

An exploration of how mental health practitioners perceive and experience the potential tensions that may arise from delivering care and enforcing control

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## **Abstract**

The emergence of recovery as an important philosophy in contemporary mental health care, alongside increasing levels of coercion has drawn attention to the potential for conflicting influences in mental health practice. This thesis examines how such conflicts may be situated in the historical, legal and professional foundation of mental health services, presenting an argument to suggest this exposes mental health professionals to tensions in decision-making.

Inspired by my own experiences as a mental health nurse, this qualitative interpretive inquiry employed multiple case studies to explore whether and how mental health practitioners perceive and experience potential tensions that may arise from delivering care and enforcing control. Data was collected using interviews with mental health professionals and observations in an acute in-patient ward and assertive outreach team. Data analysis using a theory building approach in case study research was adopted to develop an explanatory model which suggests service users are constructed as objects of risk.

Hilgartner's (1992) theory has been employed to support explanations that people with mental health problems are defined and treated in terms of risk. Such a process is enabled by a spatial, narrative and moral distance that is created between service users and professionals. The construction of service users as objects of risk is influenced by professional, organisational and social contexts. However, displacement from the status of risk object occurred when some professionals maintained proximity to service users' subjective experiences.

The study has underlined the importance of raising awareness that recovery values are not being realised in mental health practice. It has highlighted problems with the language of risk and proposed strategies that may enhance opportunities for professionals to remain connected to service users' narratives through dialogue.

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# 1.0 Introduction

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## **1.1 Chapter 1: Introduction**

During my career as a mental health nurse in the National Health Service (NHS) I worked within in-patient and community rehabilitation settings supporting people who were experiencing serious mental health problems. Dilemmas in decision-making were a common occurrence in my nursing practice. Reflecting on these dilemmas, I recognised that I experienced some difficulty when faced with instigating restrictions on people's lives that undermine their own choices; for example through the use of the Mental Health Act. On the one hand, I invested in developing relationships with service users, creating the conditions in which they feel able to be open, supporting them towards recovery and personalised goals. On the other, I had a professional responsibility to act to manage risk and reduce the potential for harm alongside ensuring that people received support when extremely distressed. Meeting this duty meant undermining individuals' choices.

It is these experiences from my previous clinical practice that provide the inspiration for this research. Perhaps these themes are evident in Foucault's (2006) perspectives on the history of madness in which contradictions between control, punishment and compassion are seen as being at the centre of mental health service provision. Undertaking an empirical inquiry into these issues begins with the question as to whether these experiences are shared with others in mental health practice. If they are, arguably there is value in developing insights into the structures and contexts that shape such experiences. This may help us consider whether these tensions are inescapable and ask, if so, what are the implications for people with mental health problems and the professionals that provide support to them? How, if at all, is balance supported to enable the interests and choices of people with mental health problems to be recognised?

The management of risk and supporting recovery superficially present divergent perspectives on the drivers for quality contemporary mental

health care. This contributes to the possibility that mental health practitioners may share the conflicts I experienced and be caught trying to strike a balance between promoting choices and enacting constraints (Morrall and Hazleton 2000, Davis 2002, Campbell and Davidson 2009, Kemshall 2009). Such tensions have been uncovered by research studies related to specific areas of mental health care such as involuntary treatment, restraint and recovery practices (Duxbury and Whittingham 2005, Roberston and Collinson 2011, Wyder, Bland and Blythe 2015, Kidd, Kenny and McKinstry 2015). There is further evidence of literature that seeks to critically examine the issues surrounding risk management, coercion and how these challenges interact with the choice and self-determination of people with mental health problems. The majority of such papers adopt a theoretical standpoint (Paterson and Stark 2001, Szmukler and Holloway 2001, Laurence 2003, Campbell 2010, Perkins 2013, Coffey and Hannighan 2013). There is, however, a lack of empirical research specifically examining the possible tensions within mental health professionals' practice posed by the potential dual influences to control the behaviour of service users and promote choice and recovery.

This thesis presents a piece of research undertaken to explore this specific issue. The study examines whether and how mental health practitioners perceive and experience potential tensions that may arise from both delivering care and enforcing control for people with mental health problems. A multiple case study design was employed to enable in-depth examination of this issue. The research study was conducted within an acute in-patient ward and a community assertive outreach team, incorporating multiple professional perspectives through the collection of data using observations and semi-structured interviews. Inspired by my own experiences as a mental health nurse, the study has been conducted with a desire to provide insights useful for mental health practice and therefore support practitioners to negotiate such tensions to promote recovery orientated practice.

# **2.0 Literature Review**

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## **2.1 Chapter 2: Historical Context**

### **2.1.1 Introduction to Literature Review**

The previous chapter introduced an argument that mental health services are subject to contradictory influences leading to potential tensions in their role. Drawing on relevant evidence and theory in the literature review I seek to establish that these tensions are inherent within mental health practice. Through an examination of the historical context of asylum care I draw on evidence to suggest that mental health services were established to provide welfare and treatment for people in need. I contrast this position with insights that imply the establishment of psychiatric care served to contain a deviant population constructed as in need of control. I consider developments in mental health legislation that demonstrated emphasis on individual freedoms competing with responsibilities of the state for protection of others. Finally, the review addresses two key themes of contemporary mental health policy: recovery and risk management. Within this discussion, arguments for the potential for these directives to drive mental health care in different directions are presented. Throughout the debate, I explore the implications these tensions may pose for the role and practice of mental health professionals.

The review, therefore, examines how tensions may be expressed and constructed in mental health practice. Before proceeding to address this issue, it is important to briefly appraise the meaning of such contradictory influences and associated tensions in mental health care in order to establish the context for the discussion. Foucault (2006) writes of juxtaposition at the heart of psychiatric care. A system evolves to both contain and care for those defined as mentally ill. Containment is enacted in the interests of the rational and serves a correctional and punishing function. This introduces the notion that the actions of psychiatric care may be governed by the interests of those outside the system. Conversely, he acknowledges that this contrasts with the view of mental distress as an illness, and its

treatment as being driven by a desire for compassion and cure. Such a position creates greater emphasis on the interests of those defined as mentally ill. Paradoxes are evident in the manner in which people with mental health problems are understood in each position. The former emphasises mental illness as an irrational state, different and distanced from the norm. The latter recognises shared humanity.

A key component of Foucault's (2006) arguments, that is central to this discussion, is the recognition that these functions coexist. Arguably because of this, tensions are inevitable in mental health care. The potential for contradictory purposes simultaneously influencing the care of people with mental health problems highlights that these issues are not easily defined and bounded. This also allows incongruities within each position to be recognised, including aspects of mental health practice that may be presented as promoting care and understanding but could also be recognised as enacting control. The complexity of such positions creates challenges for the language employed in arguments examining these. Notably as terms used within the literature such as care versus control, autonomy and paternalism can present these issues as polemical which discounts the multiple meanings that may be inherent within apparently opposing positions. I draw out these multiple interpretations, whilst also acknowledging the need to clearly articulate the potential impact of such influences on mental health practice and through this present a rationale for the study.

The term duality is therefore adopted throughout this thesis. This originates in Foucault's (2006) statements regarding the juxtaposition of correctional containment and compassion. The term is used to express the concurrent presence of different forces, acknowledging that these are multi-faceted.

These arguments indicate that attempting to define the terms of possible contradictory influences in mental health care is problematic. However, key themes arise throughout this review of the literature

suggesting that there may be certain features which characterise ‘duality’. Primarily this relates to how the interests of the state and wider society compete with the interests of the individual, including whether people with mental health problems as a group are excluded from having their individual interests acknowledged. Within this review, I present arguments to suggest that these competing interests are exhibited in struggles for control.

I seek to examine the expression of this duality through an exploration of the historical, legislative and policy context of mental health care. I consider that containment has remained a central element of mental health services throughout their development. In addition I explore the function of mental health services to enhance the well-being of people who experience mental distress and how these purposes might conflict. This review illustrates how these dual roles can be viewed within service structure and mental health legislation. I conclude with how this duality may create tensions for practitioners within contemporary mental health services. In this respect the aim is to explore the complex and interwoven dual roles of mental health care. Central to this examination is a consideration of the changing relationship between service users, mental health professionals and the state, reflecting how the concept of control is integral to this shifting relationship.

### **2.1.2 Duality; Asylums Welfare and Containment**

#### **2.1.2.1 The Growth of Asylums, Establishing a Function for Welfare**

In order to understand the role of containment within modern mental health care, it is necessary to review the origins of those services. An exploration of the past helps build an awareness of the social context for the present and the role this history has in the shaping current practice (Ion and Beer 2003). A complex process led to the development of asylum care, with the literature offering a number of different perspectives on the rationale for its growth. This may be



described in terms of a desire to treat and offer welfare to individuals, alongside a process of exclusion which provided protection for the public in an evolving capitalist society (Scull 1979, Morrall and Hazleton 2000).

The substantial growth in institutional care across Europe during the 1700 and 1800s is well documented (Wright 1997, Smith 1999, Morrall and Hazleton 2000, Foucault 2006). Individuals perceived to experience mental illness were found within institutions such as workhouses, houses of correction and private asylums (Kelly and Symonds 2003). In England concern over the conditions within private asylums and the resulting trade in lunacy facilitated a drive for lunacy reform (Porter 2002). Subsequent legislation between 1809 and 1845 allowed for the allocation of public funds to support public asylums, with the 1845 Lunacy Act making the provision of public asylums compulsory (Smith 1999, Fennell 2010, Nolan 2014). This reflected a move to a more centrally managed system of mental health care, which observed medical practitioners taking on a lead role in the operation of these asylums (Rogers and Pilgrim 2001). A subsequent growth in the number of asylums and inmates reflects an increase in the physical confinement of those deemed to suffer from insanity (Foucault 2006, Bartlett and Sandland 2007). However, various arguments have been presented for this growth which offer useful insights into the development of duality in the role of mental health services.

In the latter part of the eighteenth and nineteenth century the total population of England experienced significant growth in the advent of increasing urbanisation and industrialisation (Nolan 1993). Such significant social changes had a dramatic impact on the extent of poverty and ill health within the population (Nolan 1993). This presented a growing problem for those who were experiencing mental ill health and unable to afford private asylums. In this respect, the development of public institutions was perceived to be underpinned by an evolving sense of social responsibility, in which elite groups

within society had justified cause in treating unfortunates (Porter 2002). This period was marked by optimism for the benefits of the asylum, underpinned by the growing psychiatric profession and the commitment to institutional care as the vehicle to provide a cure for insanity (Rogers and Pilgrim 2001, Porter 2002). Lunacy reform and the vision for asylum care were supported by developing humanitarianism and benevolence within some sectors of society (Rogers and Pilgrim 2001). Institutions provided support for a significant number of people who would be unable to survive outside that system, particularly given that at the time poverty and insanity were the primary areas of social welfare in which the State was prepared to intervene (Freeman 1998). Asylum care, therefore, provided a practical solution for individuals in need (Ion and Beer 2003).

The location and structure of the buildings housing asylums reflected this focus on providing welfare and promoting good health (Philo 1987, Philo 2012, Nolan 2014). Situating institutions outside of urban centres ensured that they were away from disease epidemics which were spreading within the towns (Nolan 1993). Including designs such as airing courts and gardens highlights the importance attached to health (Hickman 2009). The expansion of asylums, facilitated by the campaign for asylum reform, was seen to provide an important opportunity for piloting new therapeutic approaches. This included attempts to abandon the use of physical restraint; examples of which can be seen in the work of Pinel in France, Chiaguri in Italy and Hill and Connelly in England (Porter 2002). The creation of public asylums was hoped to be a departure from the violent ill-treatment, which reformers perceived characterised the ad hoc provision of private and non-specific institutional care (Scull 1993, Smith 1999). Alternative therapeutic values were promoted within the York Retreat, a Quaker institution founded on the principles of Christian humanism, established in 1796. The retreat focused on the humanity of those experiencing mental health problems and promoted moral

therapy that attempted to enable individuals to remain integrated within society (Digby 1985, Nolan 1998, Charland 2007). In this respect, the growth of asylum care and confinement of the insane was an attempt to provide welfare for a large number of individuals in need and to address a growing social problem.

#### 2.1.2.2 The Growth of Asylums, Establishing a Function of Containment

Offering a radically different view, the motives of philanthropists' attempts to deliver this vision have been criticised. Scull (1982) suggests that instead it was driven by a paternalistic concern, in response to the threats to social and moral structure posed by an underclass perceived to be lacking discipline and self-control. A view typified by Jeremy Bentham's commitment to reinforcing appropriate conduct in society through the development of institutions based upon the panopticon (Bentham 2003). Such a structure emphasised the role of surveillance and strict discipline (Bentham 2003, Bartlett and Sandland 2007). This proposes an element of control by powerful groups within society throughout the evolution of the asylum system. Professions such as medicine and law took on responsibility for the welfare of those perceived to be either less fortunate or more ill-disciplined. The move to a centralised system was indicative of a shift in the responsibility taken by the state for the provision of mental health care.

It is possible to challenge the justification for the development of institutional care on humanitarian grounds. Despite optimism for the benefits of the asylum system, it none the less involved the separation of those deemed to be insane from the remainder of society. Certification was legally required for admission, which served to emphasise the custodial role of asylums (Rogers and Pilgrim 2001). Asylums have been described as 'custodial warehouses' for parts of the population who did not fit with the dominant values in industrial urban society (Morrall and Hazleton 2000, Kelly and Symonds 2003).

In this respect, state intervention in creating the asylum system was perpetuated by a rational view of society, in which the insane were perceived to be economically and socially threatening (Scull 1979, Morrall and Hazleton 2000). Containment of the insane within asylums became synonymous with the interests of industrial society (Ion and Beer 2003). The therapeutic optimism of asylum care promoted by the developing psychiatric profession offered a mechanism to return well-disciplined and reasoned members, able to economically contribute, back to society (Rogers and Pilgrim 2001). The function of the system became to serve the interests of the elite and bring regulation and order to the world of poverty (Foucault 2006). Foucault (2006) draws out the duality that this creates within an institutional system delivering confinement and offering treatment, suggesting that alongside the desire for welfare was a desire to punish. I would therefore point to a function of the asylum system for promoting control and regulation within society, presenting physical and social containment as the means with which to achieve this aim.

The social benefits of the process of confinement for certain sectors of society were underpinned by the changing views of madness itself. Explanations of insanity are culturally and historically defined, reflecting social norms and values (Busfield 1996). These have an important influence in shaping the development of asylum provision (Philo 1987). Surrounding the growth in asylum care was increasing secularisation and an expansion of the positivist ideal, which impacted on explanations of madness as well as the public's perceptions. The sane and insane became juxtaposed with the latter being emphasised for their 'uncontrollable passions, undisciplined will or irrational mind' (Digby 1985:1). For Foucault (2006) the progression of confinement expressed the process of the separation of reason and unreason. This course resulted in unreason becoming a state which could be recognised, objectified and segregated. Confinement and the asylums provided a hiding place for unreason, emphasising that this was a state to be feared. In this respect, the

process accompanying confinement and institutionalisation reflected the separation of the mentally unwell on both a physical, social and ideological level.

The changing definitions of insanity provide further evidence of the role of asylums in maintaining social order. Asylum populations grew rapidly during the nineteenth century (Barlett and Sandland 2007). The expansion was facilitated by broad notions of insanity, allowing many experiences to be classified in this way, which served the wider interests of society as well as the professional agenda of psychiatry (Scull 1979).

#### 2.1.2.3 The influence of psychiatry

The history of asylum care and the history of psychiatry are interconnected, though there are differing perspectives on the motives of such a connection. The asylum system provided the opportunity for the psychiatric profession to emerge and lay claim to be the legitimate experts in the delivery of mental health care (Morrall and Hazleton 2000, Porter 2002). The involvement of the medical profession in the increased regulation within private madhouses at the end of the eighteenth century provided a visible role for medical practitioners in administering and governing asylum care (Scull 1982). The dominance of this role was extended throughout the century culminating in the 1845 Lunacy Act legislating for medical presence within asylums (Fennell 2010). It is this role as administrator rather than a specific treatment expertise that initially supported the establishment of their power base. Such responsibility has been described as emphasising the control of psychiatrists as gatekeepers in defining moral and reasonable behaviour within society (Morrall 1998).

Wright (1997) however, points to the mistaken assumptions this argument has been founded upon, which undermines the perceived social role of psychiatry. Families had responsibilities for instigating confinement to the asylum. The process of certification included an

assessment of families' emotional and financial resources to deal with the individual (Scull 1993). For some the asylum may have provided a refuge from ill treatment within the family (Morrall and Hazleton 2000). A dominance of professional discourses in the history of mental health care, at the cost of family, social and public narratives, reflects a modernist tendency to provide a fixed view of history that marginalises opportunities for alternative perspectives (Holyoake 2014).

Despite this, it is apparent that the newly established asylums provided a vessel in which medical practitioners were able to practice and develop ways of treating insanity (Porter 2002, Morrall and Hazelton 2000). In this respect psychiatry becomes the product and the perpetrator of the asylum, establishing their dominance within the system. Psychiatric power extends across administrative, legal and clinical structures (Rogers and Pilgrim 2001, Nolan 2014). The development of asylums was consequently supported by medical rhetoric, shielding some of their social function (Nolan 1993). The advent of asylum care resulted in the expansion of the psychiatric profession and established a beneficial relationship between the State and psychiatry in the control of mental health care (Scull 1979, Rogers and Pilgrim 2001, Morrall and Hazleton 2000)

It is also within this context that the foundations of mental health nursing were established. 'Keepers' were employed to manage asylum populations and administer treatments frequently considered as punishments by those in institutions (Nolan 1993, Kelly and Symonds 2003). The growth of psychiatric nursing within the asylum structure embedded a close relationship with psychiatry (Nolan 1993). Holyoake (2014) notes that maintaining social order has been an essential part of the mental health nursing professions' historical and moral narrative. Tensions are recognised within the roles of attendants and keepers. Alongside adopting a role as enforcer, attendants were also spiritual guides, provided practical support and acted as an intermediary between doctors and patients (Nolan 1993).

The physical structure of the Victorian asylum may embody a custodial role. Whilst it has been recognised that the location of institutions may have had a therapeutic function, the design also belied an emphasis on security and maximising surveillance (Rogers and Pilgrim 2001). Their situation outside of towns and cities represents a spatial segregation from society (Philo 1987, Philo 2012). Clear physical divisions between those inside and outside the walls not only contained the mad but also provided protection of the population from contamination (Rose 1999). This serves to emphasise a concern with containment and control of people with mental health problems. To a certain extent this is exemplified through the mechanisms used to gain therapeutic benefit. The vision of asylum care was seen as a departure from physical violence; however, initially it relied on the use of mechanical restraint and physically invasive treatments. Attempts to reduce physical restraint are marked by a need to increase surveillance (Porter 2002). Interestingly, staff with the responsibility for the care of those in the asylums were themselves subject to high levels of surveillance and regulation (Nolan 1993).

#### 2.1.3.2 Moral therapy and tensions of control

One of the most well recognised therapeutic approaches that challenged the focus on external control through mechanical restraint was moral therapy. Pioneered by the Quaker run York Retreat, moral therapy was characterised by compassion, a comfortable physical environment and a focus on orderliness, the benefits of work and domestic duties, in order to enable recovery (Borthwick, Holman, Kannard, McFetridge, Messruther and Wilkes 2001, Charland 2007). Such an approach was seen to embody the enlightened hopes for a new institutional system.

However, Foucault (2006) has challenged these purely therapeutic values and suggests that they obscure the repressive role of moral treatment in which external control is supplemented for internalised

control through psychological coercion. A system of rewards and punishments becomes a mechanism to support adherence to a strict moral code. Through this process of internalisation an even more powerful form of control is achieved. I find it important to recognise that moral treatment has to be considered within the ideological context of ideas surrounding lunacy during the early years of the York Retreat. At this time, moral factors were implicated in the causation of madness (Digby 1985). The challenge to the perceived therapeutic value of moral treatment expresses a tension between enabling and oppressing, in which a balance is sought between facilitating self-government and enacting moral control (Scull 1993, Digby 1985). Scull (1993) claims that these tensions became resolved through the evolution of the more oppressive system of moral management. However, a danger of historical reconstruction is the possibility of both idealising and homogenising a historical narrative. Digby's (1985) detailed history of the York Retreat departs from a linear view. It highlights the changing nature of the Retreat's practices and ideas, documenting the relationship to moral therapy. Digby (1985) demonstrates that moral treatment is influenced by a complex interaction of factors, including the impact of the individual superintendents. Scull (1993) and Foucault's (2006) contentions could also be criticised for failing to appreciate the influence of the Quakers' own culture, values and place within society on moral treatment (Borthwick et al 2001, Charland 2007). None the less, these challenges point to further tensions within the role of mental healthcare: the inherent nature of control and the potential for therapeutic practices to be viewed as coercive.

The acceptance of moral therapy as a valid treatment by the growing psychiatric profession presented a tool to extend their professional dominance within the asylum system (Morrall and Hazleton 2000). Increasing numbers of patients, and a lack of the promised cure, damaged the hopes of therapeutic optimism instilled by the lunacy reformers. Certification, the breadth of definitions of mental disorder,



coupled with the perceived failure of moral therapy led to pessimism and an increasing focus on the custodial role of asylums (Rogers and Pilgrim 2001, Porter 2002). Psychiatry's response was to adapt, defining mental disorder as chronic (Porter 2002). In the mid to late nineteenth century theories of the causation of madness were associated with moral degeneracy and inherited traits (Porter 2002). Excluding such a threat from society, therefore preventing it from spreading further demonstrates the custodial role of an asylum. This model supported segregation and the control of interactions within the walls themselves (Nolan 1993, Philo 1987, Ion and Beer 2003). In this respect the asylum provides a containing function, protecting wider society from moral and social degeneration. Geographical segregation reflects Foucault's (2006) ideas that the state of unreason is one to be feared.

Alongside a desire to provide welfare, it becomes apparent that the asylum system provided a containing function which may have served to benefit social elites and represented increasing State intervention in the lives of those defined as mentally ill (Smith 1999, Nolan 1993). However, it is important to recognise that ever since its evolution the asylum system had critics who campaigned for a less custodial role (Rogers and Pilgrim 2001). Equally the perception that mental health care was solely institutionally based, with the late twentieth century credited with the birth of community care, can be criticised. Both the family and community based service provision had a role in meeting the needs of people with mental health problems throughout the eighteenth, nineteenth and twentieth centuries (Wright 1997, Digby 1985). Such criticisms could challenge claims of a dominant containing function of mental health care during this time. Enlightenment positivist ideas are associated with a growth in the medical paradigm for understanding madness and an allied increase in professional power. However, ideas linking madness to a disease process have existed for over 2000 years (Lester and Glasby 2006, Kendall 2009). Historical accounts are themselves products of

reconstruction (Scull 1989). Both the pre-understandings of those developing and reading the accounts, are likely to influence the interpretations that are reached. This is particularly significant given my own context when appraising the texts. Acknowledging certain representations of the history of mental health professionals suits current discourses (Holyoake 2014). Mental health nursing is therefore able to represent itself as 'progressing beyond the gatekeeper' role (Holyoake:104). In this respect, Ion and Beer (2003) warn of the implications of viewing our own contemporary practice as something that is real and transcends history. Consequently caution needs to be exercised in accepting the truth of one narrative, particularly when this narrative is dominated by professionals rather than those who experienced life in the institutions.

### **2.1.3 Summary**

Considering the historical development of asylums suggests that since its very conception centralised mental health care has struggled with a potential duality within the functions it serves. Asylums within industrial society provided welfare for people in need, initially attempting to offer the hope of improvement in the condition of those that they admitted (Porter 2002, Smith 1999). They also provided containment for a population which has been perceived to threaten the economic and social order, establishing that mental disorder is a state which needs to be managed and controlled (Foucault 2006, Scull 1993). The therapeutic approaches employed in attempts to enable these improvements have been questioned for their potentially controlling and repressive function, whether this be through a process of external or internal government. A paradox within the fabric of mental health care is constructed. In this context, a duality is expressed in the co-existing functions within institutional care to contain and control people defined as mentally ill, whilst simultaneously promoting their welfare and support. These influences create the potential for competing directions in mental health

provision which may lead to tensions between individuals' freedom and their being subject to external control.

Questions persist over whose interests mental health care serves; whether these are mutual or competing between the State, professionals, service users and wider society. An exploration of how the literature constructs the debate surrounding the development of institutional care locates this firmly within a socio-political context. The importance of this is reflected in the manner in which similar debates are constructed in the literature concerning contemporary mental health services. I will consider these parallels in the remainder of the review.

## **2.2 Chapter 3: Mental Health Legislation; Individual Rights and Social Control**

### **2.2.1 Introduction**

Legislation is a framework for control within society (Tebbit 2005). The construction and implementation of mental health law expresses the duality of mental health care, through a struggle to balance safeguarding the rights of individuals diagnosed with mental ill health and protecting wider society. Concerns with such protection reflect an emphasis on duties to guarantee that people with mental health problems have access to treatment, alongside efforts to ensure that unjustified infringements on their autonomy are avoided. Functions of legislation focused on protecting wider society highlight a need for control of people with mental health problems on the basis of threats posed to the public. These frictions emphasise the potential for tension in practice that operates within the structure of specific mental health law. In this chapter I examine how service users' choices and state control are expressed through the Mental Health Act. It focuses in detail on the Mental Health Act 1983 and its amendments in 2007 to provide a context for contemporary mental health practice.

