

The stories of four former members show that the members emplotted them into the roles of good café workers through their narratives. The process of emplotment organised and revealed their actions during the work, their interactions with others, and their perceptions of the therapeutic efficacies. The stories that people talked about their time in the Garden Café demonstrated the diverse and changing attitudes they had towards employment.

The ethnographic records of the members whom I worked with in the Garden Café also presented a diversity of attitudes towards moving on and out of Restore for employment. Some members indeed aimed to find a paid job in catering with the practical skills they learnt from the Garden Café. However, there were also many members who did not find moving on to paid employment a desirable goal for their recoveries. Instead, it was the continuity of working in the Garden Café that helped them maintain a better state of health. The ethnographic evidence in this chapter provides details for these alternative ways for one to get better, which demonstrated the multiple efficacies of the catering work in the Garden Café.

Initially, the Garden Café was a safe place for its service members to work at. It

was also a popular place for people within a 'Restore community', such as the staff and service users in other recovery groups or the Recovery College of Restore. As a community café, the Garden Café distinguished its spatial arrangement from other commercial cafes. By catering for a diversity of customers, the members could learn to deal with different real-life social circumstances with resilience.

Besides, the catering work in the kitchen and by the counter both engaged skills and techniques for learning. The process to learn and practice these skills and techniques related the novice workers to the workers with experience. The work also promoted sensory engagements and educated one's attention to a diversity of culinary materials and tools to make fresh, nurturing food and drinks on the menu for one's customers, workmates, and oneself. The sampling of the taste of the food or the temperature of the drink also cultivated a caring awareness of the demands of others.

Moreover, the work during the peak hours also generated a 'front stage, back stage' rhythm. The rhythm intensified the sensory relatedness generated by the attentive practice of catering skills and techniques. It also emplaced and empotted the members into the Garden Café's calming, safe, and communal spaces by promoting the members' agile bodily movements between the kitchen and the counter, correspondence with workmates, and responsiveness to the customers. It was the sensory relatedness that made the catering work in the Garden Café vital, productive, and therapeutic.



Fig. 6.11 Vegan chocolate cakes made by a service member and the author, with fresh salad in the background, a photo taken in December 2019

Discussion

This thesis is prompted by a burning problem of treatment evaluation. Restore as a mental health charity needs to provide evidence for its service outcome. The outcome measures that the statutory funder adopts, with inevitable bureaucratic necessities, do not look at how the service members 'do' the work in their recovery groups. Rather, the standardised measures emphasise several accountable indices such as the BMIs of the service members and the 'discharges' of them into paid employment. The thesis, therefore, presents an alternative way to assess Restore's recovery group work.

Medical anthropological studies have identified several positions and approaches for treatment evaluation. In application to my research, I made a diagram to demonstrate the different approaches to evaluate the service of Restore. The diagram builds on the table that Elisabeth Hsu made in 1996 (Hsu 1996:38, see Chapter 1), and the format is inspired by Pierre Bourdieu's (1979) diagrams in *Distinction*. The horizontal axis shows how general (accountable) or diverse (processual) an evaluation approach is, while the vertical axis shows to what extent the approach is 'down to earth', or close to the everyday life of mental health service users and grassroot practitioners.