Mental health legislation throughout the nineteenth and twentieth century embodies the shifting emphasis on ensuring treatment and promoting the interest of civil liberties. Underpinning legislative developments during the time was an increasing focus on the liberal notion of the individual as autonomous and rational. Individual rights stems from the ideal of the individual as responsible and self-controlled (Tebbitt 2005). J.S Mill's theories have been influential in debates regarding legislative based state intervention in the lives of individuals. 'On Liberty' (Mill 1859) argues that the only justification for the exertion of state powers against individuals' will is in the prevention of harm to others (the no harm principle). However, Mill (1859) explicitly excludes people with mental health problems from

this principle, thereby arguing that prevention of harm to self is an adequate justification for intervention. Hart (1963) defends Mill's position to argue that in general coercive laws to protect people against themselves are justified when not used to reinforce moral standards. This position is reflected in the 'parens patrie' principle underpinning legislation, namely that the state is duty bound to intervene and protect those who are unable to keep themselves safe (Coleman and Solomon 1976). The legislative balance between liberty, rights and state authority are evidently much debated. Within these debates rights are associated with certain ideals of the individual. Key political and legal theories specifically exclude people with mental health problems who, as the previous chapter has highlighted, may be perceived as not conforming to these ideals. This identifies them as different and undermines their access to rights in addition to justifying coercive intervention. I find these debates central to understanding the potential for tension within mental health practice. Such debates are evident throughout the development of mental health legislation in the nineteenth and twentieth centuries.

Mental health law provides a framework for constructing the relationship between mental health professionals and service users (Leiba 1998). Legislation is a vehicle through which the boundaries of control can be defined and the role of mental health professionals in administering this are outlined. This serves to both structure the function of psychiatry and aspire to provide protection from abuse of its power (Leiba 1998). These purposes can be contrasted as something of a dichotomy between the interests of the legal and medical professions (Jones 1991). The legal approach is characterised by interest in the liberty of an individual, in which mental health professionals can be constructed as potential agents of abuse. Conversely, the medical profession is held to be seeking a framework within the law to support early and effective treatment, therefore sanctioning legally supported intervention in the lives of people with mental health problems. This dissimilarity can create

tension through the difference in the discourses within which the professions operate (Borthwick et al 2001, Bartlett and Sandland 2007). This debate serves to highlight powerful competing interests within the design and implementation of the law, revealing the potential for conflict between the rights of the individual to treatment, protection from abuse and compromise of autonomy. However, it fails to take account of the role of both the public and the state in constructing these legislative frameworks. This review goes on to consider how these discourses are represented within amendments to the Mental Health Act 1983 and 2007 outlining how these contribute to duality within mental health services.

### **2.2.2 Safeguards and Rights, Mental Health Act 1983 and Mental Health Act 2007**

Legislative developments introduced by changes to the Mental Health Act in the late twentieth century have been presented as positive progress for the rights of people with mental health problems who are subject to the Act. This concern with protection from unnecessary infringements on liberties and access to quality treatment reflects Foucault's (2006) ideas regarding mental health services' role in promoting care for the mentally ill.

The 1983 Mental Health Act is seen to redress the balance created by the lack of protection afforded to service users in the Mental Health Act (1959). It legislated for the conditions in which liberty can be removed and treatment enforced, making more explicit the boundaries of this. Legislative change introduced greater opportunities for individuals to appeal, which was matched by a significant increase in the number of review tribunals in the 1980s (Gostin, Bartlett, Fennell et al 2010). It also included increased protection for those receiving enforced treatment; foregrounding the rights and welfare of those under the act (Symonds 1998, Edgley, Stickley and Masterson 2006). However, the protective power of bodies such as tribunals and the

Mental Health Act Commission to really challenge the power of mental health professionals has been questioned (Symonds 1998).

Recognition of the rights of individuals diagnosed with mental illness within the 1983 Act is significant. During the period of the amendment to the Act the face of mental health services was increasingly fragmented with a growing movement away from institutional care, highlighting the need for a clear framework for the conditions in which involuntary admission to hospital was permitted (Butler 1993). The shift away from the segregation of those perceived to experience mental disorder in the nineteenth century, to their reintegration into the community in the late twentieth century creates emphasis on the social rights of individuals with mental health problems (Goodwin 1997). This occurs in a wider social context of western societies increasingly concerned with civil rights, citizenship and access to inclusion (Goodwin 1997, Barnes and Bowl 2001, Pilgrim 2009). These movements provided grounds to critique liberal notions of the individual present in legislative debates regarding rights, as represented in Mill's theories, which masked gender and class interests (Tebbit 2005). Such developments acknowledge the rights of marginalised groups and promote a move for greater equality for people with mental health problems, supporting a drive for community care and reduced government control (Edgley et al 2006). This could represent a desire to shift away from physical containment within a segregated system and more emphasis on the protection of service users' autonomy. Advocacy was acknowledged as part of these changes, which may be construed as an attempt to offer enhanced control for people with mental health problems themselves.

#### 2.2.2.1 Proposals to Reform the 1983 Mental Health Act

Further progress towards rights and equal treatment for people with mental health problems could be viewed in initial plans published by the Richardson Committee for revising the Mental Health Act 1983 (Department of Health (DH) 1999). The expert committee was

convened to advise the government on the requirements of mental health legislation within contemporary society. The committee stated its support for the development of a legislative framework which was able to balance the rights of individuals diagnosed with mental health problems and those of wider society (DH 1999). This presented an opportunity to address the criticisms of previous mental health legislation and to extend the focus on the rights of those subject to the Act. The Richardson Committee recommended a number of key components of revised legislation; a summary of which is outlined in Figure 1.0.

Figure 1.0 Summary of Richardson Committee Recommendations

**Principles:** Non-discrimination on grounds of mental health. There should be a promotion of patient autonomy and care in least restrictive environment.

**Reciprocity:** If legislation supports compulsion of people with mental disorder, it must also impose a duty on health and social care services to provide a standard of care for those who are compulsorily detained

**Safeguards:** To protect rights of those detained to include: right to advocacy, assistance with constructing advanced agreement, right to safe containment including respect for dignity.

**Mental Disorder:** A broad definition of mental disorder be adopted with a number of specific exclusions for example where diagnosis is primarily associated with misuse of alcohol or drugs.

**Compulsion:** Recognised the continued need for compulsory assessment when informal care fails, that this application should be made by an Approved Social Worker but that the potential for this role to be extended to other mental health professionals be considered. Compulsory treatment would be allowed in specified circumstances.

Processes include compulsory care and treatment order, with tribunal who have powers to make decisions as to whether care takes place in hospital or community.

**Capacity:** That capacity in relation to decisions regarding treatment should play a key role in identifying whether there is a need for compulsory treatment.

(Department of Health 1999)



John Rawls was a political philosopher whose liberal theories provide an important framework for examining ideas regarding equal rights and the legitimate, democratic use of coercive power. As part of John Rawls' (1971) vision of civil society he proposes two key principles; that every member of society has equal right to basic liberties and that inequalities (social and economic) should benefit the least advantaged, with all having equal access to opportunity (Rawls 1971). Liberty is identified as most important to enable members of society to pursue their goals. Coercive Law (recognised by Rawls as the exercise of political power) is only legitimate when compared to publicly justified norms, rather than doctrines (e.g. religious) that may not be sanctioned by all (Rawls 1981, Quong 2013). This position recognises members of civil society as autonomous moral agents who wish to act for the good of justice in society (Freeman 2004). The Mental Health Act has been recognised as the state's 'coercive power intruding on the freedom of the individual' (Bartlett and Sandland 2007:120). When applied to mental health services, Rawls' theory of justice suggests that autonomy is prioritised. Any compromise to autonomy, exercised by mental health services has to be clearly justified. Significantly, autonomy is related to his principle of liberty rather than rationality suggesting that individuals have the right to make 'irrational' decisions (Ikkos, Boardman and Zigmond 2006). The recommendations of the Richardson Committee to include capacity for decisions to treatment reflect these principles as the emphasis is on a restoration of health to promote capacity. These principles within the proposed reforms emphasise the function of services to provide effective support and treatment for people with mental health problems; alongside challenging unjustified compromises to the autonomy of service users.

The significant revisions that the committee recommended to the existing mental health legislation were seen to move towards greater protection for people with mental health problems. In accordance with

Rawls' theory (1971), offering a more just and equal framework than the Mental Health Act 1983. This was particularly significant in the overarching principle that underpinned recommendations that the Act should be non-discriminatory and create more legislative parallels between the treatment of physical and mental health problems. The proposal that a position of reciprocity be established, with mental health services having a duty to provide care with appropriate standards for those subject to compulsory powers, provides an important indication of the aim of the committee to bring welfare to the fore.

Recent developments in the Mental Health Act (1983) may, therefore, be considered to have the aim of ensuring those in particular need of help receive it, whilst including clear protection from infringements on the rights of people with mental health problems.

### **2.2.3 Containment and Protection of Others, Mental Health Act 1983 and Mental Health Act 2007**

I have argued that protection of the rights of people with mental health problems has influenced developments in the Mental Health Act 1983 and proposals to amend this Act. However, this coincides with concerns identified that this legislation unnecessarily increases the surveillance and controls that people with mental health problems are subject to. Through these concurrent themes, the legislation serves “dual” functions. In the following section I present arguments that the Mental Health Act emphasises control of people with mental health problems without further safeguarding of service users' rights. This law expresses the juxtaposition highlighted by Foucault (2006) as being at the heart of mental health services.

The implementation of the Mental Health Act 1983 was unable to realise the promotion and protection of the rights of people who were subject to the law that it promised. In urban settings the majority of individuals with a diagnosis of psychotic illness will be detained under the Mental Health Act at some point (Churchill, Wall, Hotopf

et al 1999, Care Quality Commission (CQC) 2013). There has been further criticism of the disproportionate use of the Act amongst some socio-cultural groups, in particular African Caribbean men (Churchill et al 1999, Mind 2011, CQC 2013). The reason for these inequalities is debated, yet they highlight the potential for mental health legislation to reflect social prejudice, serving interests other than therapeutic and reinforcing its controlling function.

Administration of the Mental Health Act involves denying individuals of their right to liberty (Parker 2007). Such paternalistic action is justified in terms of the best interests of the individual (Chan 2002), reflecting Mill's notion that intervention is acceptable if it is in the persons own interest when they are defined as having a mental disorder (Tebbit 2005). Compulsory care is therefore defensible on the basis of improving health through adherence to treatment and avoiding the harm of frequent relapse: achieving good through improvements in well-being. Yet the reality of ensuring the patient's best interests are promoted within mental health legislation has been undermined (Szmukler and Holloway 2001). The benefits of hospitalisation and medication as a means to treat mental distress are much debated (Moncrieff 2003, Snow and Austen 2009). This compromises paternalistic arguments that the person's interests are served by compulsory treatment to improve health. The acceptance of psychiatric practices as treatment could therefore be questioned. Intent is significant in how the 'parens patriae' principle has been applied (Coleman and Solomon 1975). The action of both punishment and treatment may be similar but the intent defines the interpretation and justification for the action. In the example of restraining someone in a hospital and restraining someone in a prison, it is the intent to restore health in the first example that defines the action as treatment rather than punishment. Recognising the damaging impact of forced interventions and loss of freedom is therefore undermined through understanding the action as therapeutic (Coleman and Solomon 1975). Support for the position that unreason

is a state to be feared and therefore controlled is found in these claims.

The existence of the Mental Health Act has threatened the idea of voluntary hospital care (Vassilev and Pilgrim 2007). Informal admission is experienced as coercion by some service users (Churchill et al 1999, Laurence 2003, Bindman, Reid, Szmukler et al 2005, Katsakou, Bowers, Amos et al 2010). A lack of protection under human rights law is afforded to voluntary patients who may accept treatment in an awareness of the restrictive powers of the Mental Health Act and the potential for this to be invoked if they refuse (Richardson 2008). These arguments contribute to some accusations that the Mental Health Act is a form of legalised discrimination which unjustly disadvantages those who have been diagnosed with mental health problems to sanction public and state fears of the threat that madness poses (Szasz 1989, Szmukler and Holloway 1998, Vassilev and Pilgrim 2007).

These themes are significant in relation to the final amendments to the Mental Health Act (1983) introduced in 2007. The Department of Health reviewed the recommendations of the Richardson Committee and rejected a number of their key proposals (DH 2000). An extended focus on containment was developed at the cost of safeguards for individuals with mental health problems (Grounds 2001, Szmukler and Holloway 2001, Bertram and Powell 2005, Pilgrim 2007). The government rejected the recommendation that there should be a reciprocal duty of care to those undergoing compulsion, but accepted suggestions to extend supervised community treatment (DH 2000, Pilgrim 2007). This was undertaken despite warnings that extending compulsory powers of treatment into the community could have limited impact on relapse (Churchill et al 2007). A recent clinical trial confirmed that the introduction of Community Treatment Orders (CTOs) in England has not reduced hospital admissions for people experiencing psychosis, concluding

that this meant there was no justification for the restrictions placed on people's liberty (Burns, Rugaska, Molodynski et al 2013).

The inclusion of these proposals shifts the legislation away from John Rawls' (1971) principles of liberty. The position that compulsory detention is not warranted on the grounds of best interests challenges Rawls' (1981) principles of liberty where it is assumed restriction on freedoms should not occur without sufficient justification. Without the identified need for restoration of capacity to make decisions about treatment, according to Ikkos et al (2006) removal of liberty cannot be justified on health grounds. Rawls' (1971) second principle that inequality should benefit the least advantaged, with all having equal access to opportunity, is also challenged by the removal of any commitment to reciprocity from the changes to the Act. People with mental health problems are socially excluded whilst poor standards and a lack of resources within mental health services have consistently been identified, which clearly highlights these changes could exacerbate rather than reduce inequalities (ODPM 2004, Duggan, Edwards and Dalton 2014, Gillett 2014).

#### 2.2.3.1 Mental Health Act and Dangerousness

The prioritisation of containment within the Law at the cost of safeguards for individuals' rights raises concerns, including the limitations of the justifications presented for controls within the amended Mental Health Act.

Criticisms have been levelled at the arguments used by the government to justify the alterations to the Mental Health Act, particularly the disproportionate emphasis on dangers posed by people with mental health problems to others (Harper 2004, Shaw, Middleton and Cohen 2008). Compulsory detention on the basis of perceived dangerousness is problematic from a number of perspectives. The notions of both dangerousness and risk have been described as social constructs (Corbett and Westwood 2005, Lupton 2013,). The actual threat posed by people diagnosed with mental

health problems is over represented (explored in Chapter 5). However, the Home Office had a significant presence in the development of proposals to reform the Mental Health Act (Cairney 2009). Such input reinforces an emphasis on control as well as health.

The construction of the reforms exposes a tendency to separate the public and patients, without recognising patients as members of the public (Harper 2004). Perceived public interests are emphasised over safeguarding the autonomy of people with mental health problems, revealing a process where they may be treated differently from other individuals within society. This is central to the problems identified with the Mental Health Act (Szmukler and Holloway 2000). People with mental health problems have been recognised as subject to controls based on their perceived dangerousness in ways that others who may pose more of a danger and be equally 'treatable' (such as drink drivers) are not (Sasz 1989, Pilgrim 2007).

Rawls (1981) proposes that where there is unequal treatment and certain groups' liberties are unfairly restricted, social co-operation is undermined. Those who have been subject to this unfair treatment can feel humiliated and those who benefit feel that this group deserve such a mistreatment. This view underpins Morrall and Muir-Cochrane's (2002) explanation of people with mental health problems as spoiled citizens in contemporary western society which results in them being subject to increased and justified forms of social control. 'Othering' is an important concept to help understand this process. Defining 'other' arises from the identification of strangeness, which is subsequently separated from self. Otherness is feared and perceived as dangerous as it poses a threat to order and control (Lupton 1999). This serves to elucidate the means through which the discourse of risk is used to marginalise certain social groups on the basis of their perceived danger and otherness (Lupton 2013). The opportunity for people with mental health problems to exercise choice is therefore restricted by the state in the name of public interests.

Public perceptions of the dangerousness of people with mental health problems have been shown to correlate with their views relating to the need to coerce people into accepting interventions (Pescosolido, Monahan, Link, et al 1999). This points to an alternative application of Rawls' theories (1971), whereby these constraints from the state could be sanctioned on the basis of the publicly agreed consensus that such interventions were reasonable. Legislation may therefore be seen as an expression of moral and public fears of groups identified as other (Douard 2007). The impact of this process on people with mental health problems living in the community is paradoxical. Individuals are no longer excluded from the community via the asylum system yet they are judged as others, posing a threat to the community and who therefore should be subject to control (Warner and Gabe 2004). Rawls' notion that this results in humiliation may be reflected in the self-stigma which can arise from being diagnosed with a mental health problem (Brohan, Slade, Clements, Thornicroft 2010).

In contrast to providing a protective function, legislation risks becoming a tool of social control, enforcing accepted social norms in which the other is constructed as a threat to the rational autonomous individual (Symonds 1998). Compulsion may be invoked on the basis of anticipated rather than actual acts, which supports this view. Within western society, people with mental health problems are one of the only groups that can be detained without trial (Szmukler and Holloway 2001, Vassilev and Pilgrim 2007). Mental health legislation therefore becomes an oxymoron as its function is public safety rather than the protection of health. People with mental health problems experience unjustified restrictions on their autonomy. In reflection of these arguments, mental health law actually serves to discriminate against people with mental health problems (Szasz 1989, Szmukler and Holloway 2000, Szmukler 2014).

Plans to develop a new Mental Health Act were rejected in 2006 in favour of amending the existing legislation including the introduction

of supervised community treatment in the form of CTOs. These amendments developed despite significant criticism from service user and professional groups regarding the lack of safeguards and increased focus on control (Parker 2001, Daw 2002, Mental Health Alliance 2005).

#### **2.2.4 Mental Health Legislation and Rights**

Mental health legislation has been characterised as an attempt to gain a balance between the rights of the individual and the duties of services to provide treatment (Jones 1991, Pilgrim 2007). The promotion of human rights within contemporary society is reflected in the development of anti-discriminatory and human rights legislation (Carpenter 2009). However, limited protection is offered for people with mental health problems through this legislation due to exclusions of “persons of unsound mind” in certain articles of the Human Rights Act (1998). Thus, legislation fails to recognise the coercion experienced by service users (Carpenter 2009). Such a position reflects the historical omissions of people with mental health problems from challenges to coercive legislative measures (e.g. Mills) as well as liberal notions of the rational autonomous individual as the basis for access to rights (Tebbitt 2005). This culminates in a situation where individuals actually lose their rights through the mental health system (Bertram and Powell 2005). The marginalisation of people with mental health problems within rights based legislation may be indicative of people with mental health problems as spoiled citizens perpetuating their status as other (Morrall and Muir-Cochrane 2002, Lupton 2013).

The language of rights may however be part of the problem; Rose (1985) argues that an emphasis on rights discourse fails to articulate whose rights should have priority, which is borne out in the failures of policies and legislation to foreground the rights of people with mental health problems. The power of medical constructions of social reality may limit the impact of rights based discourses to challenge



containment in mental health care (Bartlett and Sandland 2007). Medical treatment is therefore sought for mental ‘disorder’ as a reflection of a powerful psychiatric discourse, Bartlett and Sandland (2007) suggest this means that providing consent to treatment may actually represent a more pervasive form of coercion. However, the United Nations Convention on the Rights of Persons with Disabilities (2008) may have implications for challenging this position and prioritising the rights for people diagnosed with mental health problems. It adopts a social model of disability, underpinning equal access including the rights to liberty, privacy and equal recognition in law. This significantly challenges the justification of involuntary treatment and potentially presents current legislation as discriminatory as it unequally restricts freedom of those diagnosed with a mental disorder (Szmukler, Daw and Callard 2014). Rawls’ principles underpinning the vision for a civil society are thus more evident within the UN convention.

#### **2.2.5 Mental Health Professionals’ Role within the Mental Health Act 1983 and 2007**

Mental Health legislation has significant implications for the role of mental health professionals and their relationship with service users (Leiba 1998). The influence of the law is evidenced not only in the responsibilities professionals undertake in implementing the Mental Health Act, but also in the reality of practicing in the context of a health law that can restrict liberty. In the following section I explore the role of mental health professionals in relation to the Mental Health Act and consider the implications for tensions within their practice.

The introduction of powers for Approved Social Workers (ASWs) in the Mental Health Act (1983) provided scope to counter the dominant influence of psychiatry. The role explicitly focused on a social perspective, drawing greater attention to the rights and autonomy of the service user (Gostin et al 2010, Bartlett and Sandland 2007). The valued independence from the medical profession created opportunity

to promote the least restrictive alternatives to hospital care leading to positive outcomes for service users (Davidson and Campbell 2010, Bressington, Wells and Graham 2011). The introduction of the ASW role represented an attempt to safeguard the rights of individuals and ensure that people most in need would receive treatment in hospital.

This role adopted by social workers in the Act competes with other responsibilities and is open to tensions as a result. ASWs were employed by the state to administer mental health law and therefore balance the interests of service users with those of their relatives and the public (Campbell 2010). The social perspective thought to be central to the role of ASWs hasn't always been emphasised, including by social workers themselves (Gregor 2010). Their role ultimately positions social workers as having some authority to detain someone against their will, inescapably leading to tensions regarding care and control (Gregor 2010, Campbell 2010). Lipsky (1980) claims such tensions are inevitable for professionals acting as 'street-level bureaucrats'. Client interests have the least influence in defining the role expectations of professionals responsible for implementing political agendas in practice; consequently the emphasis on public safety and containment dominates. The position that exposure to 'duality' is a common element of mental health practice is supported.

The role previously undertaken by ASWs was opened to other mental health professionals in the Mental Health Act (2007) as Approved Mental Health Practitioners, (AMHPs). The expansion of the types of practitioners able to undertake powerful positions in administering the Act has further highlighted the potential for these roles to focus on the rights of service users, alongside a purpose to control people with mental health problems.

The new AMHP role raised concerns that service users' rights would be further comprised by the loss of a social focus in Mental Health Act assessments (Bressington et al 2011). Extending the number of professionals drawn into legally sanctioned compromises to service

users' autonomy, spreads powers of control. Yet key competencies within the AMHP role focus on addressing discrimination and inequality, with a requirement for training to emphasise person-centred care and respect for diversity (Health and Care Professions Council 2013). This strategy may support professionals to manage the emotional labour that such authority can entail (Gregor 2010). However, such an emphasis within the competencies may be part of appearing to promote service users interests whilst actually exerting containment.

Psychiatry has challenged the extension in the range of professionals involved in both the 1983 and 2007 Acts. The Royal College of Psychiatrists expressed concerns that the new Act was “unethical and unsafe” (Moncrieff 2003a:8). The profession was dissatisfied with the implications of reform for the role of psychiatrists. The autonomy of doctors to make decisions about compulsory treatment was threatened by the proposal to enhance the role of tribunals in decision making on compulsory care; this was also seen to be at the costs of tribunals' protection of patients' rights (Moncrieff 2003a). However, resistance to reforms has been located in wider problems within the profession, such as tensions between different models of practice and a reduction in its institutional power base (Pilgrim 2007). This is particularly evident in the alteration of the responsible medical officer role to extend this to other professions, thus potentially undermining the power of psychiatry.

#### 2.2.5.1 Mental Health Nurses and Tensions of Control

The powers of mental health nurses to detain service users under the Mental Health Act were extended in both the 1983 and the 2007 Acts. These developments can conflict with the relational focus of nursing. The therapeutic relationship between service users and mental health nurses is a central characteristic of the profession (Peplau 1952, DH 2006, Nursing and Midwifery Council (NMC) 2015). Through the promotion of humanistic qualities, in conjunction with those receiving

care, a mental health nurse can support an individual to work towards recovery (Watkins 2001). With this emphasis on the therapeutic relationship, the expansion of the role of mental health nurses' powers in legislation contributes to the potential for tensions in their role. These tensions may be between delivering care which is relational and person centred, alongside making decisions that directly contravene people's wishes, undermining their autonomy.

Concerns have been expressed by mental health nurses that working as an AMHP threatens their therapeutic relationship with service users and distances them from their caring identity (Laing 2012). The traditional association between nursing and medicine contributed to further criticism that nurses undertaking an AMHP role lacked the professional power to challenge medical decision making, undermining protection of service users' rights (Coffey and Hannigan 2013). Some mental health nurses have welcomed the AMHP role, viewing this as an opportunity to further protect the rights of service users and support the therapeutic relationship through the provision of continuity of care, reflecting confidence in their interpersonal abilities to maintain relationships in the face of restrictive powers (Jackson 2009, Laing 2012, Coffey and Hannigan 2013). Yet the claim to be working in person centred ways, whilst maintaining this legislative authority, means mental health nurses can serve to legitimise the compromise of civil liberties (Hopton 1996).

The shift in the decision making role of mental health nurses in the Mental Health Act (1983, 2007) has drawn attention to their powers in promoting the containment of people with mental health problems. However, the physical proximity of nurses to service users means that their role has always been grounded in administering restriction contributing to arguments that mental health nurses act as agents of social control (Morrall 1998). This role is enacted through surveillance but also their responsibilities in imposing containment and enforced treatment. From this perspective, nurses perpetuate the separation of the sane and insane formalised in the development of

psychiatric institutions (Morall 1998). Yet social control has been recognised as a useful element of caring in nursing, as it contributes to the functioning of society. This is achieved through the regulation and support of people whose social roles have been disrupted, in the context that society is unable to function without the continuation of these roles (Kelly and Symonds 2003). Such arguments claim that, again, the interests of people with mental health problems are subjugated on the basis of wider social and public benefits.

Mental health nurses and unqualified support workers are the main professional group involved in the direct administration of involuntary treatment and containment. This occurs in the context of a professional philosophy that emphasises interpersonal relationships and shared decision-making (DH 2006, NMC 2015,). Mental health nurses could be acutely affected by the tensions that this could create in comparison with other professional groups. Clearly (2003) and Bjorkdahl, Palmstierna and Hansebo (2010) explore the complexity of these tensions as nurses in inpatient settings strive to balance their controlling and therapeutic roles. Nurses recognised that they frequently override service users' wishes whilst balancing professional responsibilities and the prevention of harm to service users. However, making simplistic divisions between controlling and therapeutic mental health nursing interventions overlooks the disciplinary aspects of care that promote conformity through more implicit means (Godin 2000). This position supports Bartlett and Sandland's (2007) claim that consensual mental health treatment represents a more insidious form of coercion. Service users highlight that even when subject to involuntary treatment, being able to exercise some agency is important, whilst nurses' personal attributes, time and understanding of them as people improved their experience of this treatment (Wyder et al 2015). These findings suggest that interventions which control may also be delivered with compassion and care. Mental health nurses may therefore experience tensions due to pressures to focus on care, compassion and relational nursing,

alongside holding legally sanctioned powers to restrict freedom and deliver enforced treatment against an individuals' consent.

### **2.2.6 Summary**

In 2012-2013 the total number of people with mental health problems involuntarily admitted to mental health services exceeded 50,000 (Health and Social Care Information Centre 2013). These figures reflect an increase of 12% over a five year period (CQC 2014). Despite policy commitments to the least restrictive environment, compulsory containment is clearly increasing.

The history of mental health legislation is complex, striving for a balance between liberty, individual rights, access to treatment and public protection. The degree of balance achieved reflects social, philosophical and political conceptions of the individual and ambiguities about whether people with mental health problems are recognised in these concepts or excluded on the grounds of being other. Tensions between the rights of, and control over people with mental health problems are pervasive within the development and implementation of mental health law. Mental health professionals are exposed to these tensions both within their own roles as defined by statute, and in their work with service users in the context of legislation that restricts personal liberties. Such debates provide further evidence that there is juxtaposition at the centre of mental health care.

## **2.3 Chapter 4: Mental Health Practice, Recovery and Control**

### **2.3.1 Introduction**

Recovery has become an important concept in contemporary Western mental health care (Slade 2009, Barker and Buchanan- Barker 2011). Promoting the recovery of people with mental health problems is embedded in healthcare policy, professional guidelines and education (DH 2004, DH 2006, College of Occupational Therapists 2006, Care Services improvement partnership, Royal college of Psychiatrists and Social Care Institute for Excellence 2007, Shepard, Boardman and Slade 2008). Yet, it is a philosophy that grew from the collective experiences of people with mental health problems, dissatisfied with the dominant conceptualisations of mental distress and unhelpful treatment they received from mental health services (Deegan 1995, Mead and Copeland 2000). As an influential philosophy in mental health care, recovery focuses on a person's rights to self-determination, whilst positioning the role of mental health services to support the person to achieve their personal life goals and enable them to rediscover a valued sense of self. Recovery aligns with mental health services as supportive and enabling, focussed on reducing barriers for people with mental health problems and challenging the 'them' and 'us' divide. Recovery, therefore, presents a fundamental challenge to the exclusion of people with mental health problems from access to the legal and social opportunities explored in the previous chapters.

The values underpinning recovery are recognised as differing from traditional approaches in mental health services (Repper 2000, Barker and Buchanan-Barker 2011a). They have also been identified as conflicting with a culture in mental health care preoccupied with risk assessment and management (Tickle, Brown and Hayward 2012, Morgan and Felton 2013). Recovery represents one element of the duality examined in this review. In the following discussion I

examine the influence of recovery in mental health care and consider how the concept undermines perspectives that suggest people with mental health problems need to be contained and controlled. The contrast that this presents with risk as a key focus of mental health services will be examined in the next chapter.

### **2.3.2 Understanding Recovery**

Recovery is recognised as a multi-faceted, complex concept that is difficult to define (Roberts 2008, Stickley and Wright 2011). It has been applied as an idea, a framework, philosophy and paradigm, offering a new interpretation of the term (Bonney and Stickley 2008, Slade 2009). Recovery describes the journey experienced by people as they learn to live with their distress and move on (Davidson and Roe 2007). It is this interpretation that reflects the application of recovery within contemporary mental health services. Part of the drive for this new understanding is to challenge the limitations caused by a focus on a return to 'normal' as the goal of mental health care.

Recovery grew from the development of a collective voice of service users, facilitated by the civil rights and service user social movements (Davidson and Roe 2007, Barker and Buchanan-Barker 2011a). Whilst organised objections to the treatment of people with mental health problems had existed for many years it was in the 1970s and the 1980s in the UK that the service user movement fully developed (Campbell 2009). As previously highlighted, this was aided by a broader social and political context that emphasised citizenship, human rights and participation (Beresford and Branfield 2012). Whilst perspectives within the service user movement are diverse, Campbell (2009) highlights common beliefs. These include: that people with mental health problems are competent and have a right to a voice through self-advocacy, that they should have their own understanding of their experiences respected and that there is an over-reliance on psychiatric medication within services. Movements emphasise the importance of recognising the wider social



determinants on the creation and maintenance of mental distress (Wallcraft 2003). These perspectives emphasise equality and challenge the position of people with mental health problems as being in need of control. The rapid development of service user organisations alongside the growth of consumerist models of healthcare provided the opportunity for service users' voices to be heard. Weinstein (2010) suggests that this created the conditions for service users to develop an 'alternative discourse' constructing a positive identity for people with mental health problems.

Within this context new meanings of recovery developed, driven by the narratives of people with experience of mental health problems. Through this, the perception of people with mental health problems as irrational and other is undermined. The challenges of defining recovery may be partly due to the claim that it is an individual experience. However, within the literature key themes emerge which suggest some common elements to the recovery process (Anthony 1993, Repper and Perkins 2009, Stickley and Wright 2011). These themes relate to having hope for a meaningful and valued life, discovering new identities and taking back control (Deegan 1996, Higgins and McBennett 2007, Wisdom, Saedi, Weis et al 2008, Repper and Perkins 2009).

In this review I have argued that people with mental health problems have been viewed as a threat and are in need of being controlled through the actions of mental health services. Recovery emphasises individuals taking control which presents an important challenge to these ideas. Using mental health services can involve a loss of control over daily life (including through the loss of liberty as previously identified) or handing this over to others; yet exercising choice is seen as a core principle of recovery so has to be addressed to support a recovery process (Anthony 1993). Actions associated with exercising personal agency such as non-compliance with treatments can create turning points for recovery (Mancini 2007). Underpinning such perspectives is the recognition of people with mental health

problems as autonomous individuals with the right to make decisions about their lives, as reflected in Rawls' vision of a civil society (Rawls 1971).

The notion of control in relation to recovery is closely linked to service users taking responsibility for managing their mental health and well-being. Self-management includes developing ways of dealing with distress and seeking support when needed (Mead and Copeland 2000, Slade 2009). Recovery planning, self-help and peer support are emphasised as approaches that can facilitate self-management (Mead and Copeland 2000, Faulkner and Kalathil 2012).

Recovery recognises that people can grow and change despite ongoing 'symptoms' (Anthony 1993, Yates, Holmes and Priest 2012), and that they do not need to be rid of symptoms to be able to participate as equal citizens. It promotes that they have a right to assistance and adjustments to enable them to access opportunities and participate in society (Sayce 2000, UN 2008). Such a perspective repositions the relationship between people with mental health problems, professionals and wider society. Mental health problems have been recognised as a disability, meaning that there is an emphasis on adaptations that should be made in the environment or organisation to ensure it is accessible (Slade 2009a). This ideological shift conflicts with the historical foundation of mental health care and its social control function to return well-disciplined members back to society. Recovery also attempts to shatter the definition of people with mental health problems as other. The focus on meaningful identity, opportunities for employment and education recognises people with mental health problems as citizens with equal rights of access (Repper and Perkins 2003). Defining recovery as possible despite the continuation of problems suggests that participation and rights may not be restricted to liberal ideals of the individual previously discussed.

### 2.3.2.1 Implications for Mental Health Practice

Recovery is perceived as a departure from the conventional concern of mental health care, with a focus on deficits and problems perpetuated by a medical paradigm (Repper and Perkins 2003, Tew 2013). Recovery has developed into a powerful discourse within mental health practice; underpinning mental health nursing education, workforce competencies and supported by the Royal College of Psychiatrists (DH 2004, DH 2006, NMC 2010, South London and Maudsely NHS Trust, South West London and St Georges Trust 2010). It has been presented as the central philosophy influencing the future direction for mental health services and is increasingly perceived as an indicator of quality care (Happell 2008, Boardman and Shepard 2009, Implementing Recovery through Organisational Change, ImRoc 2013).

Recovery orientated mental health practice suggests the role for professionals is characterised by the development of hope-inspiring relationships, supporting people to work towards personalised goals and sharing power (Borg and Kristiansen 2004, Roberts 2008, Stickley and Wright 2011). This can mean a shift in the power relationship between mental health professionals and service users, as the person's active participation and opportunities for personal power are central to recovery (Watkins 2007, Roberts 2008).

Shifting power relationships are an important response to recognising the expertise of people with mental health problems. This expertise is grounded in personal journeys through mental distress and recovery (Deegan 1996a, Higgins and McBennet 2007). A key principle of shared decision-making is acknowledging that all those involved bring specific expertise and through a mutual process this can be shared to reach the decision which is best for that individual (Deegan and Drake 2006, Drake, Cimpean and Torrey 2009). Policy directives have consistently outlined that service users should be involved in planning their care, evaluating and now commissioning and

delivering healthcare services (DH 2000a, DH 2003, DH 2012). Shared decision making enables service users to have a greater voice, as it recognises their expertise and challenges the authoritarian approach of mental health services (Drake, Deegan and Rapp 2010).

Shared decision making can also give benefits for a person's recovery journey. It is suggested that good experiences with shared decision making encourage a more active role to be taken by the person overall, ultimately promoting the self-management so vital to recovery (Torrey and Drake 2010). Service users have reported improved self-efficacy, awareness of triggers and ability to plan for stressful situations when involved with decision making (Ludman, Katon, Bush et al 2003).

Underpinning these perspectives is a respect for people who experience mental health problems as autonomous individuals, able to exercise agency and with the right to make choices about their lives. The adoption of recovery within policy and professional guidelines provides a clear directive for mental health care to support these principles, as well as undermining the position of people with mental health problems as irrational others.

### **2.3.3 Duality and Recovery**

Despite the strategic focus, adopting a recovery approach has been described as a paradigm shift for mental health services that has not yet been realised (Slade 2009, Bonney and Stickley 2008, Barker and Buchanan-Barker 2011a, Yates et al 2012). Service users' experiences of recovery reveal that mental health services continue to act in ways which undermine recovery (Mancini 2007, Happell 2008, Aston and Coffey 2012). Such concerns have been represented by survivor groups campaigning for the concept of recovery to be abandoned. 'Recovery in the Bin' challenges the colonisation of the term by professionals and believes recovery has been used to justify public spending cuts, masking the significant impact of social and economic inequality on mental health (Recovery in the Bin, 2015).

The perspective that recovery offers a new approach with the potential to transform the lives of people with mental health problems has also been questioned (Dickerson 2006 Mountain and Shah 2008). The recovery movement is underpinned by the view that mental health services of the past were concerned with diagnosing and treating problems. Institutional, medically based care is presented as the dominant treatment approach, staffed by professionals who defined patients as helpless and hopeless. Recovery is therefore presented as a paradigm with the potential to transform what is and was wrong about mental health services. This may be grounded in an inaccurate historical view of mental health care as being defined by an omnipotent biomedical perspective (Braslow 2013). Instead, professionally led movements to reform asylum care, permit voluntary admission and understand the psychological determinants of mental ill health are outlined (Davidson, Rakfeldt and Strauss's 2009). Braslow's (2013) arguments recognise the idea of duality within the history of mental health care and highlight the problems inherent with drawing on a singular historical narrative. The legitimacy of recovery as a radical new approach offering solutions to past errors of mental health care may therefore be undermined.

Recovery emphasises people's rights to self-determination, increasing their opportunities to take back control (Repper and Perkins 2003). However, doubts have been raised regarding the reality of recovery facilitating increased control. Recovery, particularly self-management, suggests individuals adopt strategies that enable them to cope with daily life alongside their distressing experiences (Davidson 2005). This process itself acts as a system of control. Scott and Wilson (2010) highlight that the Wellness and Recovery Action Planning (WRAP) approach to self-management perpetuates the view that people with mental health problems are in constant danger of losing control. Through its emphasis on monitoring, triggers and early warning signs it acts as a system of self-surveillance focussed on maintaining well-being. In addition, WRAP specifically advocates

the need for others to take control when a crisis occurs (Scott and Wilson 2010). Frameworks such as advanced statements promoted within recovery and shared decision making approaches still hand decision making power back to the institution (Adams and Drake 2006).

Individuals' constant review of well-being results in this surveillance being absolved into the accepted subjectivity of the person. As such, recovery forms part of a neo-liberalist system of governmentality (Scott and Wilson 2010, Braslow 2013). Neo-liberal values emphasise individual autonomy, whilst presenting the good citizen as one who is able to govern themselves (Rose 1999). Conduct is regulated through informed individual decision making based on goals of self-development and risk aversion (Rose 1999, Larner 2000, Braslow 2013). Self rather than state regulation is achieved as a technique of control (Rose 2000). Genuine choice becomes a myth, as behaviour that does not conform to these expected values and norms risks ostracism (O'Byrne and Holmes 2007). Recovery, and in particular self-management, offers a framework to encourage individuals to regulate their own conduct in line with these expected behaviours of an autonomous rational citizen. This is underpinned by the individualistic focus of recovery, at the cost of considering social environments which may cause and perpetuate distress; though some authors have offered perspectives on how recovery orientated practice can better account for social contexts (Tew 2013, Yates et al 2012).

Recovery provides a complimentary philosophy to that underpinning neo-liberal welfare reform (Braslow 2013, Recovery in the Bin 2015). Recent changes to the healthcare system have been underpinned by commitments to increase choice for healthcare 'consumers' (DH 2010, DH 2012). The neo-liberal ideological emphasis on choice, free market principles and a reduced role for the state are reflected in these reforms (Larner 2000). Such welfare changes form part of the redefinition of citizens as autonomous individuals exercising choices (Rose 1999). Those who fail in this self-government are defined as

‘failed citizens’. Recovery perpetuates this viewpoint, as responsibility for recovery and maintenance of well-being essentially rests with the individual, whilst social and economic inequalities are ignored (Braslow 2013).

#### **2.3.4 Summary**

A recovery paradigm grew from the lived experience of people with mental distress and has developed as an influential discourse in mental health care. Growth and discovery can develop beyond the limits of experiencing mental health problems (Anthony 1993, Repper and Perkins 2003, Shepard et al 2008), with recovery emphasising autonomy, rights and self-determination. A number of problems with recovery have been identified, yet there are other powerful mechanisms which threaten the opportunity people with mental health problems have to exercise choice and control. Tensions between promoting recovery and managing risk have been acknowledged within the literature (Pilgrim 2008, Tickle et al 2012, Stickley and Felton 2006); whilst Mancini’s (2007) research has highlighted how coercion and control on the part of mental health services can act as barriers to recovery. In the following chapter I examine risk and its implications for control, exploring how this may contribute to tensions with recovery.

## **2.4 Chapter 5: Risk, Mental Health Problems and Dangerousness**

### **2.4.1 Introduction**

The discussion has considered that mental health care has been influenced by aims to provide support and welfare, alongside structures that control and contain a group defined as other. Recovery, with an emphasis on choice, and self-determination has become influential in mental health practice. However, co-existing directives expressed through policy and professional guidelines emphasise the need to manage the risks presented by people with mental health problems. These have the potential to shape mental health practice in a direction opposed to supporting service users' choice and self-determination, providing further indication of the potential for tensions at the heart of mental health care. This final section of the review examines how risk management may conflict with recovery and express duality in the aims of mental health care.

Research has proposed a link between severe mental health problems (such as schizophrenia) and violence (Hiday 1997, Appelbaum, Robbins and Monahan 2000, Doyle and Dolan 2002). There is a longstanding perception held by professionals and the public that a threat is posed by people with mental health problems. Criticism of the research associating mental illness and violence has highlighted methodological problems, false claims of causality and the influence of other variables such as abuse (Hiday 2006, Langan 2010, Rogers and Pilgrim 2010). Despite this, mental health services remain preoccupied with assessing service users' potential to cause harm (Warner and Gabe 2004, DH 2011, Wand 2012). In order to explore the focus on risk in mental health services, I will debate this concern about the dangers posed by people with mental health problems.



### **2.4.2 Community Care, Public Safety and Risk**

The last half of the twentieth century witnessed the large scale closure of psychiatric hospitals, with a significant reduction in hospital populations and the transfer of in-patient beds to general hospitals (Nolan 1993, Porter 2002,). De-institutionalisation, on the face of it, ended the geographical segregation of people classified as mentally ill. A group largely perceived as different were now visible within the community rather than hidden behind the walls of an institution (Moon 2000). De-institutionalisation took place in a political context that supported such reforms alongside public and academic criticism of the state of asylum care (Goffman 1961, Martin 1984, Porter 2002). However, if as Foucault (2006) argues, segregation perpetuated the state of unreason as one to be feared, de-institutionalisation raises a number of issues regarding how this fear is managed.

A small number of high profile incidents, including homicides committed by people in contact with mental health services, occurred in the early 1990's. These have been associated with fuelling public fears regarding the threats posed by the mentally ill in the context of community care (Goodwin 1997, Laurence 2003, Young 2014). Media reporting of such incidents perpetuated an image of people with mental health problems as a danger and community care as failure (Laurence 2003, Kalininecka and Shawe-Taylor 2008). This recognises a role for the media in not only reporting but also constructing the meanings of such events (Paterson and Stark 2001). Moral concerns have been an influential thread in the explanations of media, public and government responses to these incidents. Some dangers are seen to result in moral outrage, a phenomenon linked to the perceived control and causality of the event (Szmukler and Rose 2013). Violence perpetrated by people with mental health problems is claimed to cause moral outrage; events are perceived as controllable with clear lines of accountability (Szmukler and Rose 2013). Alternatively, responses have been characterised as a 'moral

panic' (Sayce 1995, Muijen 1996, Hannigan and Cutcliffe 2002). Paterson and Stark (2001) employ Cohen's (1972) theory of moral panic to suggest that dangers posed by people with mental health problems are experienced as an exaggerated serious threat to safety, that is presented as such by the media. In doing so, general public anxiety regarding violent crime as a concern in the 1990s is highlighted. Stereotypes of gender and race relating to specific incidents are identified as contributing to fears constructing newly released patients as in danger of killing strangers. This draws on notions of difference to present people with mental health problems as a risky other (Lupton 2013). Invisible within this discourse was the impact of de-institutionalisation on people with mental health problems themselves and the significant risks that they were exposed to.

Further stages of Cohen's (1972) moral panic theory are recognised as taking place including, a clear response from policy makers. Policy making during this period demonstrates an acceptance of people with mental health problems as dangerous, confounded by the failure of existing models of community care (DH 1998, Hannigan and Cutcliffe 2002). During the 1990s a succession of government policies introduced changes that increased the surveillance of people with mental health problems in the community (DH 1996, DH 1998, DH 1999a). Chapter 3 has explored how this theme has progressed into more recent legislative changes. Whilst on the one hand de-institutionalisation created opportunities for more focus on the social rights of people with mental health problems, the extent to which people are able to exercise choice is constrained within a policy system that emphasises surveillance (Goodwin 1997). Such monitoring was presented as a need to assess and manage the risks posed (namely of violence and suicide) by people with mental health problems (DH 1996, DH 1998, DH 1999a). Resources of mental health professionals are directed to those perceived to be most risky,

contributing to risk being of greater importance in decision-making (Kemshall 2009).

Moral panic theory provides a useful framework to acknowledge the complex relations between the media, public views and policy making. In relation to the construction of people with mental health problems as a danger, it serves to emphasise the importance of exaggerated fears. In contrast to these fears, the vast majority of murders are perpetrated by those without mental health problems (about 85%, Laurence 2003). The rate of homicides committed by people in touch with mental health services has been in steady decline despite the murder rate as a whole increasing in the years since de-institutionalisation (Taylor and Gunn 1999, Laurence 2003, Appleby, Kapur, Shaw et al 2013). People with serious mental health problems are five times more likely than the general population to be victims of physical violence (Pettitt, Greenhead Khalifeh et al 2013). Harms that are experienced by service users such as victimisation, exclusion, discrimination, abuse or the iatrogenic effects of treatment are hidden by such an emphasis on the dangers posed by the mentally ill (ODPM 2004, Muir–Cochrane 2006, Maniglio 2009). The number of service users who experienced these harms increased post de-institutionalisation.

According to Mary Douglas (1992), risks that serve to reinforce certain moral codes receive greater attention within contemporary Western society; for example, those that maintain segregation between people perceived as pure and those perceived as deviant (Douglas and Wildavsky 1982, Lupton 2013,). Risk also functions as part of a blaming system to assign accountability and responsibility. Douglas (1992) identifies the manner in which blame for danger is apportioned to certain social groups. This acts as a protective mechanism for individuals, reinforcing boundaries and social norms. The social context is now one in which the language of risk has replaced the language of danger, characterised by a heightened awareness of hazards (Douglas 1992). Douglas' theories (1992) offer

a useful insight into the social and cultural context that may have contributed to the level of concern regarding tragic events committed by people in contact with mental health services. Here, blame is apportioned to mental health services and the failure of community care, whilst people with mental health problems are identified as a source of risk. Boundaries between ‘them’ and ‘us’ may be reinforced whilst the mentally ill are defined as in need of control to reinforce the moral order (Douglas 1992, Lupton 2013).

#### 2.4.2.1 Risk, Mental Health Problems and Strategies of Control

The closure of psychiatric hospitals and the evolution of community based care may be viewed as resulting in the destruction of a containing system of control for people defined as a threat to social order (Scull 1982, Morall and Hazelton 2000, Foucault 2006). People with mental health problems have been recognised as a marginalised group, defined as different and, as the previous section has highlighted, a potential danger to wider society. The management of such a threat, therefore, demanded new strategies of control.

Within post or advanced liberal societies according to Deleuze (1992) discipline is no longer achieved through the shaping of conduct via institutions. Significant social changes have led to a fracturing of such institutions (such as the psychiatric hospital). Instead within a control society, control is dispersed and continuous (Deleuze 1992); it is achieved through the networks and practices that shape our everyday lives (Rose 2000). Goals of self-improvement, continuous training and monitoring of health and well-being are features of such practices of control (Deleuze 1992, Rose 2000). Within this social context, the good citizen is one who takes responsibility for managing their own (and their families’) security and well-being, acting as autonomous agents, making informed choices (Rose 1999, Larner 2000). Those who do not confirm to the boundaries of such practices are identified as ‘non or failed’ citizens (Rose 1999). They are defined as such by the state or state’s agencies (Morrall and Muir-

Cochrane 2002). People with mental health problems are identified as an example of non-citizens assumed to be unable or unwilling to engage in responsible self-government and manage their own risk (Rose 1999).

Nikolas Rose (1999, 2000) proposes that this results in such non-citizens becoming the subject of a variety of agencies, creating a network of surveillance with the purpose of minimising the risk and exerting control. Mental health professionals are a central part of this network. Collecting and sharing information with one another regarding the risk is significant and helps to ensure that all individuals subject to this network can be defined as potentially risky. Consequently the assessment, management and reduction of risks are a fundamental part of psychiatric professional responsibility. This facilitates the identification of those who are safe enough to be maintained in the community and those who are 'high risk' and can be dealt with through confinement. Admission to institutions (such as hospital care) provides a mechanism by which to contain the risk until such a time as it can be managed. This leaves people with mental health problems in danger of 're-incarceration' (Morrall and Hazelton 2000). Within this context the challenge of control is re-defined as the challenge of the management of risk (Rose 1999). Networks of surveillance staffed by control professionals are tasked with the role of protecting the community from such dangerous non-citizens. They are held accountable for any harm that may come to such a community, as failures in risk management are viewed as opportunities for improvement in techniques and knowledge. This is founded within the view that uncertainty is controllable.