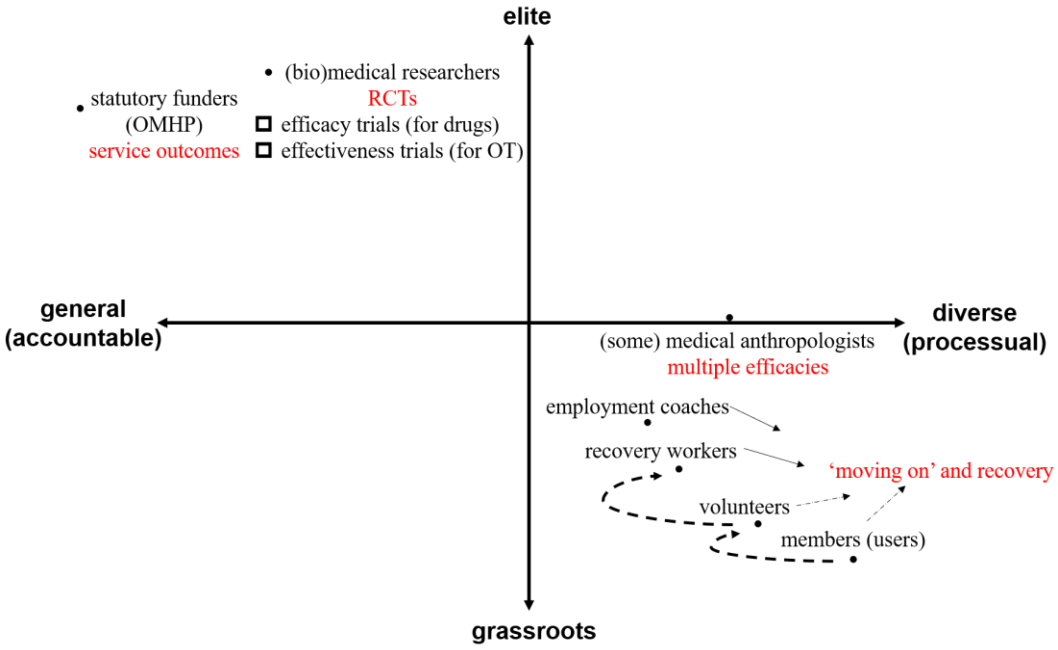


Fig. 7.1 Different approaches to evaluate the service of Restore

As the diagram above demonstrates, the medical anthropological evaluation, which my thesis initiates, explores the multiple efficacies of Restore's recovery group service. It thus emphasises the treatment outcomes which are diverse and processual. The treatment outcomes conceptualised in such a medical anthropological framework, therefore, are arguably closer to the lived experiences, life trajectories, and expectations of Restore's service members, which are ever-ongoing and diverse.

The service outcomes that the statutory funders (i.e. the Oxfordshire Mental Health Partnership) pursue, by contrast, are more general and accountable and are thus easier to monitor. However, the OMHP's audit of treatment outcomes directly influenced the definition of 'moving on' and 'recovery' at Restore, which is to move out (i.e. be 'discharged') from the recovery group within two years. One main argument of my thesis, therefore, is to propose a more inclusive and open-ended definition of 'moving on', which I shall elaborate on in this chapter.

The biomedical researchers' evaluation approaches rely on RCTs. The classification of the RCTs endorses a differentiation between 'efficacy' and 'effectiveness', while in social sciences the two words are often used interchangeably, as Chapter 1 reviewed. The hands-on activities organised at Restore could be recognised by the biomedical subdisciplines as treatments in Occupational Therapy (OT). Although my doctoral research did not take a closer look at the treatment evaluation of biomedical scientists, it might be necessary to note that the RCTs became the gold standard in biomedicine only in the late 1950s and 60s (Kaptchuk 2001: 542). The mental health professionals before the RCTs became dominant might have adopted different evaluation approaches, which were arguably more 'down to earth', diverse and processual, as the empirical materials in Chapter 2 indicate.

In the following sections, I will summarise the conceptual frameworks and research methods that my thesis has adopted to explore the multiple efficacies of Restore's recovery group work. I credit my adoption of correlating theories and methods to the approach of Sensory Medical Anthropology developed at Oxford. I will then present the findings of my doctoral research with proposals for practical applications.

Sensory Medical Anthropology's approach to therapeutic efficacies

The thesis adopted the approach of Sensory Medical Anthropology. The approach takes a sensory and phenomenological framework to work with key themes in medical anthropology which, as applied to my doctoral research, is the question of therapeutic efficacy. From the scope of Sensory Medical Anthropology, the tipping point to decide what 'worked' in a therapeutic process depends on whether the efficaciousness could be directly felt by the body (see review in Chapter 1, Section 3). Identifying the bodily-felt efficacies in a therapeutic process, therefore, demands an ethnographer to pay close attention to the bodily 'doings', precisely the body's movements through space, sensory engagements, and the practice of body techniques.

Three conceptual stances guided my adoption of Sensory Medical Anthropology's approach in my doctoral research (as reviewed in Chapter 1, Section 4). Initially, Thomas Csordas's (2011) definition of 'orientation' as a key component of corporeality helped me to identify a problem experienced in mental illness, which I refer to as the problem of orientation to being-in-the-world. Moreover, Merleau-Ponty's ([1960]1964) discussion of intercorporeality, alongside Dermot Moran's (2017) and Csordas (2008)'s reviews of this concept, guided me to look in my fieldwork diary for the descriptions of people's handling of things and their responses to group collaborations. Finally, Elisabeth Hsu's (2022) discussion of therapeutic empotment, in connection with Cheryl Mattingly's (1998) therapeutic emplotment, guided me to look for my records of the service members' attentive learning of skills and body techniques. The concept of empotment as an emplacement through bodily 'doings' also enabled me to theorise my

fieldwork findings about whether and how the service members at Restore can become 'better' without moving out or being 'discharged' from their recovery groups.