Professionals also have a key role in putting into operation the policies necessary for governance of post-modern society according to Castel (1991). This is achieved through the shift from perceptions of dangerousness located in the mentally ill subject and managed through containment, to the generation of risk factors. These factors are identified via an objective approach to collecting facts, creating

the 'epidemiological clinic' in which service users are viewed by professionals in relation to their risks (Castel 1991). The caring professional is subjugated in the interests of risk assessment (Godin 2006). This shift creates multiple opportunities for intervention to be instigated to manage the risk and reinforces a process of surveillance. It is through this bureaucratic system that professionals are subordinate to the manager and the state. Castel (1991) claims they no longer have responsibility for the processing of this collated risk information and the manager becomes the decision maker (a function of control in a post-modern society). Such identification of risks leads to the coercion of service users to follow an assigned pathway, a process particularly evident within the Care Program Approach (Godin 2006).

Both Castel (1991) and Rose (1999) emphasise a significant role for risk in post-modern society. Social theories claim risk is an important way of making sense of society (Giddens 1993, Beck 1992). Within this social context, risk is understood as representing hazard. Like Douglas (1992), Beck (1992) claims that there is a growing consciousness of risk within society in which the motivating force becomes achieving safety. However, Beck (1992) maintains that while it may be possible to identify risks it is not possible to predict and control them.

In contrast to Beck's (1992) position, risk in mental health practice is understood as a phenomenon that can be measured and managed (Crowe and Carlyle 2003). Assessing and containing risk posed by service users is a vital skill for a responsible mental health professional (Szmukler and Rose 2013). It is identified as a core aspect of mental health practice (DH 2006, Freshwater and Westwood 2006, DH 2008). Despite evidence to the contrary (Fazel, Singh, Doll et al 2012, Wand 2012), research continues to seek to improve the accuracy of risk assessment tools (Royal College of Psychiatrists (RCP) 2008). Tensions are highlighted between intuitive, professional judgement and rational risk calculation (Doyle and Dolan

2002, McGuire 2004). Mental health professionals have been criticised for subjective and inaccurate judgments of risk in comparison to tools based on scientific statistical calculations (Doyle and Dolan 2002). An increasingly technical process is created as the focus is removed from the person onto paper based tools (Godin 2004). Such risk analysis forms a discourse; one which positions some as experts and others as ‘inarticulate, irrelevant or incompetent’ (Jasanoff 1999:137). These arguments also highlight the construction of service users as perpetrators of risk devoid from the power to understand, define and consequently manage risk in accordance with their status as spoiled citizens.

The perspective that risk is a knowable quantifiable concept is perpetuated; predictions are treated as objective facts. This has benefits for decision makers as it gives the impression of reducing uncertainty and making the future predictable (McDonald Waring and Harrison 2004, Szmukler and Rose 2013). This reflects a modern system of beliefs through which people feel they can have control over danger and uncertainty. Such a set of ideas assumes that human beings are responsible for events rather than fate, for example fate (Lupton 2013).

Risk assessment and management undertaken by mental health professionals becomes a process of control (Crowe and Carlyle 2003). This forms part of a technology of control for failed citizens within advanced liberal society and reflects a set of ideas that uncertainty can be managed. Such emphasis on control contrasts with the opportunities for self-determination advocated by a recovery approach. The following section examines more directly the impact of such systems of control for the choices available to service users in mental health care.

### **2.4.3 Coercion**

The status of people with mental health problems as non-citizens, suggests that they are not able to participate in autonomous decision-

making (Rose 1999). In addition, perceptions of mental illness associated with danger, emphasise a need for people with mental health problems to comply with strategies of surveillance and treatment. Compulsion may be invoked by the use of the Mental Health Act (2007). This legislation can result in restrictions on civil liberties, meaning that compromises to individuals' autonomy are legally sanctioned. However, compliance with the requirements of services adopting a role in social control may also be achieved through more general coercive practices. Coercion that people with mental health problems may be subject to is increasing (Laurence 2003, Bentall 2013). The opportunities that service users have to exercise the autonomy recognised as significant to recovery are limited by the existence of coercive practices within mental health care (Mancini 2007, Morgan and Felton 2013). This emphasises tensions between recovery and control in mental health practice and highlights the challenges for mental health professionals attempting to navigate between these influences.

Constructs of coercion are much debated. However, it is generally recognised to involve subjecting a person to the will of another, undermining autonomy and freedom; usually involving an expression of power (Arnold 2001, Anderson 2011). Within the mental health literature, coercion has been identified as the use of physical force (such as restraint) or more broadly as incorporating a range of interpersonal interactions resulting in influencing service users' decision-making and action (Lutzen 1998, Lind, Kaltiala-Heino, Suominen et al 2004). O'Brien and Golding (2003) support a broad definition of coercion that includes manipulation of service users' wishes and restricting access to information. Whilst coercion is legally permitted through the use of compulsory treatment under the Mental Health Act, O'Brien and Golding's (2003) definitions recognise a much wider context where coercion in mental health services may be used.



Ordinarily within healthcare, respecting a person's wishes is afforded priority, reinforced by the dominance of a principles based approach to ethical decision making ( Beauchamp and Childress 2001, Olsen 2003). In these circumstances a person is viewed as competent, able to exercise autonomy and make decisions free from pressure or influence. However, exceptions to this principle are deemed to be justified in certain situations within mental health care. Most commonly coercion is rationalised using principles based ethics on the basis of paternalism. Specifically, that acting against another's wishes is justified to minimise harm and enhance benefits (Beauchamp and Childress 2001).

These arguments rest on an assumption that the autonomy of people with mental health problems is limited (O'Brien and Golding 2003). As highlighted in Chapter 3, it is only in mental health care that people can be locked up and forced to undertake treatment (, Vassilev and Pilgrim 2007). It also reflects an understanding of service users as 'non-citizens'. Service users are perceived to be unable to make rational sensible decisions for the sake of their own good, requiring protection from succumbing to their 'irrational urges' (Adams and Drake 2006). Professionals have been criticised for taking a refusal of treatment to signify that a person lacks competence rather than specifically assessing this using Mental Capacity Legislation (Seo, Kym and Ree 2011). This is emphasised by recent criticisms of it's under use in mental health care (CQC 2013).

Prevention of harm to themselves or others forms part of paternalistic justifications of coercion (Seo, Kym and Ree 2011), particularly in relation to mental health law. However, this justification has been criticised for muddling what is in the person's and society's best interests (Szmukler and Holloway 2001, O'Brien and Golding 2003). Significantly, this review has proposed that the identification of people with mental health problems as the perpetrators of violence is constructed as part of a social system. Evidence suggests that they are more likely to be the victims of violence, whilst the ability to

assess the likelihood of such harm has been seriously questioned (Fazel et al 2012, Wand 2012, Pettitt et al 2013). Mental health professionals have been shown to be more likely to predict false positives (i.e. overestimate the potential) when it comes to assessing the risk of harm (Buchanan 1999, Morgan 2007), meaning there are no grounds for coercive interventions. The prevention of harm can therefore be questioned as a justification for overriding a person's wishes through coercion. Additionally, the level at which compulsory care is used creates further problems. It is estimated that 85 orders of community treatment would be needed to prevent one hospital admission and 238 to prevent one arrest (Kisely and Campbell 2007). The suicide rate for people in touch with mental health services is actually increasing (Appleby et al 2013), despite the high numbers of people being treated under the Mental Health Act.

The rationale for the use of coercion in mental health care has been debated. Those who are admitted to hospital voluntarily report experiencing coercion (Bindman et al 2005, Katsakou et al 2010). Viewing care and treatment as coercion can deter people from accessing help (Davidson and Campbell 2007, Swartz, Swanson and Hannon 2003). Coercion and pressure to comply with treatment are barriers to recovery (Mancini 2007). Service developments such as locked wards are recognised as inherently coercive (Bentall 2013); whilst concern was expressed in the development of assertive outreach services that conformity and coercion was a key agenda (Williamson 2002). This has developed in light of service and political commitments to a recovery approach.

Nozick's (1969) notion of threats and inducements has been used to further explore coercion in mental health practice. Szmukler and Appelbaum (2008) describe a series of treatment pressures that may be used to encourage service users to make a decision or comply with treatment, ranging from persuasion to threats and compulsion. Whilst not all these are identified by the authors as coercive, treatment pressures offer a useful insight into the range of tools that mental

health professionals can use to restrict people's choices. The focus on treatment pressures is useful particularly in the light of initiatives such as payment for taking prescribed medication being identified as non-coercive (Claassen, Fakhoury, Ford and Priebe 2007).

Included in Szmukler and Appelbaum's (2008) definitions of coercion are interpersonal leverage, inducements and threats. Interpersonal leverage involves professionals exploiting therapeutic relationships to signify approval or disapproval of decisions. Whilst inducements offer a reward, threats express a course of action that may leave a person worse off. These pressures are enacted to encourage compliance with treatment or services. Mohanan, Redlich, Swanson et al (2005) found that around half of the service users participating in their study had been subject to treatment leverages to adhere to a plan of care. Leverages included access to housing support, finances, probation and supervised community treatment. Burns, Yeeles Molodynski et al's (2011) replication of the study in the UK found that a third of service users had experienced similar treatment leverages. Consistent across both studies was the tendency for these to be used more on young people, those who misuse substances and those who were the most unwell. Whilst coercion in the context of the Mental Health Act may be the most visible and therefore debated, these studies uncover a concerning trend of services manipulating the choices of people with mental health problems. Particularly as this research was conducted following political and professional commitment to recovery in both jurisdictions (Department of Health and Human Services 1999, DH 2001,)

Despite the problems with justifying coercion it is recognised as a frequent part of mental health practice, albeit one that is ethically and emotionally difficult for practitioners (Davidson and Campbell 2007, O'Brien and Golding 2003). Practitioners highlight the challenges of fulfilling their professional responsibilities while promoting the rights of service users (Cleary 2003). This has involved acknowledging that

such interventions may conflict with their own therapeutic values and fear that a lack of action results in increased harm (Godin 2000, Clearly 2003, Kidd et al 2015). Professionals are identified as part of a social system answerable to political and public demands to control people with mental health problems (Godin 2006).

### **2.4.3 Summary**

Recovery grew from the collective voice of a survivor movement and emphasises a persons' rights to autonomy and self-determination. Mental health professionals can act as facilitators in this journey, developing hope-inspiring relationships and making a range of treatment options available for the person to use as they decide, in taking control of their own lives. Recovery has been recognised as a central philosophy that should underpin contemporary mental health services. Yet in the era of mental health care located within the community setting, people with mental health problems have been identified as a threat to the safety of the public. Government policy has required their monitoring and increasingly their containment. These function as part of a system of control within advanced liberal society for a group identified as unable to govern themselves. A network of surveillance has been constructed with mental health professionals adopting a key role in assessing, managing and consequently controlling this risk. Coercion offers an example of how such risk is governed in mental health practice. These influences of recovery and risk appear in discourses of mental health practice, once again presenting a notion of duality; at once caring and controlling.

### **2.4.4 Literature Review Conclusion**

The starting position for the review was to outline an argument from Foucault (2006) that there is juxtaposition at the centre of the mental health system. In the arguments presented, I have examined tensions in the history of mental health services between the development of

welfare and support for people in need, alongside the separation and containment of a deviant population. The expression of this juxtaposition in contemporary mental health provision has also been examined through the implementation of the Mental Health Act and the challenge to strike a balance between access to treatment, rights and control. Finally, the influence of recovery as a philosophy that undermines the position of people with mental health problems as other and promotes choice and self-determination has been considered. The review has demonstrated how this position has been threatened by an emphasis on risk management, once again presenting people with mental health problems as in need of monitoring and control. A core theme at the centre of these conflicts is the issue of how the interests of people with mental health problems are understood in relation to the interests of wider society and the role of government and professionals in managing these interests.

The exploration has suggested considerable presence of these co-existing influences as they permeate through the foundation of mental health services, legislation and, as this review has claimed, the practice of mental health professionals. Examining the influence of such tensions on mental health practice would have the potential to support practitioners to negotiate through such ‘duality’ to promote recovery orientated practice.

## 3.0 Methodology

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### **3.1 Chapter 6: Study Design**

The presentation of a coherent and well justified account of the research process is one of the benchmarks of high quality qualitative research (Denzin 2002). This section provides a detailed discussion outlining the epistemology, process and ethics of the research undertaken for this thesis. It begins with a discussion of the specific aim for the study.

#### **3.1.1 Research Aim**

To explore whether and how mental health practitioners perceive and experience the potential tensions that may arise from delivering care and enforcing control for people who experience mental health problems.

##### **Objectives**

- Examine mental health professionals' experiences of potential contradictions between promoting recovery and managing risk in decision making
- Explore how, if at all, mental health practitioners resolve such tensions that may arise in their decision making with and about the people they support

The review has highlighted that conflicting influences in mental health practice co-exist and are multifaceted. In order to examine the impact of such influences empirically it is essential to consider where, if at all, such tensions may be evident in practice to ensure the research is focused, exploring the issues outlined in the research question. This thesis, therefore, examines these tensions in the context of decision making. The presence of such directives is likely to be more easily identified where professionals are working with service users to plan and decide on a course of action during which such influences may be more explicit. This position draws on the

literature review which highlighted tensions present in relation to decisions, for example; use of the Mental Health Act, response to risk and planning for recovery.

The research question adopts the terms of care and control to express the potential conflicting influences in mental health care. These concepts were identified to provide a reflection of the perspectives indicated by the contrasting positions outlined in the review. It is acknowledged that these terms are in many senses problematic. The previous discussion has highlighted that these influences are multifaceted which provides the context for the aim. The terms have been adopted to ensure that the research's focus is as clear, specific and relevant as possible in a topic that is problematic to define (Robson 2002).

### **3.1.2 Study Epistemology**

The philosophical foundations of nursing are much debated (Rocha, Lima, Peduzzi 2000). Nursing research has been criticised for failing to acknowledge and explain the epistemological approaches it adopts (Avis 2003, Debesay Náden, Slettebø 2008,). This section provides an overview of the epistemological assumptions relevant for the development of my thesis, outlining the justification for the research design.

#### **3.1.2.1 Theoretical Context**

The desire to explore the perspectives of mental health professionals and develop an understanding of how they perceive and experience potential tensions in the delivery of mental health care suggests an interpretive approach. This assumes that human action has subjective meaning and value (Hughes 1990). Knowledge is gained through the interpretation of these meanings, rather than examination of an objective external reality. Inquiry seeks to develop understanding through a process of interpretation. This involves the researcher gaining an understanding of the point of view of the participants in



their study in order to be able to build a picture of the social world. The methods of inquiry for this research are based on a case study approach to explore whether and how mental health professionals experience potential tensions that may arise from delivering care and enforcing control, using tools of data collection including interviews and observation. This highlights the focus in my research on an attempt to interpret the subjective meanings that participants attribute to their social reality. The study is therefore an interpretative qualitative inquiry.

Jurgen Habermas's theories will be considered in order to explain more fully the epistemological framework that has been used to inform the development of this study. Habermas claims that the development of knowledge through inquiry within society is guided by certain knowledge interests (Habermas 1972). His theories of knowledge interests are built on a critique of purely positivist and hermeneutic approaches to epistemology. The first knowledge interest he describes is technical. This interest contributes to the development of empirical analytic approaches within natural and social sciences (Habermas 1972, Scambler 2001). Here the natural and social world may be broached as matters of potential knowledge. These types of inquiry therefore aim to generate testable explanations. Technical interest incorporates the perspectives of positivism, though Habermas highlights the mistake of the natural sciences is in viewing this knowledge as neutral. The second type of knowledge interest is interpretive, underpinned by a practical interest in the development of shared understand and self-reflection. Understanding and communicating with others enables cooperation (Benton and Craib 2001). This interest supports inquiry that pursues inter-subjective understanding and is therefore hermeneutic. The final type of knowledge interest is emancipatory, defined by the need to be free from forces of domination (Habermas 1972). Through adopting a reflexive approach to understanding ourselves and the ways of thinking about the world, a reflexive understanding of these interests

is enabled (Giddens 1993). The development of this critical dialect, in order to create emancipatory knowledge, enables oppression to be overcome (Mill, Allen and Morrow 2001).

Habermas' explanation of interpretive, technical and emancipatory knowledge interests emphasises these as complementary rather than competing epistemologies. His theories create the capacity for pluralism rather than prioritising one form of knowledge interest and therefore inquiry over another. It also assumes knowledge is constructed not discovered (Mill et al 2001). The position adopted in this inquiry reflects these arguments and is informed by the pursuit of interpretive-hermeneutic and emancipatory knowledge interests.

#### 3.1.2.2 Personal Context

My own context, which forms the background for the research, may be seen to reflect Habermas' explanation of knowledge interests. The focus for the research was inspired by my own practice as a mental health nurse working with service users with serious mental health problems. I felt torn in making decisions between supporting choices that the people I worked with might want to make and meeting the pressures to manage risk. This situates the research in the context of mental health nursing. Nursing is a practice of caring for the whole person (Porr 2005). Caring in this manner involves building an understanding of the beliefs and subjective experiences of those whom you are caring for. Locating the study within the context of mental health nursing, places it in this social world. The focus is therefore on the meanings that people give to their context, rather than the external environment itself.

The inspiration for the study arising from my own practice suggests that I have built experiences, beliefs and assumptions in relation to the area of inquiry. It already situates me as an 'insider' and as such, unable to adopt an objective detached position as a researcher. Examining my beliefs becomes part of the research process itself, as I consider the way that they influence my assumptions and

interpretations. This relates to the hermeneutic knowledge interest. Finally, nursing is action orientated. Recognising the difficulties I felt balancing individuals' self-determination alongside risk reflects a 'problem' within my own nursing practice. The motivation to examine this experience represents a desire to conduct research that has meaning and value to the practice of nursing. This position acknowledges that there is an aim to build insights beyond the individual scenarios of the research and make some claims about the validity of these explanations which allow them to be useful to mental health practice.

### 3.1.2.3 Interpretive -Hermeneutic Interests

The research is concerned with developing an understanding in relation to the experiences of mental health professionals. The tradition of hermeneutics offers a framework for building this understanding. This decision is based on an acknowledgement of humans as meaning-creating. According to Gadamer's approach to hermeneutics, understanding arises through a genuine dialogical encounter (Giddens 1993). This understanding is situated within our linguistic and historical traditions (Binding and Tapp 2008). As researcher and participant engage in an open dialogue, the preconceptions of each become fluid to enable new meanings to be uncovered (Binding and Tapp 2008). It is through this 'fusing of horizons', that we can come to understand the other (Benton and Craib 2001), revealing our own history and assumptions (Hughes 1990). This represents a fusion between the past and present. Within hermeneutics, a part can only be understood in terms of the whole, and the whole can only be understood in relation to the parts; an ongoing process of interpretation that forms the hermeneutic circle (Debesay et al 2008). Drawing together the parts into the whole enables understanding, helping to uncover meanings that may have been unclear (Debesay et al 2008).

For this genuine dialogical encounter to occur within the research situation, certain conditions are viewed as central. It is being open to new possibilities and recognising that we are not in a position of already knowing which enables us to be open to the participants (Binding and Tapp 2008). This requires recognition of my own prejudices. One of the key premises of the hermeneutic approach is that understanding can only be achieved within the context of our shared beliefs and practices (Geanellos 1998, Chang and Horrocks 2008). Hermeneutics enables the researcher to be recognised as a social actor themselves. This stance offers a fundamental challenge to positivism in which the acceptance of an objective view of reality suggests that it is the role of the researcher to adopt a detached position, free from bias and prejudices. Hermeneutics argues that it is these very prejudices which enable understanding. The personal context of the study emphasised my own experiences are central to the motivation for the research. My appreciation of the research phenomenon will continually be influenced by my identity as a nurse and my engagement with the theoretical context of the study. Hermeneutics situates these experiences as essential to the process of enabling understanding to develop.

Constructing an argument within this thesis to create a rationale for the research provides some insight into my own position. Notably, that there are deep rooted tensions within mental health services between an individuals' rights to make choices about their lives and the duty of mental health services towards individuals' best interests and the interests of wider society. Those tensions are something that are experienced by mental health professionals but are influenced by the historical, legal, political and ideological context in which they work. It locates the origins of this position in practical experience as part of my role as a nurse, recognising that this tension is something that I have experienced. Researchers adopting this epistemological framework should engage in a process of reflexivity to help provide a critical account of the political, social and moral position that has

been adopted (Koch & Harrington 1998). I have attempted to present such reflexivity throughout this study; enabling the recognition of my own prejudices.

Historical perspectives are significant within this research, providing the context for an examination of a potential duality within mental health practice. Gadamer emphasises the importance of historical positions that shape both our experience and understanding of that experience (Hughes 1990). However, this uncovers a significant limitation of pure hermeneutics as applied to this research. There is no opportunity to examine differences between and within traditions. Gadamer's writing appeals to the dominance of tradition without providing scope to explain what is influential in its development and in this respect, there is no framework to offer a critique. Hermeneutics does not consider a role of social structures in determining action and is therefore limited in informing an exploration of structural and organisational power. The literature review situated the experience of tensions for mental health practice within a social and political structure, underpinned by power relationships. This provides further justification for looking outside of individual understanding as a foundation for the research inquiry and incorporating other knowledge interests. It is useful to return to the motivations for the research, in which, understanding a phenomenon of mental health practice is part of the story. The study is also motivated by a desire to inform practice development and therefore change. Understanding through a hermeneutic approach alone would not enable the conditions for change (Habermas 1972).

#### 3.1.2.4 Emancipatory knowledge Interests

Speech acts, according to Habermas, enable emancipatory communicative action when mutual understanding is achieved between two people who are capable of speech and action. Speech acts are related to the objective, social or subjective worlds (Habermas 1987). The emphasis on dialogical interactions is

significant to the interactions between myself and research participants, with particular emphasis on engaging in discussion relating to our social and subjective worlds. To pursue the aim of communicative action within research relationships required that I embraced and respected the participants' insights, conceptualisations and means of positioning themselves. It also meant reflecting on and sharing my own positions and assumptions (Porr 2005).

Within Habermas' (1987) work there is a differentiation between the life world, with its conditions for open communication and the systems world directed by the drive for power. In the systems world speech act validity claims are not favoured, as justification for action is based upon success orientated behaviour (Habermas 1987). The conditions for open communication that characterise the life world are undermined in a systems world concerned with efficiency and achievement. The life world has been described as being colonised by the latter. These concepts have been applied to healthcare in which the development of business principles within services, the drive for cost reduction and efficiency undermines opportunities for dialogue and debate that support communicative action (Godin, Davis, Heyman et al 2007). These conflicts have also been viewed in the relationship between professionals and patients. A paternalistic systems world of medicine colonises the life world of patients. This is explained through the lack of opportunities for patients to participate in decision-making, but also in the increasing medicalisation of social and emotional life (Godin et al 2007). Recovery may be perceived as an attempt to reengage with the life world of people who experience mental health problems and challenge the systems of power inherent within psychiatry.

#### 3.1.2.5 Implications for Empirical Study

Habermas' critical foundations provide a framework for offering a critique of dogma (Mill et al 2001). This addresses some of the criticisms of hermeneutic theory that it would limit the understanding

gained in this study to the individual participants' perspectives, overlooking the impact of social structures. Habermas' theories therefore enable this issue of power relevant for mental health practice to be explored. They allow for different knowledge interests to be complementary and inform this inquiry. Critical Theory therefore promotes individual in-depth 'ideographic explanation' built through understanding individual cases but also incorporating recognising and explaining patterns across contexts (Mill et al 2001: 114).

Through communicative action, understanding, learning and enlightenment can be achieved (Habermas 1987, Godin et al 2007). The implications of Habermas' theories for empirical study emphasise dialogue as being at the heart of the research process to enable the development of understanding, but also create the conditions for change. Interpretive- Hermeneutic and emancipatory knowledge interests recognise the researchers' own beliefs and experiences as central to the research process. These form part of the framework through which understanding is achieved and knowledge co-constructed. These interests acknowledge the context of the social structures in which research interactions take place and create the capacity for building explanations based on the drive for change. Habermas' critical theories (1972, 1987) have therefore informed the epistemological foundations for my research.

### **3.1.3 Research Design; Case Study**

Empirical research design is influenced by both the questions and the theoretical framework (Denzin and Lincoln 2011). The research question is concerned with the meanings and experiences that mental health professionals associate with potential tensions that may arise from delivering care and enforcing control. A critical theoretical background emphasises the social context in which professionals and the researcher construct these meanings. A case study methodology was adopted for this inquiry. Case studies provide a method to

explore and understand relationships, processes and different interests within a specific context (Perry 2011).