When I did fieldwork in the three recovery groups of Restore, the training in Sensory Medical Anthropology guided me to be aware, and make use of, my own body's sensory engagement. The approach also drew me to a more immersive version of participant observation, precisely participant learning (or participant experience). The fieldwork method guided me to learn the essential and intricate skills and techniques with my own body to a degree that I could independently undertake some hands-on tasks when I volunteered in a recovery group of Restore (review in Chapter 5). Instead of observing service members as research 'subjects', the approach of Sensory Medical Anthropology also prompted me to experience things happening immediately 'between us' as a group of collaborating workmates. This approach thus enabled me to identify and describe the intersubjective and intercorporeal relatedness, the rhythms for collaboration, and the processes of therapeutic emplotment during the recovery group work, as Chapters 4 to 6 have demonstrated.

After the abrupt termination of my fieldwork due to the outbreak of the COVID-19 pandemic, the approach of Sensory Medical Anthropology inspired me to extend my body's sensory engagement when I studied archival images, transcribed the audio recordings as spoken discourses (See Chapter 2), and organised online interviews with photo-elicitation (Chapter 3). The approach made me more reflexive when I worked with a diversity of empirical materials. I became aware of my own body's imaginative experience of sunlight and air when I looked at archival images of the public asylums.

I also recognised the truth value behind the overlaps and interjections in the seminar participants' group discussions.

With the approach of Sensory Medical Anthropology, the empirical studies in the thesis offered an alternative way to evaluate the effectiveness of the recovery group service at Restore. They should contribute to medical anthropology's study of treatment evaluation. On a practical level, the empirical observation of the thesis also serves as valid evidence of the therapeutic efficacies that should impact Restore's future funding. In the next two sections, I shall summarise my research findings respectively in the two aspects.

Cultivating sensory relatedness

What do gardening, craftwork, and catering have in common? To Marcel Mauss, they are the 'special industries with special uses' (Mauss [1967]2007:40). One needs to learn and practice several body techniques to work in an allotment, a woodwork shed, or a community café. Alternatively, Hallam and Ingold may conceive the work as processes of making and growing. They may examine the different things and materials engaged in the processes to question the classificatory boundaries between artefacts and organisms (Ingold and Hallam 2013: 15). My thesis asks a similar question about the commonality of the three hands-on activities. It explores the therapeutic efficacies of gardening, craftwork, and catering when they were organised in the recovery groups of Restore.

With the approach of Sensory Medical Anthropology, I looked at people's bodily

‘doings’ when they worked in their recovery groups at Restore. The focus on bodily ‘doings’ drew on my medical anthropological inquiry of multiple efficacies, while the method also resonance Margaret Field’s ethno-psychiatric study in rural Ghana in the 1950s (review in Chapter 1) and Restore staff and volunteers’ observation-based assessments of the service members’ progress (discussed in Chapter 4).

By looking at the service members’ bodily ‘doings’ when they worked and collaborated in groups, I propose that the gardening, craftwork, and catering work at Restore became efficacious through the sensory relatedness generated immediately during the work. With ethnographic evidence in Chapters 4-6, I propose two key instances that promoted the cultivation of sensory relatedness. The first instance is the education of attentiveness in the learning of body techniques and skills. The second is the synchronisation to the rhythms when one collaborated with others in groups.

Initially, all work at Restore enacted techniques and skills. One needed to learn the ways to use one’s body to check if an apple on the branch was ready to be picked, if the junior hacksaw ‘liked’ the way one saw on the bamboo stick, or if a tomato was firm enough to be cut into pieces for the salad. The learning and practice of these skills and techniques educated the body to be attentive in orientation to a diversity of things, such as plants, tools, woods, and culinary materials.

As Tim Ingold notes in his review of Erin Manning, attention is not consciously directed by a subject. Rather, it is emergent in the event as the fundamental mode of being-in-the-world (Manning 2016:154 in Ingold 2017:19). The therapeutic efficacies, therefore, did not arise from one’s taking up of a fixed position in relation to other

people, plants, or tools. Rather, the recovery group work became efficacious because there were events of learning and practice, during which one's body became actively orientated to other people, things, and the world.

Moreover, the techniques and skills that people learnt and practised at Restore embodied the charity's ethos to be a 'store' that catered for the local community it belonged to (introduced in Chapters 3 and 4). The learning of skills and techniques, which I participated in alongside the service members, volunteers, and staff in the recovery groups, also educated a caring attentiveness to the preferences and demands of their regular customers. Most importantly, the caring attentiveness to others was considered important to transform the service members into skilful workers who were respected and valued by their workmates and customers.

Besides the learning of skills and techniques, the rhythms of group collaborations also contributed to therapeutic efficacies. They emerged from people's mutual attentiveness and orientation. When the gardeners formed small groups to pick apples, harvest pumpkins, and do weeding, their intercorporeal relatedness in the groups took shape and intersected with the ways how the plants grew themselves in the plots (see Chapter 4). When the craftsmen and craftswomen gathered around the table to work on their ongoing projects, they formed in circles which facilitated them to offer help and advice to each other (see Chapter 5). When the café workers collaborated to process the piling orders during the peak hours, they moved between the kitchen, the counter, and the seating areas to work with a 'front space, back space' rhythm which was fast in pace (see Chapter 6).

As the ethnographic examples in my thesis show, the rhythms of the work coordinated the Restore members' movements through space while relating them through mutual attentiveness. As Elisabeth Hsu notes, the anthropological discussion of rhythms and interspecies synchronisation has inspired medical anthropological research on the effectiveness of treatment (ibid. 92). By working along the rhythms, the service members contributed to and benefited from a sense of togetherness. They also became emplaced and empotted into caring and productive relations with others.

Towards a more inclusive definition of 'moving on'

During my fieldwork between 2018-2020, the service members and staff at Restore talked about 'moving on' as moving *out* of one's recovery group. After the Oxfordshire Mental Health Partnership (OMHP) became the Charity's biggest funder, 'moving on' became compulsory for all Restore users. The existing members were encouraged to consider opportunities elsewhere than their recovery groups, while new members would be informed at the registration stage that Restore provided only a 'stepping stone service' which did not usually last for longer than two years.

An important reason for the 'moving on' to become compulsory for all Restore members is the OMHP's monitoring of service outcomes. The OMHP demanded Restore make monthly reports about the number of users being 'discharged' from its recovery groups. The OMHP also asked for details about the 'destinations' of discharge and expected at least 60% of users to move on to paid employment, structured volunteering, or education and training programmes. Specifically, it demanded at least

18% of users move on to paid employment, which made employment an outstanding outcome in comparison to the other two types of 'destinations'. Indeed, there are bureaucratic necessities to make the services accountable and sustainable, but my thesis highlights another story by questioning the degrees of realities that the OMHP measures can reveal regarding the therapeutic effectiveness of Restore's recovery group service.

In a way, the OMHP measures of 'number of discharges' and 'destinations of discharge' assume that the places which provide effective treatments should be segregated from everyday settings, that people had to be isolated to be treated, so they could return to a 'normal' life in 'the community' for 'common people'. This mindset has long been critiqued due to the bias it generates regarding what counted as normality and what made a community. It might be carried over from the time when the major mental health care was provided among institutions with physical boundaries and enclosed management, which made the 'discharge' of patients (or 'inmates') straightforward to discern, as studies in Chapter 2 demonstrated. However, the 'inside' and 'outside' of contemporary community mental health services like Restore have been arguably more fluid. Whether 'discharged' or not, members could benefit from the connections they made through working in a recovery group. I shall compare the Restore journeys of Ariel and George to demonstrate the nuances.

Ariel worked at the Elder Stubbs for roughly one and a half years and 'moved on' to start a traineeship in catering in a local social enterprise. She had a relapse after the first couple of months and was transited to intensive hospital care for three months in winter. At the time, her Restore membership was closed, possibly marked as an incident

of ‘dropping out’ rather than ‘moving on’. She started working at the Elder Stubbs again in the spring of the following year and started volunteering as a cashier in a downtown charity shop on weekends. When her Restore membership came to an end after a total of around fifteen months, she started a traineeship in catering at a local social enterprise. Ariel said she needed to pay for the training but would gain structured work experience afterwards. Her ‘Restore journey’ then had a clear ‘destination’ for the OMHP to monitor.