Yin (2014), Stake (2000) and Flyvbjerg (2006) agree on three defining characteristics of a case study:

- It examines phenomenon within its 'real-world' context
- It is a bounded system and that defining boundaries creates a case
- Is concerned with depth and richness.

These characteristics reflect the concerns outlined in the research question and theoretical framework therefore informing the choice of case study methodology. Case studies provide a research approach that can help draw relationships between situated practical complexities (i.e. tensions related to delivering care and enacting control) and theory (Luck, Jackson and Usher 2006). The focus of the study is grounded within and influenced by a motivation to inform mental health practice, demonstrating the concern with complex practical situations. This empirical inquiry examines the process through which mental health professionals' deal with tensions associated with duality in mental health services. Considering questions of 'how' are important to achieving this aim; for example, how do professionals experience these tensions? How are they dealt with and resolved? Case study can provide a useful approach to explore questions of how and why (Andrade 2009, Yin 2003). Utilising case study to explore this phenomenon allows for detailed and in depth examination.

A review of the literature suggests that there are certain agendas within mental health services which may conflict, creating tensions for mental health professionals within their practice. Articulating the nature of these tensions within the context of the study has been difficult. Case study offers a useful structure for inquiry in such instances when an issue is not easily separated from context (Yin



2014). Through a case study approach this research aims to develop further understanding of the processes through which these tensions are dealt with. In this respect, an insight can be built through an examination of potential tensions within the context in which they arise. It also provides an opportunity to consider the multi-faceted influences on this, notably as case study supports an exploration of beliefs, relationships and decisions which may have a bearing on the research problem (Yin 2003).

The use of case study as a research approach has been debated. A number of reservations about its value as a research tool have been raised including: researcher biases, problems with generalisability and challenges to the use of case study in theory building (Tellis 1997, Andrade 2006, Flyvbjerg 2006, McGloin 2008). Many of these problems arise from different interpretations of case study, based on epistemological position.

In contrast, the value of case study research is presented through the opportunities it creates to study depth of research phenomenon in its 'real' setting (Flyvbjerg 2006, Ruddin 2006, Watts 2007). According to Stake (2000) this relies on focusing on what is particular and facilitates an exploration of the complexity of the research situation. This entails the collection of rich description. Value is accorded to the process of interpretation, as the researcher seeks to gain an insight into a case and examine the perspectives adopted by participants in the study, in order to be able to build a picture of the social world. Whereas Yin (2003) claims insights in one 'unit' can be applied to a larger number of units, through a process of theory replication leading to generalisation. The rich description of Stake's (2000) interpretation of case study builds understanding through interpretation, where-as Yin's (2014) builds explanation through repetition. Rather than adopting the learning from a case and applying this to another setting, it is the in-depth context bound detail of case study that gives it value in developing knowledge (Stake 2006). This emphasises the role of the reader of the research in

deciding what learning may be relevant for that person's context. Alternatively, Yin (2003) suggests analytic generalisation may be claimed where there is replication across more than one case study. This replication reflects support for a theory (or rejection of a rival theory). Yin and Stake's positions present a dichotomy between particularisation and generalisation. Though they do agree that context provides richness and therefore that building interpretation does not involve seeking a specific sample or being representative. Returning to the epistemology of this study suggests that the inquiry seeks to build both understanding and explanation, reflecting the different knowledge interests of critical theory (Habermas 1972, Mill et al 2001). Consequently the design and conduct of this case study research has been influenced by the seminal works of both Robert Yin and Robert Stake. As such the study is in line with many contemporary case study researchers who aim to surmount these polemic positions (Perry 2011, Luck et al 2006).

#### 3.1.3.1 Case Study Selection

An important component of case study is the provision for flexibility within the study design to allow the researcher to both address the research question and respond to the emerging data (Stake 2006). I developed an initial proposal for the study design but the adaptability afforded by case study frameworks allowed me to respond to emerging insights to make choices regarding where and how to collect data. This section provides an outline of the proposed design, including decisions made in response to emerging interpretations.

Within this inquiry, case study is a means to understand and explain mental health professionals' experience of potential tensions associated with delivering care and enforcing control in mental health practice. A wealth of definitions exists of a case within research, yet defining the case is a vital stage for researchers (Raigin and Becker 1992). This study adopts Stake's (2000) definition of instrumental case study. The case study therefore provides insight into an

identified phenomenon, rather than for example, aiming to understand the specific case itself (intrinsic case study). Electing cases is informed by the desire to understand the specific issue.

In order to identify cases which were most likely to enable the richest insights to be developed, consideration was given to the desirable characteristics of these cases. The literature review suggested that issues of control and the potential for juxtaposition are particularly evident within contexts pertaining to adults experiencing mental health problems who are receiving intensive input from mental health services. The theoretical context for the study incorporated a discussion of how these issues have been viewed through institutional and community contexts. Recovery grew from individuals who had experienced serious mental health problems whilst much of the debate related to risk management in mental health also concentrates on this group (Deegan 1996a, Fazel et al 2012). It has previously been identified that the inquiry aims to explore the perception and experience of potential tensions in the context of decision making. The case studies were selected to take account of the likelihood that these features would characterise the case.

Three mental health teams providing services to adults experiencing mental health problems were identified as the initial cases. Two of these services were located in a large integrated Trust in the East Midlands. This included one within an in-patient acute mental health care environment, one community mental health team and one peer support service delivered outside the National Health Service. Through identification of a case the researcher outlines the choice of what is being studied and consequently what makes up the study's context (Stake 2000, Flyvbjerg 2011). The case studies are the teams and the context is the setting in which they delivered care. This identifies the setting and context for the research both in terms of the environment and the potential participants. I aimed to explore the perspectives of those involved with such teams.

The inquiry proposed to use multiple-cases (a collection of instrumental cases) to address the research question. Multiple-case study design enabled the exploration of how the research phenomenon exists and is experienced within different contexts. Given the breadth of services provided within mental health care, there was significant value in consideration of more than one setting. The organisation and culture of teams can differ significantly between in-patient, community, statutory and non-statutory settings. The selection of more than one case was undertaken to strengthen theorising across different contexts and broaden understanding (Stake 2000, Yin 2003, Jones and Lyons 2004).

In-patient and community adult mental health settings were purposively identified as it was perceived these areas would provide the richest and most detailed understanding of the existence of tensions associated with duality within mental health practice. Additionally, the nature of the tensions associated with issues around risk and recovery suggests that it is in these areas that the tensions are most likely to be acutely experienced and as such these cases should offer the most opportunity to learn (Stake 2000). Cases were selected based on the view these were most likely to offer the deepest insights. Such a selection strategy reflects Flyvbjerg's (2006; 230) 'information orientated approach' to the identification of the cases.

Since the publication of The National Service Framework for Mental Health (DH 1999), multi-disciplinary teams have been the core structure of mental health services. This policy promoted the development of specialised teams providing support for client groups with specific needs. Effective multidisciplinary teams are important in promoting quality recovery focussed care (West, Allimo-Metcalf, Dawson et al 2012). Multi-disciplinary teams often consist of psychiatrists, nurses, unqualified support workers, and team administrators. More varied between different teams is membership of psychologists, occupational therapists and social workers (West et al 2012). Participants within the study were likely to include some or

all of these practitioners. The research aims to explore mental health professionals' experience of potential tensions related to mental health practice. As multidisciplinary teams are central to the organisation and delivery of mental health care, examples of these were selected to form the bounded cases.

Acute in-patient wards are an essential part of mental health services for adults, despite a reduction in the number of beds (Quirk and Lelliott 2001, RCP 2011). These wards provide 24 hour care for adults in periods of crisis and extreme distress. A lack of social support, acute illness and the potential for harm to themselves or others can contribute to admission on an acute ward (Bowers, Brennan, Winship, Theodoridou 2012). Service users going into acute care are increasingly likely to be detained under the Mental Health Act (CQC 2014). The quality of in-patient care has been heavily criticised in recent years, contributing to efforts to raise standards. This has included demands for greater involvement of service users in their care, recovery orientated practice and increased psychological support (RCP 2011). Acute in-patient care is therefore a hub for adult mental health services. It is a setting where people are likely to be detained under the Mental Health Act, and needs to enhance involvement and recovery for service users. These factors were considered as important features relevant for the research question and an acute inpatient ward was selected for these reasons.

The majority of mental health services are provided within the community. Assertive outreach teams were developed to engage with individuals with serious mental health problems (Sainsbury centre for Mental Health 1998, DH 1999b). Assertive outreach are specialist community teams established to provide support for service users with complex mental health needs, who have had multiple admissions to hospital, poor social support, were socially excluded may be at risk of homelessness and may have contact with the criminal justice system and/or substance misuse problems (Hemming, Morgan and O'Halloran 1999). This is the specific client group that many of the

policy and legislative changes examined in the literature review have been designed to target. At the time when the research was initiated, assertive outreach teams were one of the main services providing support for service users with serious mental health problems. It was identified that consequently an assertive outreach team may be likely to experience potential tensions and such a team was chosen for these reasons.

Within information orientated selection, an atypical case can be helpful to elucidate more information from the position of difference (Flyvbjerg 2006). A peer support service provides an opportunity to study an atypical situation, as it offers an alternative to the statutory system where the majority of adult mental health services are delivered. This includes a different environment, context and potential participants in terms of peer support workers. Examining this area in depth provides scope for comparison with regards to the commonalities and differences in the experience of tensions across the diverse settings, enabling consideration of the impact of relationships, structures and context on the research phenomenon. Variety within and between cases enriches understanding and explanation (Stake 2000, Yin 2003).

Case studies therefore involve selection; the primary selection questions relate to deciding on the field of research and identifying what makes up the case (Gangeness and Yurkovich 2006). The flexibility of case study design, in addition to taking account of the importance of context, meant that the boundaries of the teams evolved and were set upon commencement of data collection. Spending time in the case study settings facilitated better insight into who made up each team. Selection of whom to invite to participate in interviews was therefore defined by the boundaries of the case. All members of the multi-disciplinary team who participate in decision making were included in the case. Defining teams is challenging, consideration needed to be given to those who had experience of the research phenomenon. Selection within qualitative research is informed by the

desire to develop rich insights, therefore those who are perceived to be part of the area under investigation are selected (Patton 2002). Consequently, professionals who may be linked with a team but not participate directly in decision making in the sites regarding the care of service users were excluded; this included a pharmacist and all team administrators.

#### 3.1.3.2 Study Setting

The statutory site for the instrumental case studies was a large integrated NHS trust. There were a number of assertive outreach and acute in-patient teams that could have been approached for inclusion in the study. As a lecturer in nursing I had regular contact with some areas of the Trust who were also my previous employers. My own experiences as a researcher have been acknowledged as being significant within the research. However, prior to the selection of case study sites, it was important to consider the impact that these factors could have had on the study. One of my roles as nursing lecturer is to provide support for students undertaking placements on acute wards within one area of the Trust. I decided to avoid any of these areas for the in-patient case study setting, in order to reduce any muddling between my role as researcher and the responsibilities I have for providing placement support. This could have had a potential impact on the practicalities of data collection, in addition to moving me further inside the practice setting which may have limited the potential for me to see new insights (see observation and analysis sections for further discussion). The confusion of these two roles could have resulted in staff feeling pressurised to participate in the research. The team approached for the in-patient case study was part of the same Trust, but situated in a different geographical location and not one of the areas I link with as a lecturer. This was less of an issue for the assertive outreach team as I had no specific experience of working for or with such teams.

### **3.1.4 Design of Study**

Access to the case study settings is considered within the ethics section. The following discussion provides an overview of the design of the study. The next chapter examines the data collection methods undertaken.

Flexibility is an important feature within case study research in order to pursue unexpected paths, though this needs to be conducted with rigour (Yin 2003). The case study adopted an emergent design that enabled me to make decisions relating to who and what data would be collected in response to developing interpretations (in accordance with ethical permissions granted). The design was initially conceived as a multiple embedded case study design. Despite the need for boundaries, identifying the case is recognised as one of the fundamental challenges of case study research (Yin 2003, Gray 2004). The research problem within this inquiry focuses on the potential for tensions within mental health practice. At the time of the study design my understanding of potential tensions, within the study settings, was limited. The first stage of the research, therefore, aimed to further define and examine potential tensions. This created a capacity for focus on specific sub ‘units of analysis’ (Yin 2003:44, Gray 2004), the tension itself, representing an embedded case (Stake 2000). Analysis of this stage sought to examine commonalities and features of identified tensions that could be explored in further depth through embedded cases.

In the initial stage, one-to-one interviews were to be conducted with members of staff exploring their perspective on potential tensions in mental health practice, identifying how these were constructed and through this exploration identifying embedded cases. The use of multiple methods of data collection is a common feature within case study research (Gangess and Yurkovich 2006); serving to enrich insights, as well as providing the opportunity to clarify interpretations (Stake 2000, Yin 2003, Casey 2006). In addition to interviews, I



would conduct unstructured observations of mental health team interactions; for example multi-disciplinary team meetings where decisions were likely to take place, initially to consider the nature of tensions and issues creating dilemmas within mental health practice. Examining multiple perspectives using both methods provided opportunities to explore and clarify meanings.

#### 3.1.4.1 Phase Two -Embedded Case study

The second phase involves exploring the tensions arising within each case in-depth within that setting, using embedded cases. Supplementary one-to-one interviews with the specific participants interacting with the tension were to be conducted. This was dependent on the data emerging from the first phase, and aimed to seek to explore their perspectives on the tensions and definitions previously identified.

What constitutes the embedded case studies would be defined by the emerging data. However, when designing the study, it was envisaged that this was likely to relate to situations in which the dual influences of care alongside pressures to control may be brought to a head when a decision is sought. This might include, for example, a specific review to discuss discharge from hospital, medication review, and goal planning in a care programme approach (CPA) meeting. The examination of multiple perspectives within case study not only involves the meanings constructed by participants, but also consideration of interaction between the participants themselves (Tellis 1997). Interviewing all those who were involved in these specific scenarios created the potential for me to explore the perspectives of service users and their families. This acknowledges that the experience of the process by which tensions are dealt with is likely to differ depending on the position and perspectives of the participant (Andrade 2009). Conducting direct observation of the embedded cases was also considered to facilitate greater depth.

Clarity of interpretations within research should be promoted as much as possible (Stake 2000). This may be supported with a process of triangulation, through comparison of different perspectives and the findings from multiple methods of data collection (Stake 2006, Yin 2014). Interpretations can be checked when comparing the results of both interviews and observations featured in the study design.

### **3.1.5 Development of Study Design**

Prior to approaching the first study setting, the inclusion of an atypical case study was reviewed. The rationale for examining a non-statutory service was valuable given the variations in culture, organisation and staff. However, when considering the practicalities of the research, particularly attempting to collect data in three case studies using two methods of data collection in a two phase research design, I perceived it was beyond the scope of a single researcher within the time frames of the study to include all three. Case study research can involve a significant time commitment within the field, collecting information (Yin 2014). In addition, the design could produce large amounts of qualitative data. Managing these issues can be overwhelming for researchers new to case study design. In order to ensure the study remained manageable with my resources and to avoid compromise to the quality through making it too wide, I decided not to include an atypical case. I focussed on the two instrumental cases as it was envisaged that comparing two cases which shared some characteristics was more likely to lead to detailed findings, supporting the development of theory through repeated themes and insights across the settings. Disconfirming evidence within a study is important to extend theories proposed (Eisenhardt 2002). It was anticipated that disconfirming evidence is likely to be stronger in an atypical setting. However, this highlights that consistency and depth is required in order to develop these theoretical propositions in the first place. The shared characteristics of the

statutory settings were thought to be more likely to promote this consistency and lead to the development of explanations.

Once the first stage of data collection, using observations, had begun in the in-patient setting, the examination of embedded case studies was reconsidered. This was informed by my reflections on the emerging data relating to tensions in mental health practice. Identifying embedded cases in phase one to consider in phase two, meant clearly establishing the boundaries of the case. However, observations on the ward suggested that there were multiple scenarios in which these issues may be present but they were fluid and fast moving. I began to question the practicalities of isolating instances when these conflicting agendas were influential and exploring the perspectives of those involved within a time frame where they were still memorable to those staff, service users and families involved. This was compounded when considering some of the constraints on data collection created by being a part-time researcher. When I noted that different agendas may be present within decisions about clients care, in these early observations I reflected that they did not necessarily appear to be causing tension.

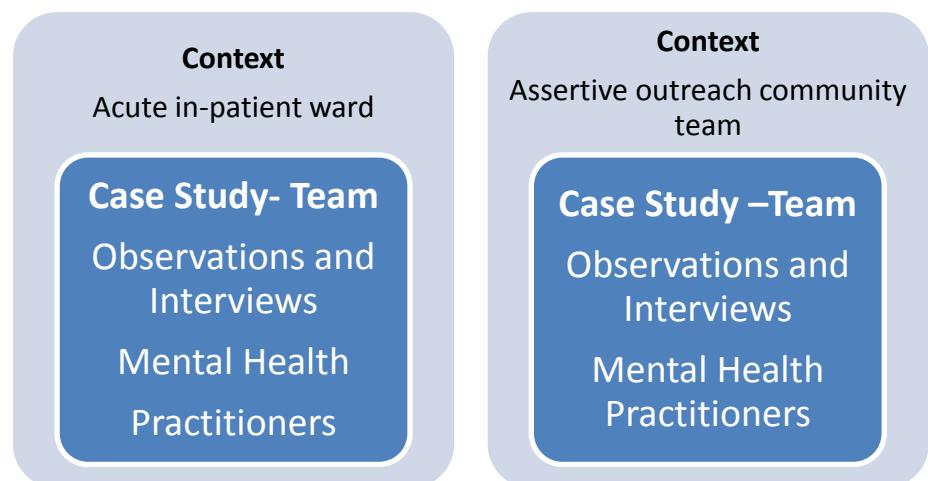
*“There seemed to be a lot of times where control could become an issue, like leaving the ward or patients observations but these didn’t necessarily seem to cause dilemmas for staff, policy was being followed or there was what seemed to be a clear cut ‘no’ ... I found this surprising...”* (Extract from research journal day 2 of observation).

These insights suggested that my prior perceptions of how a tension could be defined were perhaps naïve; actually these were complex and potentially unable to be “bounded” into an embedded case. Making decisions under the influence of these agendas may be resolved in different manner from that which I was expecting. Explicit within such assumptions are my own experiences of tensions between risk and recovery. These early stages of the research suggest

some potential differences between my experiences and those of the participants.

At this point in the study I questioned whether phase two would either be possible or necessary. This was confirmed once data collection for phase one was complete, as there was a large volume of data relating to participants experiences of the influences on decision making in mental health practice. Therefore, in accordance with the emergent design, phase two was not undertaken. The early stages of the research highlighted the invisibility of service users within decision making (which continued to arise throughout the study). Examining this observation enabled me to consider issues of power and, in itself, began to suggest that perhaps service users' and carers' perspectives had less of an influence on tensions in decision making than I had anticipated. Data collection therefore maintained a focus on practitioners' perspectives.

Figure 2.0 Design of Study



Adapted from Yin (2014)

### **3.1.6 Ethical Issues in the Study**

Ethical processes are essential within research to guide decision making. This section examines the ethical issues both informing and arising from the study. The first section focuses on ethical governance of the inquiry, whilst the second section considers an example of an ethical dilemma I experienced as a healthcare professional undertaking qualitative research in the practice setting.

#### *Ethics Governance*

The research study was conducted in line with codes of practice supporting research undertaken at the University of Nottingham (UK Research Integrity Office 2009, University of Nottingham 2013). This involved adhering to certain principles in the planning, implementation and reporting of the research in order to promote good conduct, protected participants and maintained accountability.

#### *Ethical Foundation for the Research*

This study has to have a clear rationale for the research to be conducted. Development of knowledge in the subject area should be a central aim (UK Research Integrity Office 2009). This chapter has established that the inquiry seeks to make a contribution to knowledge in an area rarely examined empirically. Through the development of a critical literature review, a rationale has been presented of why conducting research in this area may be of value. Building explanations that may be useful for mental health practitioners dealing with potential tensions related to the delivery of care and pressures to enact control highlights that the aim of the research is also to be practically useful. Through these arguments I have presented a claim that there is ethical justification to carry out the research.

The possible benefits of the research need to be weighed against the potential that any harm may occur as a result of the study. As a qualitative inquiry data collection relies on the development of

rapport through an interpersonal relationship between the participants and researcher. However, this creates the potential for the research situation, in particular interviews, to facilitate disclosure of sensitive issues (Clarke 2006). There is potential that this could have arisen as part of the inquiry because the focus relates to areas of mental health practice that may have been emotive or stressful for participants. Such issues could have been shared in the interviews by participants. Being observed may have resulted in members of the team feeling uncomfortable knowing that the researcher is watching a discussion that they are contributing to. A further burden may be the time commitment required for individuals to participate in interviews either within a busy working day or volunteering time outside of working hours.

The benefits to be considered against the costs relate to the opportunity to share their perspective on a complex area of mental health practice. This includes the provision of a space to reflect on this issue and potentially contribute to the development of the evidence base for mental health care. These ethical issues are examined more fully in the discussion of data collection, though as the study focussed on participants working practices, the likelihood of sensitive issues being raised was judged as small. Measures were taken to minimise these costs and protect participants (see avoiding harm section).

The study was planned and designed to address the research question using established frameworks in qualitative research. The proposal for the research design was reviewed by my PhD supervisors and has been subject to an internal assessment process. As a result, refinements to the wording of the research question were made. The research was submitted to the Derbyshire Research Ethics Committee via the integrated research approval system and gained final approval on 13<sup>th</sup> October 2010 (see Appendix I). The study was approved by the NHS Research and Development office for the organisation where the study took place. No amendments to the study design were

requested by the Committee or the Research and Development department.

As a registered mental health nurse I act in accordance with the NMC code of practice (2015). The code governing the actions of nurses is complimentary to the maintenance of ethical practices in research. This involves upholding human rights, securing informed consent before acting, maintaining confidentiality and ensuring that I have the necessary knowledge and skills to undertake a task (NMC 2015). As a researcher I have a duty to ensure that my own capabilities match the requirements of the study (UK Research Integrity Office 2009, University of Nottingham 2013). To prepare, I undertook a module in qualitative research methods and attended post-graduate workshops on case study and interview analysis. I participated regularly in supervision and used this forum to learn from the expertise of experienced researchers. Supervision provided an important space to review the quality of the inquiry and enable me to reflect on the research process. The development of my own skills was informed by learning from my previous experiences of undertaking and participating in qualitative research. These experiences were particularly valuable for the development of interview technique and data analysis. Building a detailed, current knowledge of case study methods and the area under study is an important aspect of ethical research (Yin 2014). Whilst developing the thesis I have strived to meet this aim. Through engaging in these processes I endeavoured to ensure that I was skilled to undertake a piece of research that was safe and of good quality.

#### *Avoiding Harm to Participants*

Researchers must ensure that individuals' are fully informed about the research and able to make a choice about whether to take part. The process of providing accurate and clear information began with approaching areas to gain access to the case study settings. Once permission to undertake the study had been granted by the Ethics Committee and relevant NHS research office, I wrote to the team

leader in each study setting with information regarding the study outlining expectations of participants and ethical permissions. This was supplemented with a phone call to ensure the receipt of information and which provided the opportunity to discuss further queries. All contact with potential study settings made clear that taking part in the case study is voluntary and that the additional informed consent of each participant would be sought prior to involvement in data collection. I was invited to attend team meetings in both study settings by the managers to discuss the nature of the study. During these meetings I was able to answer queries from potential participants. No objections to the study were raised by members present at the team meetings. Team leaders discussed permission for the study with their teams following this meeting. A follow up email conversation with the managers confirmed they agreed for the study to be based within their teams. The team leader of the assertive outreach identified the study as a useful opportunity to inform the teams' reflections relating to recovery and risk.

#### *Recruitment and Consent for Data Collection*

Boundaries were applied to the initial identification of people likely to be present during observations as those mental health workers who were expected to participate in decisions and was informed by discussions with the teams when negotiating access to the settings. In the acute ward this was mainly mental health nurses, healthcare assistants and doctors. Within the assertive outreach team this was care co-ordinators, team managers and doctors. To ensure team members were able to provide informed consent for observations of discussions to take place, the team leader forwarded a letter from the researcher to all potential participants at their organisational address to inform them of the study. Participant information sheets relating to observations were attached to the letter (see appendix II). In accordance with good ethical practice, team members were offered a verbal explanation of the information sheet and the opportunity to ask further questions at the start of the shift on the days the observations



took place. During these discussions I emphasised that participation in the study was voluntary and they could withdraw at any time. Participants were then asked whether they consented for the researcher to observe their discussions. Consent was given verbally in accordance with ethical permissions granted for the study. For the observations of meetings to take place, consent had to be given by all attendees at meetings (such as handover) in order for me to attend. Participants were informed that if a particularly sensitive matter was being discussed that they did not want the researcher to be present for, they could ask me to leave for that aspect. This did not occur and all staff involved gave their consent for me to undertake observations.