George, by contrast, had been a member at the Elder Stubbs since the early 1980s. While Ariel was usually quiet at work, George was an active member who was often seen chatting, joking, and laughing with others. Many staff, volunteers, and members knew George by his handwaving greetings and his offers of caramel wafers.

After ‘moving on’ became compulsory for every Restore member in 2015, George remained working at the Elder Stubbs for another five years. To the OMHP, Ariel’s journey was an accountable outcome that validated the efficaciousness of the service of Restore, while George who spent the better time of his life at the Elder Stubbs would be labelled as ‘getting stuck’. However, George did not have fewer activities to participate in than Ariel, although he did not leave the recovery group within two years.

Besides working at the Elder Stubbs on Fridays, George volunteered at a community café run by a church in South Oxford on Mondays. There, he did table service and the washing-ups in the kitchen. The work was unpaid but the café offered a free lunch and some snacks, as did at Restore. On Tuesdays and Thursdays, George attended peer-support groups and art sessions at a wellbeing hub run by the Oxfordshire

Mind, another organisation funded by the OMHP. On Wednesdays, George met some of his friends from Restore and Minds at another café for free coffee and cakes. It was a special offer from the café owner to the mental health service users. On Saturdays, he watched football matches at the Oxford United club with John, a friend he made at the Elder Stubbs. He then took a break on Sundays.

George told me that most activities he participated in were introduced by Restore's employment coach and Julia, his Shared Lives carer. [163] When George left the Elder Stubbs recovery group in 2020, he had already found a new activity for Fridays, which was to volunteer in a charity shop in Abingdon, a small town near Oxford. After his membership terminated, George maintained a connection with Elder Stubbs by calling the on-site telephone at lunchtime to say 'hi' to everyone. When John, another member who befriended George, let George know about the group's outing to the woodland on Boars Hill, George showed up at the allotment on the day and cheerfully joined the trip, although his attendance was unexpected to the recovery workers.

The Restore journeys of Ariel and George show the limitation of the OMHP measure of 'discharges' as evidence of Restore's service outcome. Whether leaving the Elder Stubbs within two years or not, George and Ariel discovered different places to go to and a diversity of things to do in a week. They each made progress in ways that kept them content, and even satisfied.

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[163] The Shared Lives Scheme was an adult social care service of the Oxfordshire County Council. The Scheme matched people who needed additional support to live independently with a carer who provided accommodation, food, and family-like companionship. The carer would be paid for the caring work at a rate between £333.96 and £455.40 per week (2021 rate). For more information, see: https://www.oxfordshire.gov.uk/residents/social-and-health-care/adult-social-care/housing-options-and-care-homes/shared-lives?utm_term=nil&utm_content=

Besides George, other service members also made a diversity of progress by working continuedly in a recovery group of Restore. Jane began volunteering on a farm after finding herself enjoying working outdoors when she did gardening at the Elder Stubbs. Jasper fulfilled his long-term goal to hold a one-man show of his artwork in the Garden Café and sold some of his paintings to the Café's visitors. He also enjoyed teaching other members craftwork in his recovery group. Sophie, one of the star bakers in the Garden Café, had her photography work made into postcards, which made a good sale for Restore at the Café's counter. With the craftwork and IT skills she learnt at The Orchard, Lillian started selling handmade jewellery and other small handcraft pieces on Etsy. Encouraged by her Restore workmates, Florence became a mental health activist on social media. She was committed to reducing mental health stigma in the community.

With evidence of multiple efficacies that the thesis presented, I propose a more inclusive definition of 'moving on' which considers not only the service members who move out of Restore for opportunities elsewhere, but also members who become better by working continuedly within Restore, either as service users or in-house volunteers. In this way, the service at Restore will not be constrained by the goals for a 'stepping stone service'. Instead, it can allow more diverse ways for service members to cultivate vital and productive relatedness, and thus enable long-term recoveries to take place.