Managing consent for data collection using observations is recognised as complex (Mulhall 2003, Moore and Savage 2002). Responding to these complexities involves researchers addressing ethical dilemmas as they arise within the field (Mulhall 2003). As a registered nurse, my own response to these dilemmas is also guided by my professional code (NMC 2015). Within the assertive outreach community setting all team discussions took place at the base and therefore the presence of individuals in these discussions from outside the team was minimal. On one occasion a clinical psychologist attended to facilitate a multi-disciplinary discussion, they were provided with verbal information, offered an information sheet and gave verbal consent for me to attend the meeting.

However, on a busy acute ward people who were not directly part of the case study appeared and left the study setting during the observations. This included on call clinical leads, approved mental health practitioners and service users. When professionals attended the ward and appeared in the research field, I explained my role, details of the study and asked them whether they consented to my presence in the meeting or observing their discussions. They were offered an information sheet at this point, though not everyone took one. All shifts observed included a bank healthcare assistant who had not received a letter from the team leader. Invitation letter and

information sheets were provided to her on the first shift. The same process was followed for service users on the wards that were within the communal areas which formed part of the field of observation. The majority of observations took place in the ward office and meeting rooms, though some time was spent in a 'gathering place' for service users and staff in the ward (see data collection section for more detail). I provided verbal explanations of the study to service users, invited queries as well as offering an information sheet. The service users gave verbal agreement to my presence observing the discussions. I maintained an awareness of any verbal or non-verbal cues that may have indicated that consent had been withdrawn. Excluded from these scenarios was anyone unable to demonstrate capacity to give informed consent (informed by demonstration of understanding of study requirements and what was involved). All of the service users observed during interactions with staff had been on the ward for a minimum of 2 days and some had been there weeks or months. None of the service users present were judged as being unable to demonstrate capacity to give informed consent. Spending time can be an important way to maximise opportunities for information sharing and monitoring on-going consent in acute care, helping to ensure as a setting it isn't excluded from research (Roach, Duxbury, Wright et al 2009). I introduced myself and explained my role at the start of the shift (and on meeting people for the first time). Observations occurred during the whole shift of up to 8 hours, providing opportunity to revisit consent which was followed up when the same service users were on the ward during the next observations. There appeared a genuine interest in the study, service users in the setting and professionals coming to the ward would often offer an opinion in relation to the research focus.

The team leader forwarded a letter from the researcher to all team members at their organisational address inviting them to take part in interviews. A participant information sheet was enclosed (Appendix III). The letter included a reply slip with a section declaring whether

they were interested in taking part in an interview. Participants signified an interest by returning the reply slip to me via post or contacting me at my organisational email address. I did not meet with any participants for a minimum of one week after receiving their reply to allow them to fully consider the information and avoid any pressure to participate. When meeting with the team members individually, they were asked whether they had any questions regarding the study and were invited to sign a consent form if they agreed to participate (see appendix IV). One copy was retained by the researcher and the other was kept by the participant.

All information provided to participants made clear that participation in the research was voluntary and that they had the right to withdraw at any time without adverse consequences. No participant withdrew their consent during the research.

Team leaders and clinical supervisors within case study settings were aware that the study was taking place and I planned to encourage participants to access their managers and supervision if needed. Contact details of further sources of support such as counselling services were included on information sheets alongside the details of my PhD supervisors. These steps were taken with the intention of minimising the potential costs to participants of taking part in the research. During the data collection phase the need didn't arise to suggest to participants to follow up on sources of support; however, these contacts were available to them if they identified this outside of the interview scenario.

#### *Data Management*

In accordance with national and local guidelines, steps were taken during the research to ensure the careful storage of research data (University of Nottingham 2013). This included mechanisms to maintain participants' anonymity.

Field notes gathered during the observation were made using abbreviations and therefore no identifiable characteristics relating to

participants were included in raw data. Notes were stored in a locked filing cabinet in my organisational location. This thesis contains direct quotations from participants and subsequent publications may also contain direct quotes. This is valued within qualitative research as a means to enhance credibility through ensuring the participants' perspective is central and that the interpretations of the researcher are fully supported by the data (Mays and Pope 2000). All characteristics which identify participants have been removed from quotes. Participants were allocated a code during data collection and have subsequently been given a pseudonym during analysis, which only the researcher has access to in order to ensure the anonymity of participants in the presentation of data.

Interviews were recorded on a digital recorder if consent was provided by participants and digital recordings were transferred onto the researcher's University network password protected files. These were transcribed for the purposes of data analysis, characteristics identifying participants have been removed during transcription. When the PhD is complete, the research data will be archived in accordance with university policy (University of Nottingham 2013) for a period of 7 years. Digital recordings of interviews are considered to be source documents and will be transferred onto audio-CD for archive. Participants were asked for permission to record interviews, when permission was not given (one participant in the study) I recorded interview data through note taking during the interview. These notes have been stored in a locked filing cabinet and will be archived along with all the other research data.

### *Research Write Up*

Research that is conducted ethically incorporates the creation of rigorous records. This includes disseminating the research findings and, taking account of the need to protect participants' anonymity (University of Nottingham 2013). Within the thesis and any subsequent publications the case study settings have been given pseudonyms. Characteristics within data that may identify the

organisation where the study took place were removed. Similarly anything that may identify participants in quotes has been removed which would be maintained should the work go on to be published.

Good ethical practices in interpreting data and developing a study report are closely linked to enhancing quality and rigour in qualitative research. The next chapter examines how the study attempts to maintain these standards and is evidence of further steps taken to enhance ethical processes in the development of the thesis.

#### 3.1.6.1 Ethical Moments in the Research

With the focus on subjective experiences, often of marginalised groups qualitative research has the potential to raise many ethical issues for the researcher that can be impossible to anticipate at the point of planning the study. During my own study, there have been a number of these tensions. Guilleviun and Gilliam (2004) describe such instances as ethically important moments, where researchers may be faced with difficult questions, unanticipated events, alongside emotive issues and have to consider how best to respond. This section explores an example of such a moment, examining how I managed the situation to consider a broader interpretation of ethics than that covered by ethical governance of research alone.

#### *Dual roles*

As noted, I made efforts in choosing the case study settings to avoid any practice areas I was currently or had previously been involved with. Despite this, on the second day that observations took place within the in-patient setting, one of the service users who was on the ward was a person I used to be the care co-ordinator for. Since working with her she had moved to a different location. Masie (name has been changed to maintain confidentiality) feared that she was being targeted and that her life was in danger. This made it hard for her to trust people. When we met as I was introducing myself to service users and explaining the study, she told me she felt she couldn't talk to anyone on the ward because she thought they may be

dangerous. Later that day she approached me to ask if she could talk to me as she had done in the past because she was frightened and wasn't sure who she could trust. Guillevis and Gilliam (2004) use the language of ethical moments as opposed to dilemmas as they highlight that the course of action can be quite apparent, yet there is still potential for different outcomes. The response to Masie was clear in that I wouldn't be able to provide what she asked me to, though I was unsure at the time if I should report this to the ward staff. I did encourage her to approach one of the team members on the shift to share her fears. Leaving someone in a state of distress was difficult for me and compromised the principles that I adhered to as a nurse and still do as a tutor. Morse (2007) recognises that therapeutic and research goals can conflict. Researchers can become a source of support for participants in the clinical setting when there is a close presence (as is the case with observations). However, she suggests this invalidates the researchers' data since they are closely involved and alter the situation for the participants, consequently it should be clearly accounted for within the research report (Morse 2007). Whilst Masie was present within the research setting, no field notes were taken relating to her and no discussions linked to decisions of her care were observed. Nevertheless, this interaction provides an example of the challenges of being a nurse collecting data within a healthcare setting. The boundaries of these two roles are not easily drawn.

### **3.1.7 Summary**

This discussion has provided an overview of the design, planning and ethical approaches underpinning the research study. In the following chapter data collection and analysis will be considered.

## **3.2 Chapter 7: Data Collection Process**

The study collected data using observations followed by semi-structured interviews in both study settings.

### **3.2.1 Observations**

The tensions examined in this thesis are situated in the context of decision making. Observations provided the opportunity to consider decisions within the practice setting as they were taking place, enabling me to focus on interactions between participants within this process. Observations can provide insight into participants' actions, helping to uncover perspectives which may be unseen within the individual narratives of interviews (Mulhall 2003, Morse 2007). Collecting data through what is seen and heard in the case study setting provides the opportunity to explore the context of action, considering how participants interact with their environment (Angrosino and Rosenberg 2011, Bloomer, Cross, O'Conner, Endacott and Moss 2012). This reflects the emphasis within case study research on understanding context. These factors informed the choice of observations as a data collection method for this study.

Direct observation involves a researcher describing and interpreting the actions of people within their natural setting, through a process of recording what has been viewed (Robson 2002). Traditionally distinctions are made in the type of observation, governed by the level of researcher participation; though increasingly the utility of such distinct typologies has been questioned (Mulhall 2003). However, undertaking observations, like interviews, involved a process of selection of the approach used to gather this data which was shaped by my experiences and engagement with the literature on this topic. This emphasises data collection through observations as a process of co-construction. Notably though, it was undertaking the observations that led to me questioning some of the assumptions I had made about

how tensions may be present within the study settings. The observations focussed on mental health professionals involved with decision making. They were informed by Robson's (2002) explanation of unobtrusive observations in which the researcher does not seek to take part in the activities of those observed and is able to adopt an unstructured approach.

Observations were conducted prior to the interviews. This method of collecting data can be exploratory and alter as familiarity is gained with the case study, in response to the emerging data (Mulhall 2003). Observations can also inform further questions and topics to explore (Angrosino 2007). The early phase of data collection initially intended to explore the nature of tensions within decision making. Observing activities within the practice settings enabled me to consider how and when these may be present. An opportunity to clarify these interpretations, potentially examining these in more depth through then undertaking interviews, was provided by conducting observations first. The interview schedule was not altered following observations (in line with ethical requirements). However, in interviews participants spoke about some events that I had observed. This enabled me to make connections, relate narrations to context and gain a more holistic perspective.

#### 3.2.1.1 Focus of Observations

I had purposely selected the actions and behaviours of mental health professionals involved in decision-making to observe and this highlights that although the observations were unstructured, I had made a decision about what was to be the focus. Dialogues, customs, habits and social hierarchies are important components of what makes up observations (Denzin 1989). However, adopting an unstructured approach enabled me to remain flexible to altering what was observed when data collection had started, once I had gained familiarity with the context (Mulhall 2003). It is also useful when less is known about the area of the research (Casey 2006), which has already been



highlighted as relevant for this study. Focusing on situations in which decisions may be made enabled me to consider these issues in relation to the research question. This further emphasises the influence of my own pre-conceptions as I had selected the processes to observe based on my own clinical experience and my engagement with the theoretical context.

I undertook observations of full working days within each case study setting. Temporal factors can be central components to consider within observations (Tjora 2006). I observed two late and one early shifts on the acute ward, each was 8 hours. Within the community setting, the team was divided into two sub teams. I observed two mid shifts of 8 hours each in the two sub-teams and an afternoon MDT meeting that I wasn't able to capture on these shifts. The observations were scattered across different days of the week and spanned a period of a month in each area. Spreading out the observations aimed to maximise the potential breadth of activities, interactions and routines observed. It provided the opportunity to gain insight into changes in the context of the settings; for example, periods when the ward was full or had empty beds. Whilst observing a whole shift at a time aimed to facilitate the observation of how practitioners dealt with tensions and made decisions in the moment, as well as explore responses to unfolding events. This recognises the potentially unpredictable nature of mental health care. A total of 58 hours of observations were undertaken for the study.

Mirroring the working hours of the health professionals ensured that I was able to attend a number of decision making forums in the one observation period, such as handover. My attendance from the start of the shift was intended to increase the likelihood my presence would be experienced as unobtrusive. Consequently, to undertake the observations I situated myself within the location where interactions between staff and, on the ward between staff and service users took place. For the assertive outreach team, this predominately involved the team office, though included a meeting room. For the in-patient

settings this predominately involved the ward office but also a communal area, meeting rooms and interactions on the ward. This reflects Polit, Beck and Hungler's (2001) definition of multiple positioning in which the researcher does not remain fixed to a specific person or location during observation.

#### 3.2.1.2 Records

Detailed field notes were kept during observations. These were recorded whilst observing events and interactions in the case study setting and/or immediately at the end of the shift. The records made included information on environmental features, such as the layout of the settings, and contextual details including the number of service users that the areas supported. Most information within the notes related to detail of interactions between participants and outcomes of decisions where discussion had been observed. Describing events, experiences, organisational characteristics, interactions and the interpretations of the researcher have been described as important elements of field notes in observational research (Robson 2002, Mulhall 2003, Tjora 2006).

A research diary was maintained throughout the research. During the observations this was used to record initial thoughts and assumptions' regarding patterns, dominant issues and links in relation to what was observed, alongside reflecting on my own responses and actions. The journal was therefore able to contribute to a trail of my decision making and thought processes during the research. This was directly seen in the decision to adopt a single phase study following some of these reflections on observations. Explicitly recognising these interpretations in the journal contributes to a reflective record of the influence of my own position on the process of collecting and interpreting data (Mulhall 2003).

### 3.2.1.3 Observer's Role

Researchers can adopt a number of different roles informing their approach to observation (Angrosino 2007). During unstructured observations it is recognised that the researcher is likely to move between such roles (Mulhall 2003). The culture which I share with participants, to a certain extent, pre-defines part of the role that I adopt within observation. A prior understanding of practicing within statutory mental health services and previous employment within the organisation where the study is located suggests a level of participation within the setting which may have enabled me to build a rapport with participants and develop an initial understanding of the context. This reflects an insider view.

An 'insider's' position in observation is perceived as advantageous in part because it provides motivation to research (Labaree 2002). My own experience as a nurse working with people with serious mental health problems has been highlighted as a key inspiration for this study. Sharing common experiences with participants' favours insider perspectives and can help build relationships (Labaree 2002). This may have inadvertently enabled me to gain access to the settings and obtain consent from the participants to be observed. Whilst this was not explicitly discussed with practitioners, there may have been a greater sense of trust and safety created by the knowledge that I was a nurse too. May (2011) argues that interpretations will have enhanced accuracy the more the researcher knows and understands the language used in the study setting. My previous experience as a mental health nurse provides me with insight into jargon, customs and processes used within the case study settings. This may have informed the manner in which I made sense of actions occurring during the observations; in addition to enabling me to be 'accepted' by the teams that I was studying. This intimacy, according to May (2011), enables a researcher to get beyond initial public 'performances' that participants may present for social desirability. This can contribute to a deeper level of understanding than if insight into this language and

culture is lacking (Labaree 2002). Acceptance of me as an insider in the study may be evidenced by examples of when participants checked whether their recollection of events was accurate or asked for my views on changes within the NHS during the observations.

Describing myself as an insider in this manner, may however, be problematic. Being viewed as an insider is clearly contextual. Nurses were the largest group of practitioners to be observed (and interviewed), yet they represented only some of those present in the case study settings. I didn't necessarily share the cultural world of social workers, doctors, health care assistants and service users. Sharing some aspects of identity does not preclude the need to build trust to facilitate relationships that enable the interpretation of meanings (Labaree 2002). This is reflected in the thought given to how I presented myself during the shifts, including for example making tea as a strategy to promote my acceptance. The disadvantage of this shared culture is also the difficulty in separating yourself enough from the context to interpret new information (Bonner and Tolhurst 2002).

The study took place in two practice areas I have never worked in as a qualified professional. My presence in the settings as a researcher took place a number of years after leaving the organisation. Nurse education has been criticised for its distance from the practice setting (Kellehear 2014). My current role may therefore facilitate the role of 'outsider'. However, this position can also provide advantages for the research. Some degree of 'outsider' separation facilitates sensitivity to actions and routines that may be relevant to the research and difficult to identify as an insider (Bonner and Tolhurst 2002). Fresh perspectives that might otherwise be hidden by my emersion in a context may be seen. Adopting such a dual position meant that in reality I moved between the insider and outsider view, depending on the nature of the observation, the participants and my own reflexivity. At times I was included within 'banter' in the settings, highlighting the intimacy associated with an insider position. At other times I

reflected on struggles to make sense of actions, for example the response of qualified nurses within ward round and such reflections identified me as an outsider.

This dual identity highlights the insider-outsider role is fluid rather than dichotomous (Labarre 2002). It is suggested that this dual role enables the researcher to gain most insight (Bonner and Tolhurst 2002).

### **3.2.2 Interviews**

Interviews were used within this research study to gather data. Interviews are one of the primary methods of data collection within qualitative research, aiming to gain an insight into the meaning that participants give to an aspect of the social world (Hewitt 2007). Interviews are undertaken when the researcher seeks to learn about what another person communicates about their experience. One to one interviews, therefore, provide the opportunity for practitioners and I to enter into dialogue to examine the meaning of tensions related to duality within professionals' practice. The literature review presented an interpretation of tensions present within the context of mental health practice. This represents the presuppositions of the researcher, informed by relevant published work. Interviews with mental health professionals aim to examine their own interpretations of this phenomenon and whether they perceived it had meaning within their own context. Narration presents a holistic perspective on this experience, encompassing thoughts, emotions and discussion of behaviours (Nunkoosing 2005).

The literature review highlighted that limited empirical research has been conducted examining professionals' perspectives on the potential tensions of delivering care and enacting control in mental health practice. Due to their capacity for detailed exploration, interviews have been identified as useful when little is known about the topic (Tod 2010). This provides a further rationale for interviews being used to collect data in this study. Interviews provide a flexible

tool to explore the research phenomenon in-depth and were for these reasons adopted in this study (Robson 2002).

Within an interpretivist paradigm, understanding is created through the process of dialogue between researcher and participant within interviews (Binding and Tapp 2008). The researcher is a central tool of data collection; the interaction of their beliefs and experiences is an important feature of the research process. This inquiry examines a phenomenon that is difficult to define. I used semi-structured interviews to gather data in both case studies having identified that there was a need to provide some focus within the interviews to promote discussion relevant to the topic. Semi-structured interviews involve pre-planned questions that are asked to all participants. The order and wording of these is flexible (Robson 2002). This enables the researcher to control the focus of the interview, yet adapt to participants' individual perspectives and agendas (Tod 2010). The boundaries and existence of tensions are unclear; therefore, for the research focus to become tangible there was a need to locate this in relation to an area of mental health practice. Semi-structured interviews were employed to structure discussions around decision making, where it was perceived that tensions are most likely to be present.

The interview schedule was informed by the literature review and subsequent discussion with supervisors, which contributed to the focus on decision making (see Appendix IV). The questions were asked to all interview participants with alterations to the order depending on topics arising from discussion. Different prompts and additional questions were used for each participant, reflecting the issues they discussed. Open questions were employed in the interviews to encourage detailed responses, whilst closed questions were used as prompts to clarify points and check my interpretations during the discussion.

I had met the majority of participants prior to the interviews taking place due to the period of observation; this facilitated the development of discussion and building of rapport to ensure that participants felt at ease. Good interview technique involves researchers establishing rapport with participants through engaging in 'ordinary conversation' (Fontana and Frey 1994). The interview schedule developed for this study began by posing a general question designed to provide practical information and enable the participants to settle in to the interview situation. Later questions within the interviews focussed more specifically on tensions. My own experience as a mental health nurse clearly influenced the use of communication techniques within the interviews to establish rapport and aid discussion.

Employing these skills involved my attempts to mirror the language used by the participants within the dialogue. Power dynamics are an important issue within research interviews. The way in which questions are constructed can provide participants with the framework within which the phenomenon of the research is to be viewed. Whilst this may have the advantage of gaining focus, it has the potential to narrow answers and lead the participants. My use of participants' own language endeavoured to create space for their meanings alongside avoiding my own pre-suppositions dominating the interview. The interview questions therefore avoided any reference to control, care, risk or recovery to recognise that tensions may be constructed differently by participants or be influenced by different factors. However, my pre-suppositions may have been revealed in the follow-up prompts, for example asking some participants to explain their views on risk in more detail where this was mentioned.

All the participants interviewed were currently working in adult mental health services. Researchers and participants who have similar backgrounds can develop a mutual language that facilitates understanding and sharing (Manderson, Bennett and Andajani-Sutjahjo 2006). Prior to working in an academic setting, I worked as a

nurse within adult mental health services. Interviewer and interviewees, may have therefore, shared a similar professional language that could have aided discussion. However, the specific professional backgrounds did differ from my own in five interviews which may have also impacted on the dynamics within the interview.

#### 3.2.2.1 Recruitment

Thirteen nurses were employed on the acute ward at the time of the study. One of these nurses was on maternity leave; one was on long term sick leave and another on permanent nights. Ten healthcare assistants worked in the ward and four psychiatric consultants who were supported by three specialist registrars providing treatment to service users. All were invited to participate in the study. Seven reply slips were received resulting in six interviews taking place. I contacted the seventh person via email in addition to leaving messages on the ward, but no reply was received. In seeking to strike the balance between encouraging participation and enacting coercion, I interpreted the lack of reply as a withdrawal of her interest in participating in the study.

The assertive outreach team was sub-divided into two sections (specific details are outlined in chapter 8). In Team A there were six community nurses, four community support workers, a social worker and two doctors (one consultant and one specialist registrar). Though between the period when I met with the team to explain the study to negotiate access and initiating data collection the specialist registrar had left the team. One of the community support workers was also on sick leave. In Team B there were seven community nurses, five community support workers and two consultants. Team A and Team B were jointly overseen by two managers, a nurse and a social worker. All were invited to participate in the interviews. Twelve replies were received which resulted in eleven interviews. Three of these were nurses from Team A. From Team B four of the interviewees were nurses, the two consultants and one community



support worker. One team manager also participated in an interview. The reply from the twelfth person resulted in an interview being arranged for which they did not arrive; this occurred twice and the person declined to rearrange.

Given the size of each team there were a high number of people who chose not to participate in interviews. This includes representatives of all professions but is highest amongst unqualified staff. The reasons for non-participation are inevitably unknown. However, it is possible that they may have been influenced by the demands of a busy healthcare environment. The interviews took place after the observations in which, due to the nature of decision-making, I had spent more time around qualified members of staff and particularly nurses. This rapport may have impacted on the nurses' willingness to be involved. In Peel, Parry, Douglas and Lawton's (2006) study, interviewees identified their participation in interviews was influenced by altruism and the opportunity to offload. Given the emphasis on evidence based healthcare, which may be more familiar to qualified members of staff, it is perhaps more likely that the interviews would have been perceived as an opportunity to contribute to the development of evidence and therefore as helpful.

#### 3.2.2.2 Location

All interviews were conducted within the case study settings to minimise the costs to participants of taking part. Interview rooms within the ward and community setting were used to create privacy and minimise the chance of interruptions. The location of interviews can influence the way participants and researchers locate social characteristics, potentially shaping the interview dialogue itself (Hyden 1997). Situating the interviews within the case study setting aimed to enable participants to feel at ease, recognising Manderson et al's (2006) claim that conducting interviews in the researchers' environment favours the researcher. Instead, I was within the participants' settings. Interviews were conducted during the working

hours of participants' and efforts were made to arrange these at a time when participants' work demands may be less, for example on a night shift when the ward was quieter.

#### 3.2.2.3 Interpersonal Dynamics

I planned, designed, and conducted the research. This positions me in an authoritative role within data collection as the agenda of the research is one that I have set (Karnieli-Miller, Strier, Pessach 2009). Yet as the epistemological background established, the research has an emancipatory interest to be meaningful to mental health practice. Creating an informal, caring atmosphere within the interview that enabled interviewees to share their story was important to work towards this emancipatory interest and facilitate the demonstration of acceptance of the validity claims of the participants (Habermas 1987). I aimed to achieve this through engaging in informal conversation when meeting participants, clarifying understanding of the study and responding to topics they raised within discussion.

The epistemological background considered the shared context that I have with some of the participants in the study. This background, alongside other social characteristics of both the participants' and I will have influenced dialogue and therefore the co-construction of meanings within the interview situation. Being a mental health nurse gives me a shared context with the majority of participants I interviewed. This insider role may have facilitated the development of understanding through shared language and experiences; creating a more reciprocal power relationship. My distance from the clinical setting may have, however, contributed to fluidity in this insider role dependent on the nature of discussion.

Such power relationships between the other participants and I may be influenced by differences in professional status and hierarchy. This was perhaps notable in that the only participant who did not give permission for the interview to be recorded was a community support worker. This may be reflective of an initial lack of trust of the

researcher or an aim to maintain power through minimising the possibility of narratives being misrepresented.

Within an exploration of relationships within the interviews, it is important to recognise that participants are not passive and do exercise their own agency (Corbin and Morse 2003, Nunkoosing 2005). This includes their decisions regarding what and how they share their experiences. The level of responsiveness to interviewers' questions may be a way of interviewees establishing power including by providing socially desirable answers (Karnieli-Miller et al 2009). I had expected that participants' discussion of the strategies they undertook to support service users involvement in recovery orientated decision making would dominate the interviews. The emphasis within both local and national policy on recovery would suggest this could be the 'desirable' answer. I reflected that participants' expression of such answers may be confounded by my identity as a lecturer, in which they may anticipate I would be searching for 'correct' information. However, this was evidently not the case when undertaking the interviews as recovery perspectives had minimal presence. This suggests that the participants did not necessarily provide the socially desirable answers and may therefore reflect a more reciprocal relationship.

It may also be influenced by how I presented myself within the research situation. My research journal relating to the first meetings on the ward notes that I am not quite sure how to introduce myself and which role should come first (nurse, researcher, teacher). It reflects on whether this is likely to have an impact on how I am perceived by the team and which of these identities is most likely to facilitate trust. Such reflections highlight the participants' potential influence on researcher's identity (Mulhall 2003).

The frequency with which interviews are used in research has been criticised for contributing to a lack of critical examination of the interview as an inter-personal process (Hewitt 2007). This

compromises the recognition of the co-construction of knowledge, through the process of dialogue between participant and researcher within the interpretive paradigm. It has been argued that the interview is itself a process of social construction and may therefore be limited in its contribution to developing understanding of the external context (May 2011). Addressing these criticisms involves honesty and transparency regarding the influence of the researcher on the process. This section has considered the impact that my own experiences, skills and perceptions may have had on the interview situation. This transparency should be embedded throughout the research process. It also involves, drawing out and debating contradictions, not just commonalities in the data created from interviews (Fontana and Fey 1994).

Examining the context that participants discuss within interviews is an essential way to develop a deeper understanding outside the dialogue itself (May 2011) and can aid in addressing some of the criticisms of interviews. Observation provides an important tool to achieve this.

### **3.2.3 Concluding Data Collection**

I interviewed all participants who declared an interest in participating and agreed to an interview in both settings. The number of hours undertaken for observations was planned to include a broad range of relevant forums such as MDT meetings, though the number of days was not decided until data collection was underway (and was conducted in line with ethical permissions granted for the study). However, it can be a delicate balance between too much and not enough data to enable thorough analysis and the development of theoretical insights (Yin 2013). Theoretical saturation is reached when a researcher is unable to extend their learning as a matter has already been seen consistently, which informs the choice of when to stop adding new cases or data (Eisenhardt 2002). I ceased observations when I judged that there was frequent repetition of the

matters being observed and I was not offering any new insights in my accompanying reflections. Theoretical saturation is defined by the careful and systematic collection, analysis and reanalysis of data which is immersed in the research process itself (Tuckett 2005, Bowen 2008). As a result, the decision to cease data collection was not fully reached until the analysis of data and comparison with the literature was undertaken and theoretical propositions had been tested.

### **3.2.4 Data Analysis**

The interpretation process within case study research is continual. The flexibility enables researchers to explore patterns within the data, amending design and data collection processes in response (May 2011). This highlights that data analysis is not confined to distinct stages initiated when data collection is complete. Discussions so far within this chapter have highlighted how my reflections upon the data have informed methodological choices, alongside how interpretations of my own meanings and experiences have influenced the research process as it progressed. Yet in order to achieve depth of understanding and develop explanations, specific systematic analysis of data was undertaken to search for similarities, differences and patterns within and across each case. This section provides an account of the inductive analytic approach adopted highlighting how this is connected to an ongoing process of interpretation.

#### **3.2.4.1 Preparing for Data Analysis**

I transcribed each interview verbatim. During transcription long pauses and non-lexicals were included as it was identified this could be relevant to the meaning participants communicated; for example, highlighting emphasis within a sentence. Such decisions relating to how to display the conversation within transcribed accounts represent part of the interpretative process and the role of the researcher in co-constructing meanings. Riesmann (2002) emphasises this in the claim that there is no single true way to symbolise spoken language in

the written word so interpretations take place as this process is attempted. However, the inclusion of participants' statements of expressions such as 'um' 'er' aimed to capture as much detail as possible in the transfer of the interviews onto written transcribed documents which were used as part of data analysis. This informed my decision to transcribe the interviews myself, which also enabled me to become very familiar with the data arising from the interviews and aided me to maintain this familiarity over a period of time as a part time researcher.

Field notes from observations were typed up to ensure legibility and provide ease of management of the data. Efforts were made when typing up the notes to ensure that these were a direct copy of information recorded in the field. Such a process enabled me to be as acquainted with this data source as the transcripts from the interviews. However, the original notes have been used as a reference source throughout interpretations where clarification may be beneficial or to check readings of specific elements of text.

These transcribed, anonymised documents were stored in the computerised data analysis software programme Nvivo. Programmes such as Nvivo can offer an efficient way to organise, store and manage research data (Bringer, Johnston and Brackenridge 2004). Nvivo has been designed to assist researchers to build rich interpretations, yet there are concerns that the use of such software can lead to rigidity within analysis, limiting the scope of interpretations (Bringer, et al 2004). Within this study Nvivo was predominately used for the storage of data, recording of patterns and organisation of data categories once identified. It was also used to assist the identification of relevant quotes when presenting data analysis. Searching for patterns, links and differences within the data was conducted by hand. This was informed by my previous experiences of analysing qualitative data, in which I have found the visual and spatial arrangements afforded by the use of Post-its, coloured pens and paper helpful to aid my thinking. I had not used

Nvivo prior to this study which may have influenced my capacity to fully employ all the functions in the package to aid the analysis in this way.

#### 3.2.4.2 Analysis

The process of data analysis in case study research has been criticised for only receiving cursory attention within the literature (Tellis 1997, Yin 2014). However, there is some commonality in the approaches advocated by the key proponents of case study methodology regarding the presentation and comparison of interpretations of case study data (Eisenhardt 2002, Stake 2006, Yin 2014).

The execution of my own analytical strategy had to be grounded in the purpose of the research alongside the type of case study adopted (multiple instrumental case study). Within this research developing an understanding of mental health professionals' experiences of potential tensions related to delivering care and enacting control is an important focus of the study. Such an emphasis centres on describing the particular within each case to aid the development of understanding (Stake 2000). However, the study also aims to inform mental health practice. This highlights that in working with the data I am seeking to go beyond describing what appears to be happening to attempt to consider explanations. Consequently, the strategy for analysing data within this study was influenced by the processes advised for building theory in case study outlined by Eisenhardt (2002) and explanation outlined by Yin (2014). These also share some similarities with Stake's (2006) application of assertions in multiple case study research analysis.

This study includes two case study settings and two methods of data collection in each setting. Analysis of data therefore needed to be systematic to ensure that differences and similarities between the cases were fully explored, using the design to effectively triangulate the findings. This phase of analysis was initiated by examining the data in each case individually. Within-case analysis started by

focusing on the in-patient ward as this had been the first site of data collection. Dividing the data by method of data collection is recommended by Eisenhardt (2002) as a practical strategy for organising data analysis, as well as maximising the insights gained by using multiple methods.

I began by reading and re-reading the observation notes from the in-patient setting. During this process I kept a log, noting my initial impressions including for example, issues that were mentioned frequently and my perceptions of their potential meaning. This log aimed to enable me to record possible insights to follow up on during later stages of data analysis. However, one of its primary functions at this point was to note my early assumptions regarding the data enabling these to be challenged and tested as the analysis progressed. Thorne et al (2004) emphasise the potential for less experienced researchers to struggle to move beyond the inferences that they had at the start of the study and be heavily influenced by a desire to make the data fit. Consciously aware of such issues in light of the context for the research (a PhD thesis), I perceived the log as an important tool to enable me to be open about these assumptions and therefore aim to critically examine the impact of them on the study findings.

Recording such notes can also assist with conceptualising data and as Yin (2014) recognises is frequently used in analytical approaches aimed at building theory. This was built upon in my second reading of the observation notes where I began to record keywords. These keywords were identified as frequently occurring topics, concepts that were recorded or mentioned that related directly to the research question and the theoretical framework for this question. On a third reading of the data these keywords were recorded onto Post-its with a brief summary of the issue identified in the text included under the keyword. These Post-its were grouped where connections between keywords were evident. A summary of these key words was recorded within my analysis narrative log alongside reflections on my interpretations of what these could mean.



I repeated this phase using the transcripts gained from the interviews in the acute ward. Given the quantity and depth of data arising from the interviews, this process extended the keywords captured, although commonalities existed between the two, perhaps influenced by the use of quite broad keywords such as 'structure of decision making'. Notes were made within the written log regarding notable differences between participants' perceptions on these topics. The brief description I captured under each keyword category also provided a record of this. Constant comparison between the particular within case study data, the case itself and the context are important aspects of analysis (Stake 2006). At this point, concerned about context being lost by the use of keywords, I returned to the transcripts and observation records to produce written summaries of the observation days in the acute ward and each interview, drawing out in each interview and set of observations repeated themes of discussion and issues that were shared, related to the research question. This helped to situate such topics in relation to both the ward and the person's context. It also formed a checking process for the keywords.

The analytical strategy so far enabled me to see some commonly occurring concepts and events in the data, to provide some insights into one of the cases. Having reviewed the interview and observation data separately and cross matched the keywords; I progressed to undertaking this process for the assertive outreach team. Rather than conducting cross-case comparison with a deeper interpretation of the data, comparing across the cases at this point provided a mechanism to test out the relevance of the keywords to the research question. Eisenhardt (2002) acknowledges that moving between within and cross-case comparison provides a more diverse and robust way to manage the data, guarding against what she identifies as human tendencies to jump to definitive conclusions without adequate evidence. I repeated the phases outlined for the observation data and interview transcripts collected in the assertive outreach service. As previously highlighted, the team was defined as one case but there

were divisions in terms of how the team operated. Reviewing of the data was undertaken for Team A first, followed by Team B, providing another opportunity for checking and triangulation. This process led to examples of some differences between the acute ward and the assertive outreach team being noted, for example relationships with service users appeared as a keyword more often in assertive outreach. These were highlighted to be revisited following further analysis to examine how consistent these differences were. Whilst some differences in the details related to each keyword had been identified between participants and case study, this initial review of the data in both settings gave rise to shared key words from observation and interview data across both settings. During this time I maintained the analysis narrative log and noted further assumptions that I identified during this review of the data in the assertive outreach team.

These keywords were reviewed and where necessary collapsed if related concepts were identified to form a coding framework for the data (see chapter 8 for themes). Transcripts from interviews and observation data were coded according to this framework. Extracts from the data were highlighted according to which code they reflected; some extracts appeared in more than one code. Nvivo allows the capturing of comments, patterns, connections and reflections within the programme (Richards 1999) and was used to code and record the categorisation of data. This facilitated the inclusion of extracts in more than one category. The research question focuses on tensions associated with delivering care and enacting control and participants were asked in interviews to provide examples of dilemmas. Consequently, vignettes outlining specific dilemmas either described by interviewees or noted during observations were also captured in a separate category to enable me to review these examples in depth. Coding resulted in the combination of both interview and observation data into each category, though all data extracts highlighted the source of the data. Categorisation was undertaken systematically on a case by case basis. Data from both

case study settings was eventually recorded under one category, extracts were grouped together according to whether they were from the in-patient or assertive outreach setting to facilitate a comparison between case studies. This process culminated in the presentation of themes. Theme categories were broad, which enabled the capturing of different positions on the same concept. It also facilitated the majority of data from both interviews and observations to be included within coding. The analysis log was updated with any new patterns or assumptions that I noted during this further interaction with the data.

The generation of themes outlined helped to structure and manage the data, whilst retaining some of the descriptive detail so important to richness within case study (Stake 2000). It also provided me with the opportunity to consider patterns within categories and compare how themes behave in the different case studies. Throughout this process, my own knowledge of the literature in the topic area and influence in defining the research questions is likely to have had an impact on the identification of keywords. A number of strategies were used to enhance the credibility of this process in light of the influence of my own experiences. This included reviewing the transcripts a number of times to re-check the keywords, development of broad categories to avoid the exclusion of data that doesn't 'fit' a narrow coding framework, use of Nvivo search functions in addition to reading to ensure all relevant data extracts were incorporated in themes.

The analytic strategy undertaken at this point had the advantage of providing descriptive detail. However, it presented limited depth of interpretation or insight into the connections between concepts and their relational influence. Through an examination and testing out of these patterns in the data, explanations can be built (Yin 2014, Eisenhardt 2002). Central to this process is the identification of propositions, which may be theoretical insights or initial statements of explanation related to the data (Yin 2014). I revisited the assumptions and reflections captured as part of the analysis narrative

log that I had maintained whilst developing themes. At the end of reviewing all the data in a case study, within the log I had summarised in bullet points a series of statements relating to what I interpreted was happening within the data and how these patterns potentially related to each other.

Reviewing these statements, initially I was shocked by what they suggested in terms of the distancing between service users and staff, reflecting a lack of focus on recovery. This evoked feelings at times of disappointment in my profession. Such recognition made progressing analysis difficult at this stage as I struggled to be critical by looking further into these explanations. I was aware of the pressures on healthcare teams and I felt disloyal by having the luxury of considering these interactions at a distance from the experience of delivering mental health services. I addressed these concerns through discussion in supervision and pushing myself into an outsider position during such a key stage in the analysis. This involved focusing on my responsibilities as a researcher and not necessarily as a nurse, recognising that being critical did not exclude research from having an impact on nursing practice. This experience was perhaps complicated by further recognition that these insights potentially represent a departure from my own assumptions regarding the expression of tensions, including the influence of recovery and autonomy.

After reviewing the statements in my analysis log (outlined in the findings section), I adopted these as emerging explanatory propositions. This involved mapping how these propositions across both case study settings may be related to each other. A sample of data from each study setting was initially used to compare with the proposition, to provide an indication whether there were grounds for more detailed comparison or as to whether there was no further evidence to support the proposition. Propositions were then represented diagrammatically to hypothesise how these may influence one another. Using the initial version of this map, I compared each

section, representing an explanatory proposition with all the data in both case studies. Where the propositions were confirmed, variations in the expression of the proposition were noted, to develop further clarity in how it may be interpreted. This is recognised by Eisenhardt (2002) as an important method of shaping propositions and developing validity in the proposed meanings. Comparing these with all the data enabled me to discover evidence within the case study to support (or reject) the proposition, as well as compare strength of explanation within and across cases. All data from the acute ward was examined before moving on to the assertive outreach team. This process highlighted that some propositions appeared consistently, which led to these being revised and the explanatory relationships altered to reflect the significant influences seen in the data.

Reviewing all the data again in relation to the propositions, revealed that there were two interviews in particular that disconfirmed some of the propositions. It was noted that this was particularly significant in itself and consideration was given as to how the relationships between propositions may be expressed differently in order to explain this finding within these interviews. Disconfirming evidence aids the development and extension of the theories proposed (Eisenhardt 2002). The map was re-modelled to reflect these further interpretations, resulting in the development of an explanatory model that outlined how the identified concepts and insights were influenced by one another. All data was revisited again to compare this model to the evidence within the case studies, on a case by case basis. Following this further review of the explanatory model minor amendments were made to reflect this comparison with the evidence in the case studies and clarify the potential relationships in the data. This is the model presented on p.157, figure 4.0. Themes derived from the data can provide the building blocks for the development of theory (Andrade 2009) and actually formed part of the explanatory

framework, although they were integrated in different aspects of the model.

An important part of building explanation involves keeping an open mind and exploring alternative explanations for the patterns arising from the data (Andrade 2009, Yin 2014). Throughout the iterative phases of data analysis I strived to maintain this position through reflexivity, assisted by the continuation of the analysis log. My own experiences will have informed the lens through which I viewed the data and the insights gained, emphasising the data analysis as an individual process built from my own interaction and immersion in the data (Cutcliffe and McKenna 1999). Identifying instances within the data that offer alternative perspectives and disconfirm theoretical propositions is important to demonstrate the authenticity of this process, challenging criticisms of case study that it is biased. Flyvbjerg (2006) suggests such criticisms are commonly challenged by case studies that undermine researchers' preconceived assumptions, as has been my own experience in this research. Extracts from the data and literature which indicate alternative perspectives to those presented in the explanatory model have been highlighted throughout the discussion section of this thesis.

Having reviewed the evidence within the data that supported or challenged the explanatory model, the analysis progressed to undertaking a comparison of the explanations with the wider literature. Initially I sought to review existing theories or literature that linked to the explanations offered in my research. This process provided insight into two key theories: Hilgartner's (1992) 'The Social Construction of Risk Objects' and Nussbaum's (1995) 'Objectification', which have been used to underpin the discussion section of this thesis. These theories aided the development of depth in the explanations offered. Their use to inform the construction of the discussion section, alongside extracts from the data, emphasises the continuous nature of interpretation. Through this write-up further comparison of the data with the explanatory model and existing

theories takes place, inevitably leading to insights being further refined. Eisenhardt (2002) emphasises that it is essential for building theory from case study that this comparison with the literature is broad and encompasses sources that conflict with the explanations offered. This aids the development of quality and trustworthiness of the findings. Comparison with existing literature presented in the discussion also draws out alternative interpretations which are influenced by sources that may contradict the explanatory model proposed from the data in this research. This process has been informed by returning to the theories examined in the literature review to compare their relevance to the explanations offered.

As identified previously it was at this point that the decision not to collect further data was finalised as I judged that theoretical saturation had been reached following comparison of explanations with the data in both case study settings and the wider literature.

### **3.2.5 Quality**

Denzin (2002) proposes a series of questions that may be used as an evaluative framework for examining the quality of the interpretative process (see Fig 3.0). Utilising these questions the following section adopts this framework to examine the rigour of the research and analytical processes.

Figure 3.0 Denzin's (2002) Interpretative Criteria

#### **Interpretative Criteria (Denzin 2002)**

- 1) Do they illuminate the phenomenon as lived experience?
- 2) Are they based on thickly contextualised materials?
- 3) Are they historically and relationally grounded?
- 4) Are they processual and interactional?
- 5) Do they engulf what is known about the phenomenon?
- 6) Do they incorporate prior understandings of the phenomenon?
- 7) Do they cohere and produce understanding?
- 8) Are they unfinished?

Interpretations have to be situated within the idea of lived experience. The study adopted data collection methods that aimed to gain insight into the experiences of mental health professionals. It is grounded within an epistemology that values subjective meanings and interpretation. Yet narratives can become distorted through the process of interpretation (Hewitt 2007). This can lead to participants' identities being misrepresented. The study aimed to ensure that the focus on lived experience is maintained through the inclusion of data throughout the thesis to support interpretations; this includes the data that offers disconfirming evidence for the explanatory model. The collation of detailed field notes, interview transcripts and study records aids the contextualisation of materials. This is supported by the adoption of a case study approach to the research which helps locate the participants' experiences in their social and professional context. Denzin (2002) suggests that interpretations should be historically and relationally situated. This includes providing an account of the social relationships between the participants. The study aspired to achieve this through the situation of the research in relation to the wider literature. This involved examining the influence of the historical context on interpretations made in the research. Social relationships between participants form part of the explanatory model of the study and therefore have great significance in grounding the findings. The process of interpretation should be clear and demonstrate interrelationships between different elements (Denzin 2002). The outline of data analysis provided in this chapter aims to offer a clear and justifiable account of process, whilst the relationships drawn out in my interpretations are explored throughout the thesis.

A central tenant of good interpretation is the inclusiveness of this process to ensure that nothing relevant is discarded in order to enable the advancement of understanding (Denzin 2002). The analytic account has highlighted that I attempted at all times to incorporate



broad categories, to promote the inclusion of all data. Such a process is additionally evidenced by the inclusion of data extracts that don't 'fit' with the explanatory model in both the analysis of data and the presentation of the thesis. Interpretative processes have been considered from the perspective of my own history and relationship to both the participants and the data. This has included the maintenance and provision of a reflexive account of my potential influence on the interpretations made, emphasising the significance of my prior understanding in shaping the findings.

Coherence is an important part of quality within interpretation. Cohesiveness is achieved in the presentation of a detailed, descriptive contextual account of the research (informed by the previous criteria). Therefore, all relevant data is incorporated and the research provides a meaningful report of interpretations and the processes undertaken to reach them. This thesis has aspired to provide such an account. One of the steps taken to achieve this is the construction of a discussion section that includes extracts from research data. Finally, Denzin (2002) returns to the hermeneutic circle, recognising the ongoing process of interpretation. Interpretation is never finalised which is expressed through the idea that undertaking research reveals more to be explored and the researcher cannot expect to uncover all that can be known about a phenomenon. Within my own study the interpretation process has continued through the phases of analysis, writing and editing the thesis, shaped by my own experiences and the revised understandings I have gained from interaction with the literature. Whilst conclusions have been offered based on the insights gained, recommendations aim to indicate what other areas may be explored on the topic of the research. Berry (2011) highlights that temporal restrictions inevitably bound case study research. However, opportunities exist for these to be continuously revisited, particularly in light of new theoretical insights. The recommendations arising from this research aim to reflect these ideas.

The use of criterion to assess the quality of qualitative research is much debated, yet the need to clearly articulate what makes good quality qualitative research is consistently advocated (Cutcliffe and McKenna 1999, Tracy 2010). Denzin's (2002) work has been used to outline how I have aimed to adopt a meaningful and rigorous interpretative process, to conduct a piece of qualitative research that is authentic and has relevance for nursing practice.

### **3.2.6 Methodology Summary**

The methodology has provided an account of the research process undertaken. It has situated the study in relation to Habermas' knowledge interests (1972) and identified case study as the research design adopted. The chapter has outlined the process by which observations and interviews were undertaken in an in-patient acute setting and an assertive outreach team. These were conducted in order to build interpretations that examine whether and how mental health practitioners perceive and experience potential tensions, which may arise from delivering care and enforcing control for people who experience mental health problems.

## 4.0 Findings

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## **4.1 Chapter 8: Data Summaries**

### **4.1.2 Introduction**

The findings chapter provides a descriptive summary of the data, including an overview of each case study. Presented are the key stages of data analysis and the main interpretations made at each of these stages. This includes, interview and observation summaries, theme summaries and explanatory propositions. An overview of the patterns collated as the data analysis progressed, aims to present a transparent analytical process. These descriptive summaries offer context for the discussion section. It is within the discussion that the relationships within the data are fully explored and related to relevant literature.

### **4.1.3. Case Summary; Lawrence Ward**

Lawrence ward is a 25 bedded acute in-patient ward. It is located in a small mental health unit on the grounds of a large general hospital in a town in the Midlands. The ward has a focus on ‘treatment and therapy’ (personal communication). Within the organisation, the majority of in-patient acute wards are identified as having this explicit purpose. This recognises that people already known to the service are frequently admitted to the ward and highlights their role in treating mental health problems. The ward serves the population of the Midlands town, but also more rural areas spread throughout the county.

Within the unit in which Lawrence Ward is located there is a locked acute in patient ward for adults (smaller with 11 beds) and a psychiatric intensive care facility. There are also, wards for older people with mental health problems, psychotherapy, community teams, ECT services and a 136 suite.

There were 13 members of nursing staff based on the ward at the time of study, with ten healthcare support workers. These were managed

by one ward manager and a band six charge nurse. During the time of the study there were two nurses who were not present due to sickness and maternity leave. One nurse worked permanent nights. The ward manager was on long term sick leave. During all the days observed temporary bank staff were employed on the shift. Four consultant psychiatrists alongside three specialist registrars and a junior doctor made up the ward's medical teams. The acute recovery team visited daily and ran creative activities. The acute recovery team was made up of an occupational therapist and support workers. A ward clerk supported the team with organising documentation and taking phone calls.

During the time I spent on the ward there were between 23 and 25 people under the care of the ward each day. Each time over half of these service users would be under a section of the Mental Health Act (section 2 or section 3 with one person being under section 37). New admissions to the ward arrived on each occasion of observation

#### 4.1.3.1 The ward environment

Lawrence ward was on the second floor of the unit. The ward had an 'L' shaped layout; at the top of the ward near the door was the ward office. In here, there was a large white board with information including; service users' names and section status. Opposite this was a TV lounge. Further down the ward there were side rooms with single occupancy. These had windows where the shades could be adjusted from the outside for the purpose of observation. There was a communal seating area here, where staff sat to conduct structured observations, especially health care assistants. Service users would often join them in this area. Towards the bottom of the ward were shared dormitories with bed space demarcated by curtains. Next to these was a large meeting room where ward round meetings take place. The clinic room was at this end of the ward, alongside the staff locker and break room. The ward was unlocked; service users not on a section have freedom to leave. The door was located next to the

staff office enabling staff to view who leaves and enters the ward. The ward was a mixed ward for male and female service users.

#### 4.1.3.2 Contextual Issues

The ward was due to move to a temporary location two months after the research took place. This was to update the facilities and provide more single rooms. As part of this refurbishment a lock was going to be added to the ward door so people would be unable to leave (or enter) without being let out by staff.

The nursing team regularly rotated between Lawrence ward and the smaller locked facility. This was generally unpopular amongst the team. From the managers' perspective, it aimed to improve working relationships between the two areas and help each team understand both the wards. However, it was an enforced move and concern was expressed by the staff that it was detrimental to team working. Nursing and healthcare assistants were rotated every three months.