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Appendix 1. Population by ethnic groups in the six wards in East Oxford

Ward*	White British	Ethnic Minority Groups
Temple Cowley	54.6%	Other White Non-British*: 12.5% Pakistani: 6.4% Indian: 4.4%
St. Clement's	65.6%	Other White Non-British: 11.5% Pakistani: 4.4% Indian: 2.3% Black African: 2.3%
St. Mary's	65.8%	Other White Non-British: 13.1% Pakistani: 4.6% Indian: 1.9%
Donnington	52.9%	Other White Non-British: 13.3% Pakistani: 12.0% Indian: 3.5%
Cowley	57.6%	Other White Non-British: 12.2% Pakistani: 6.8% Black African: 3.8%
Churchill	57.9%	Other White Non-British: 10.9% Other Asian*: 5.2% Indian: 5.0%
Oxford City	63.6%	Other White Non-British: 12.4% Pakistani: 3.2% Indian: 2.9% Black African: 2.9%
Oxfordshire	83.6%	Other White Non-British: 6.2% Pakistani: 1.2% Indian: 1.2% Other Asian:1.2%
England	79.8%	Other White Non-British: 4.6% Pakistani: 2.1% Indian: 2.6% Black African: 1.8% Other Asian: 1.5%

* As the 2011 Census defines, the 'Other White Non-British' refers to the While Non-British population excluding White British, White Irish, and White Gipsy, while the 'Other Asian' referred to the Asian population excluding Indian, Pakistani, Bangladeshi, and Chinese.

Data sources:
Oxford City Council, Local authority profiles:
https://www.oxford.gov.uk/downloads/download/819/local_authority_reports
Small area (ward) profiles:
https://www.oxford.gov.uk/downloads/download/1228/ward_profiles_-_may_2021_onwards

Appendix 2. The Garden Café's menu in 2020

Item	Sub-types and notes	Price
Lunch meals and savoury pastries (Hot meals available between 12-2pm)		
Toasted Sandwich ('Toasties') All made with thick sliced seeded brown breads served with a small garnish salad and crisps.	Simply organic cheddar; Mozzarella, pesto, and sundried tomato; Tuna, cheese, and red onion; Ham, cheese, and tomato salad; Houmous and roasted vegetable; Monthly Special	£3.80 for the organic cheddar, £4.95 for the rest
Jacket potatoes	Choose two toppings from: Baked beans, cheddar, stilton, houmous, roasted vegetables, tuna, and sweetcorn.	£4.25
Soup of the day Daily recipe written on the board	Any one from: (list not exhaustive) Leek and potato; Carrot and ginger; Broccoli and stilton; Tomato; Mix of winter vegetables	£2.50 for a mug OR £4.50 for a bowl with a thick slice of rustic bread and butter
Quiche of the day Daily recipe written on the board	Any one from: (list not exhaustive): roasted vegetables; mushroom and onions; smoked salmon	£3
Salad bar	Five to six from below for each day (list not exhaustive): Fresh leaves; Coleslaw; Greek salad; Potato mayonnaise; sauteed asparagus; Honey roasted carrot and parsnips	£3.80 for a bowl of 4 portions OR £1 per portion
A selection of sandwiches	Organic cheddar and chutney; Tuna mayonnaise salad; Houmous and roasted vegetables; Ham salad with wholegrain mustard; Free range egg mayonnaise salad	£2.85
Vegetarian pasties	With spinach and feta filling	£2.20
Mushroom roll		£2.20
Drinks, dessert, and snacks (Available throughout the opening hours between 10am-3.30pm)		
Slice of cake	Four to six from below for each day (list not exhaustive): Viennese swirl; Seedy flapjack; Banana bread; Vegan chocolate cake; Chocolate	£2.20

	brownie; Clementine cake; Lemon cake	
Coffee and hot chocolate Decaf and plant milk options available	Americano (Small/Large) Espresso (Small/Large) Cappuccino (Small/Large) Latte (Small/Large) Mocha Hot chocolate Babycino	£2.0/£2.40 £1.80/£2.20 £2.25/£2.80 £2.25/£2.80 £2.80 £2.80 £1.0
Tea Decaf and plant milk options available	Breakfast tea Herbal and fruit tea (list not exhaustive) Earl Grey, Lemon and Ginger; Chamomile; Mint Tea; Jasmine Tea; Green Tea; Cranberry and Raspberry	£1.60 £1.80
Cold drinks in the chiller	Luscombe Organics, Pip organic juices, Belvoir lemonades, Karma cola, One tinned still water, sparkling water, Elderflower, Ginger beer	From £2
Ice creams	Marshfield farm Ice creams Lickalix organic Lollies	£2
Snacks	Crisps, chocolate, energy bar, etc.	£1