#### **4.1.4. Case Summary; Assertive Outreach Team**

The assertive outreach community team worked with service users who experience psychosis. They aimed to develop therapeutic relationships with service users who have been identified as 'difficult to engage' (organisation website). Service users were often isolated from communities and may have other complex problems such as contact with the criminal justice system or drug and alcohol dependency. They are likely to have had multiple previous admissions to hospital and been cared for under the Mental Health Act. Alongside supporting people with their mental health problems the service offered practical help, input with benefits, access to training and help with housing (organisation leaflet)

The assertive outreach team was located in a large community base in a city in the Midlands. The building provided a base for a number of

other community mental health teams as well as offices for Consultant Psychiatrists.

The assertive outreach service in the city was divided into two sub teams. There were two team managers that oversee both of these teams, a social worker and a nurse. The sub teams were divided according to the geographical location of the service users GP's in the city. This governs the allocation of referrals to each team once accepted into the service.

#### 4.1.4.1 Team A

There were six nurses in the team, five of these were band six and one was band five. There was one social worker in the team who undertook a care coordinator role. Four community support workers were also employed. One consultant psychiatrist was linked with the ward and one specialist registrar who rotated out of the team during the time of study.

The team identified that they adopted a pure assertive outreach model. Service users had an allocated care coordinator but were visited regularly by several team members. This 'team approach' is characteristic of the original US assertive community treatment model (Bond, Drake, Mueser and Latimer 2001). Team A shared one office with communal meeting space at one end and desks at the other end of the room. A large white board in the room listed all the people that the team support, their location, section status, date of next visit, date of last visit and 'dot' status. The dot system was used to identify service users in accordance with a level of concern, with a red dot being severe concern that would require action and, green denoting the need to be more vigilant. The team was supported by an administrator, part of their role involved taking calls that came into the team.

The team supported 74 service users. Of these six people were on CTOs and six were in acute in patient care. Between eight and ten

were identified with a dot against their name during the period of observations.

#### 4.1.4.2 Contextual Issues

There was a proposal to replace a band six post with a band four post, which was causing concern amongst the team, particularly the qualified members. There was a feeling that this devalued the role of the qualified staff, as well as increasing their level of responsibility, as they would be accountable for supervising the conduct of the support worker.

Changes to the meeting structures had fairly recently been introduced, as a result of an ongoing homicide inquiry in another assertive outreach team in the organisation. This inquiry was continuing which appeared to cause some frustration in the team and a feeling that they were under a microscope.

Recovery is an important agenda for the organisation that the teams worked for (see organisational context). Whilst this was not necessarily shared by all members of the team, a meeting observed to discuss the team's targets for recovery revealed in some members a feeling that this agenda had been forced upon them.

#### 4.1.4.3 Team B

Team B was made up of seven nurses, six of whom were band six and one was band five. The team had five community support workers and was managed by the same social worker and nurse as Team A. Two consultant psychiatrists were linked with the team.

The team had adopted a case management model where individual nurses acted as care co-ordinators. With the assistance of specific community support workers, it was their care co-ordinator that a service user would have the majority of their contact with. They continued the intensive input of assertive outreach but had departed from the traditional team approach (Bond et al 2001). Caseloads for



some of the nurses were around 14 clients, although it was suggested the caseload maximum should have been ten. Team B were based in a large office opposite Team A, with workbenches against the wall and computers and telephones located on these. There was a large white board at one end containing details for all the service users the team support, with information regarding care co-ordinator, date of next appointment, date last seen, section status and medication due date. Dots were placed against names on the board. Similar to Team A they were also supported by an administrator.

Fifteen of the team's clients were in acute wards during the time of the study. Of these eight were under a section and two had been recalled on a CTO. A further two of the clients were under CTO's in the community. Three were in prison and two were in homeless hostels. Ten had dots recorded against their name during the period of observation, though the majority of these were green. The team supported 75 service users.

#### 4.1.4.4 Contextual Issues

Team B raised the ongoing homicide inquiry. Impacting on both teams, during the study, was the announcement by the team manager that commissioning arrangements were under review. The period of compulsory commissioning of assertive outreach services established following the National Service Framework for Mental Health (DH 1999b) had now finished. There was no longer an obligation to fund this type of service. Assertive outreach input could therefore be incorporated into community mental health teams. No decisions as to the future structure of the service had been made but the options were being reviewed.

Another member of Team A was due to leave the team soon and it was unclear whether they would be replaced due to cost saving imperatives in the organisation. Staff in both teams expressed concerns regarding the impact on the service users and well-being of the team members.

#### **4.1.5 Organisational Context**

Both teams were part of a large NHS Trust. At the time of the study the trust provided Mental Health and Learning Disability Services County wide. As an organisation, it is a pilot site for a national project to implement recovery. This reflects a focus on promoting recovery as a philosophy for a number of years, which has included the appointment of a recovery lead at Trust level and the identification of recovery champions in service sectors. The national project aims to support mental health service providers to underpin their practice at all levels with a recovery approach. Challenges that the Trust is working towards meeting as part of this work include; developing personalisation and increasing choice, establishing a recovery college and altering risk assessment and management approaches (Organisation website). Recovery strategies have been established to outline plans for how these challenges will be addressed.

The NHS is under constant pressure to curb rising financial costs. At the time of the study the health service was facing the possibility of a three year freeze on real term funding (Powell and Thompson 2010). Costs saving initiatives were under way in the organisation where the study took place. There was the possibility of service cuts and restructuring. This included the freezing of posts and reduction in management positions.

For the case studies included in this research, recovery was a visible part of the organisational agenda with an increasing requirement for them to identify and demonstrate the approaches that were taken to support service users towards recovery. Yet as is often a feature of employment in the NHS, financial cutbacks, staff pay freezes and organisational restructuring provide the background to this work.

#### **4.1.6 Data Summary**

The data summary section provides a brief overview of the observations conducted in both case study settings and each interview. Key words denote the consistent and important issues arising from reviewing each piece of data. Sample quotes have been used to enrich description.

##### 4.1.6.1 Lawrence Ward

###### *Summary of Observations*

Non-compliance was discussed by staff frequently with the need to improve medication adherence emphasised. Risk was discussed in relation to service users' vulnerability and the risk of the person to others. A number of admissions of new patients took place during the period of observations. Notes regarding the situation when people were admitted highlight not taking medication and concerns over specific hazards such as level of aggression were identified in the handovers between staff. Levels of distress were also noted by some. Organisational changes were discussed between staff including introduction of payment by results. The introduction of a locked ward was debated.

###### Extract from Field Notes, Day Two, Early Shift

*Daisy – was put on observations following hitting two other service users the night before. She attempted to leave the ward unescorted that morning. The nurse stopped her and explained that the observations were introduced to protect others as they have a duty to protect others. Daisy was encouraged to take responsibility for her actions, with the nurse suggesting if she did the observations wouldn't be necessary. When Daisy emerged from her room that morning (prior to this exchange) she was greeted by the HCA with "You won't be causing any trouble today, I'm not having it".*

### *Interview Summaries*

#### **Natalie**, Nurse Band 5

Qualified 7 years, HCA 12 years prior to this

Natalie highlighted that it is concerns identified by staff regarding patients that will prompt discussion; leading to action and a decision. Different structures for decision making on the ward were discussed. These included ward rounds but decisions were also made informally when people come together. Team decision making deals with escalation of concerns as the situation develops. This takes place through handovers, office discussions and ward rounds. Within formal structures the consultant holds the power for decision making. The role of acute wards was described as to manage risk. Natalie explained that confidence and experience as a professional influenced practice around risk. Management of risk was linked with consultants' role and a fear of blame. She suggested that patients should have involvement in decision making but that they don't tend to be.

*"She is here in tears, had some time with her ...went into a room with her tried to persuade her to take some medication , thought it might help calm her down but she wouldn't have it. She wanted to go for a walk, we said well if things were OK for the next half an hour then we'll look at going out for a walk, we'll respect your wishes. So it's kind of a joint care between the patients and staff and everybody involved in the persons care, it doesn't always work like that."*

#### **Emma**, Nurse Band 6 Charge Nurse

Qualified 8.5 years

The process of decision making was described as hierarchical, she perceived disagreement as being between doctors and nurses though did briefly discuss a lack of consensus between nurses. Emma highlighted a paucity of patient involvement in decision making. Risk

was identified as a key factor in whether someone is discharged from the acute ward. Decisions are deferred to doctors when risk is greater. Emma related decision making to back covering and fear of blame, particularly from the organisation. She had experience of being involved with an inquiry and coroner's court. Examples of dilemmas relating to observations, including the role of gut instinct influencing perceptions of possible risk.

*"I still think it's very much the consultant; I think they keep saying they want to work away from that, from institutional ward rounds where the consultant kind of leads it. But I still think it's very much consultant lead care in general so that guides your major decisions."*

**Zoe, Nurse Band 5**

Qualified 10 months

The process of decision making on the ward means that riskier, bigger decisions involve medical staff. These included reducing level of observations and discharge. Zoe suggested an escalation to the decision making process which was related to fear of the consequences. This was linked with the NMC and media coverage. She highlights difficulty in getting the balance between individuals' independence and service interventions. Sharing decision making with other professionals and team working was highlighted as important particularly with her level of experience.

*"I think it depends on what the decision was as to how important it was, if it was for a minor decision then you might discuss it among the people on the shift or just make that decision on your own then disseminate it. If it's a bigger decision with more impact you definitely would discuss it with your colleagues and also the MDT as well, certainly get the input of the SHO and consultants even just in a general chat in the office."*

## **Kimberley, Nurse Band 5**

Qualified 21 months

Kimberley discussed sharing decision making with the team and talking with others; though recognised her confidence in making decisions has increased with experience. An attempt to involve people in decision making was recently introduced through recovery sheets used in ward round but she highlighted that in reality people aren't involved. Kimberley brought up that there are some issues of power in decision making and expressed difficulty when doctors don't agree. Kimberley was due to attend coroner's court soon. She highlighted she didn't feel responsible for the death and she feels everything that should have been done was. Kimberley discussed concerns about service users 'doing something' (to themselves) and linked this with fear of losing her registration. Examples of therapeutic risk taking and consequences when didn't go according to plan were discussed.

*“One example could be when I was in ward round, I was the only qualified present, obviously there was myself the patient, the consultant and crisis. I felt the patient was ready to be discharged but the consultant disagreed so I was in the ward round and it's hard sometimes you get so frustrated because the patient wanted to go, he had his heart set on going and I thought he was ready to be discharged and the crisis team were happy to visit him and to try and support him in the community but the consultant was like no...He staid another week but wasn't really given a rationale as to why... so that's annoying. Sometimes I do think you know you are on the ward 24 hours a day and you see what this patient is like, consultants will come once a week for an hour and it's frustrating.”*

NB Kimberley had spent 3 months working on Lawrence ward but at the time the interview took place had just rotated to the locked ward.

**Edward, Consultant Psychiatrist**

He suggested that decisions are largely consensual and team based though later highlighted that the role of consultant can be to 'enable' decisions to be made when there is a lack of clarity or struggle for resolution. Edward highlighted that doctors are often involved where there are concerns or a need to consider medication. However, he feels this mirrors a 'real' role around taking managing risk, medication can be used as code for bringing these concerns to the doctor. Edward identifies the role of society in perpetuating doctors' responsibilities for maintaining social order, which was linked with status and expense of psychiatrists. He also suggests that the organisation seems to want to share decision making but focus on the doctor when "things go wrong". Currently requested to appear at two coroners cases but not that involved with the service users that the cases were about.

*"Some months later he went missing and was eventually found dead, so I am not quite sure why I have been asked to attend the coroners hearing. The other was somebody that I had seen for the last time about nine months before he killed himself and again why am I you know? I'll do it, its fine, perfectly comfortable with what happened. But why am I being asked to go along at all? There's something about being the psychiatrists who was identified with that particular person; immediately says to the coroner I must see that doctor."*

**Charlotte, Nurse Band 5**

Qualified 6 years 3 months

Where risk and dilemmas are concerned team working and sharing decision making in the team is important. Patients are involved through 1:1's and presenting views in ward round, though ultimately the decision was viewed as the consultants. Charlotte expressed that it

is difficult to make decisions about observations, particularly reducing observations. Described herself as cautious person and this has influence on decision making. Has attended coroners court following a patient's suicide, experience was unpleasant and she was very aware of how this influences decisions currently, though considered the process as a fact finding mission.

*“Usually the patient is discussed in their absence and then they are brought into ward round and then their points of view are put across - their own point of view rather than ours. Sometimes a decision is made before the patient is actually seen but then when the patient is actually seen decisions made might change, it depends on what the patient wants or how the patients presenting.”*

#### Key words

Following are the keywords consistently identified within the data from the in –patient setting.

- Risk
- Power
- Structure of decision making
- Blame
- Roles and responsibilities
- Relationships
- Dilemmas discussed related to these areas; observations, admissions, nurses holding powers, non-compliance, restraint, gaps between ideal and possible, medication, safeguarding

#### 4.1.6.2 Assertive Outreach

##### *Observations Summary*

Team A



Team discussion included how changes to team meeting structures are linked with a death in another assertive outreach team. Members of the team debated dilemmas linked with CTO's, medication, service users' preferences and how these reflect the 'real world'.

In observations of meetings, including with the psychologist, there was discussion of shared notes and recovery priorities. The agenda for this focus was questioned by the team present. Coming off medication discussed between some qualified nurses in the meeting though the potential for success was queried. Team discussion highlighted that they need to be seen to be using recovery frameworks but this is challenging with an assertive outreach client group. Some team concerns were raised such as freezing posts and commissioning of service.

#### Team B

Examples observed of messages relayed by administrators regarding service users' mental health. Responses from the team were deferred to the person's key worker when next on shift. Dilemmas debated in office informal discussion included, gambling and admission. Capacity was discussed during MDM's (often though not exclusively raised by manager or consultant). Team discussions of changes in structures (e.g. shift patterns) were linked with risk. Conversations took place regarding a coming off medication group and different perceptions of this in the team. People identified that those supporting the group need to understand that AO clients have to be stable..

#### Extract from Field Notes, Day 2 Team B

*Discussion in MDM - Feedback from doctor regarding male service users – presented that he is looking for admission, but can't get people in except on section so couldn't admit him. The person had suggested "well if I stop taking my depot you would have to recall me". Nurse highlight he is hearing voices and in own world and is socially isolated so*

*admission would be to have people around him. Nurses put forward suggestion for shared accommodation but not supported by his key worker. It was concluded couldn't afford to admit for current reasons.*

### *Interview Summaries*

#### **Team A**

#### **Eric, Nurse Band 6**

Qualified; unavailable

Eric discussed the process of decision-making and the different forums for this, including supervision and MDT meetings. He identified that sometimes no decision is a decision. Eric mentioned tensions between the team held and care coordinator approach in the assertive outreach team, particularly when it comes to prioritising with paperwork & legal responsibility. Risk is perceived as a big influence on decision-making and as the reason for admission; he suggested the bar for this is increasing due to changes in services. He discussed differences in individual team members' perceptions of risk. The doctor is involved in decisions to help maintain people in the community. They are particularly involved when the person is having a relapse or risk is present, though their lack of presence in MDT forums can delay decision making. Example of negotiation between client wishes and what perceived 'best' in situation. Responsibility and role of doctors is linked with wages.

*"There is a dilemma that actually is only partly related to client work in the sense that there is quite a tension between being part of the team and being an individual care coordinator its nicer to work in a team which has a clearer team focus because it gives you better confidence that other members of the team know your clients and will discuss them with you , it gives you better confidence when you go on holiday. However as care coordinator if you have a busy day*

*going around visiting everybody else's clients and ignoring your paperwork then you can get into a lot of trouble or if there's a serious incident or something like that you know it's the care coordinator who has the legal responsibility."*

**Felix, Nurse Band 6**

Qualified 27 years, 10 years in Assertive Outreach

Decision-making was described as structured through care coordinator and shared in MDT though doctors not always present in MDT. Risk is a framework for prioritising in decision making and planning care. Felix referred to the NHS and organisations influence on priorities a number of times. He had experience of attending coroner's court when working in in-patient services which he said had some impact on his practice now. He identified some tensions between acute and community care and a growing requirement for the use of mental health act to get people admitted. He doesn't feel dilemmas are common as risk wins out, patient involvement and person centred approach can only go so far due to this.

*"I think people's skills are very important; no matter how many issues, relationships are the key, developing that kind of relationship with the service user really. If you have got that sort of good rapport with them, half the work is done. Without that I do not believe any work could be done with the client. They run away from you or whatever, once you have got that established you have a fighting chance to help the person to change the person's life or quality of life."*

**Ife, Nurse Band 5**

Qualified 2 years

Sharing decision making in the team is important, particularly as she identified due to having less experience. There is potential for disagreement within discussions but will go along with things that she

doesn't agree with as this could be the right thing to do. Decision making was seen to rest predominantly with the Community Care Coordinator (CCO). However, she highlighted she wouldn't go against what the consultant advocates, particularly if they wouldn't sign up to the care plan. This was linked with fears of being blamed, the consultant is the first line of defence and there is a feeling that you don't want to be isolated if things go wrong. Blame mentioned a number of times in relation to the pressure to prioritise public protection. Documentation was therefore described as important. Risk also mentioned in this context and as significant influence on decision making. Some reference to role of service and how this is perceived by others.

*"I didn't think that I could give consta, these are the situations you face day in day out isn't it? So I just said well I'll go back tomorrow. I have spoke to her and said I come in tomorrow to give you your injection and she said yeah she will try not to drink before I get there at nine thirty in the morning. But it is a big dilemma that most anti-psychotics have got sedative effects and most of my clients they drink. By the time you get there to give them their injection they're either so drunk that you're giving something that sedates them, is it right ethically? Where do we stand morally? I just find it a big dilemma personally."*

Team B

**Andrew**, Nurse Band 6

Qualified: Unavailable

Andrew identified decision making is shared in MDT, difficult decisions are directed towards MDT forums. Assertive Outreach and engagement were recognised as supporting the development of therapeutic risk taking. He has experience of coroner's court due to an individual who died of accidental overdose; the influence of this

now is to make him more careful about documentation and being thorough. Andrew gave some examples of working with service users in decisions and/or negotiation. Risk described as an influence on decision making, example given was linked with medication.

*“I think that’s a big part of it really, because I know with other teams the view is that if someone’s unwell, I mean obviously you can then get the crisis team involved but there is kind of a lack of consistency with that. Whereas you know, we know them reasonably well and they know a lot of faces from the team reasonably well. It means that we can instead of a stranger going in and assess them we can, I guess it’s about knowing your clients isn’t it?”*

**Louise, Nurse Band 6**

Qualified 9 years, 4 years in AO

Louise identified decisions are made together with the service user, focus is on negotiation with the client and the MDT. Decisions were described as involving the MDT more where there is risk. Louise highlighted her own values and the influence of these on the approach taken with clients. Also the impact of team dynamics and pressure if there is disagreement. Professional codes are part of decision making. Influence of others outside the team was identified in relation to decisions, particularly related to admission to hospital. This included housing, police, neighbours, carers and society. Risk was seen as a barrier to decision making, consequently the focus becomes on maintaining quality paperwork rather than quality care. She recognised it’s difficult in terms of risk for people to escape their past. Examples of supporting people to come off medication were given. Raised issue of coroners court and responsibility, hasn’t had personal experience of this though had experience of client involved in a ‘serious incident’ which was in the media.

*“I think I’m probably more, I mean you have got to weigh up the risks don’t you. I mean don’t get me wrong, I’m perhaps more willing to let people find their own way, may be make their own mistakes and kind of learn. I think we all are to some extent but there are little differences in the way people work with people and kind of how far people might go really. I think I am probably less likely to take kind of big controlling methods than maybe some people. Even though I said about the CTO with this person I am very reluctant really to have anyone on a CTO for example.”*

**Marcus, Nurse Band 6**

Qualified 26 years, in AO 5 years

Power was highlighted as central to decision making. The consultant was seen to hold the power for decisions but ultimately the service users’ had some control, for example whether they chose to take their medication or not. Capacity was recognised as a concept that is being used to help decide in some scenarios. It was identified that the service agenda seems to define the approach to working with service users rather than the people themselves, particularly through the paperwork requirements. Public perceptions of the service were also mentioned as significant. Choice and control were highlighted particularly in relation to appointeeship. Marcus mentioned differences in perceptions of risk, informed by how well a nurse knows the client.

*“I guess there’s the management structure, the way the service is perceived by the public, as well. What we talk about care plans and what service users want but in reality that often gets squeezed and it’s very much we are dealing with a service agenda and you know our agenda is to have a review every year, our agenda is to see you once a fortnight, our agenda is to give you medication our agenda is to like to make sure that you are registered with a GP, that you have a*

*health check, its all these tick boxes, tick tick tick have you done this have you done that - is that their agenda?"*

**Sebastian,** Consultant Psychiatrist

Qualified Consultant for 14 years, AO 15 years

He described that doctors have authority which is reinforced by legislative powers. He talked about attempts to dissociate from that authority through, remaining quiet and leaving space for client and team to make decisions. Relationship with service users was described as significant for decision-making, though sectioning creates tensions in that relationship. Risk management and resource pressures place more emphasis on doctor as authority figure. He gave some examples of scenarios where respecting individuals choice would be negatively perceived by others. Documentation was discussed by Sebastian as influencing decision making agenda and side-lining client's views. Sebastian suggested that the organisation is protecting themselves (through documentation). Responsibility he highlighted is a key issue related to when things go wrong. Society perceived as important influence – control individuals through legislation and documentation.

*"That's often how the risk stuff is couched and if we are going for strengths based model, then we should be discounting the negative information about someone, I'm aware the GMC wouldn't be happy with this way of working. But an interesting clinical scenario arises when I have a client who says OK I will talk to you but you are not allowed to read my old notes because they have written so many bad things about me, how are you supposed to respond to that? And again if something bad happened and it came to court, I suspect I would get into trouble if I hadn't done so, but I think clients do have the right to ask me not to look at their old notes".*

**Prima, Nurse Band 5**

Qualified 3 years

Decisions were identified by Prima as taking place where there is deterioration and intervention is needed. Prima discussed scenarios where she felt she had been excluded from decision making, due to being a band 5. She focussed on the role of families in decision making either prompting a decision or as a barrier (e.g. family doesn't want the person admitted when that is what the client wants). Risk is described as an indicator for discharge to a different team. Also talked about situations where the decision is right from the client's point of view but wrong from the Care coordinators or team's point of view. Prima provided examples of different situations with clients to illustrate issues.

*“At the moment I have got a client who, I mean he can't manage his finances and it's quite difficult for the mum and the mum is the nearest relative. She's been struggling with him for quite some time. We spoke about him last time and we actually the team actually made a decision for him to have appointeeship. We can't just do, we have to I went to speak to him and you know and he agreed because he's not managing his”.*

**Lilly, Consultant Psychiatrist**

Qualified; Consultant (and in team) 6 years

Varied views in team were described as common which leads to frequent lack of consensus in decision making. A lack of hierarchy is positive and helps contribute to this open sharing of views. However, 'external' chair useful in enabling team to consider different perspectives. Sometimes decision making is inhibited by pressures of the need to “do the right thing”. Risk has a significant influence on decision making particularly in context of previous homicide inquiries associated with this or nearby teams. Lilly identified the



impact is that a professional can feel blame from the organisation and coroner which can make different ways of working difficult. Shared decision making, supportive relationships in the team and knowledge/relationship with the person have supported her to take therapeutic risks. Organisational agendas and some paperwork systems are perceived to be driven by being seen to do the right thing.

*“I am reasonably comfortable taking risks if it feels right for that person. Because actually, the sense that someone is so stuck and so unhappy where they are that actually, as long as it’s not a very clear high risk with a high likelihood of terrible outcome which very rarely is the case, I often think it’s a reasonable thing to do, if its shared with that person... But if someone is making a decision that sounds perhaps a little bit risky but you think it might help them in order to move on - so that’s how we all move on in life”.*

**Tanisha**, Community Support Worker (interview not recorded)

Worked in healthcare 14 years, Assertive Outreach for 9 years

Tanisha discussed issues with service users, finding out what they want and then brings this back to the MDT for decisions to be made. Relationship with service user identified as important for decision making. Sometimes there is a lack of agreement about what should be done. She suggests clients from Afro-Caribbean backgrounds don’t like medication and can be suspicious of it. Back home in Jamaica they would be accepted for talking to themselves but here it is something that the person is seen as needing medication for. Understanding a person’s culture and background is important and Tanisha is able to do this for service users from Afro-Caribbean background. Sometimes it can be difficult if families don’t want the team to visit or don’t understand the persons illness.

*Went to see client yesterday, discussed when council tax housing benefit will be suspended. I mostly work with Afro-*

*Caribbean clients. She speaks patwa - the housing people can't understand, what she is saying on the phone. I went to offer some support and help with communication. I need to support her with clearer communication.*

**Jack**, Social Worker Manager (Manages Team A and B)

Qualified; 6 years as manager 7 years qualified

Jack described decision making as related to external frameworks such as best practice, legislation and organisational targets, sometimes tick boxes can eclipse what the team should be doing. Power exhibited in different ways but often law is the ultimate decider. Mental Health Act assessment seen by community staff as panacea but this is not necessarily the case. External advisors can facilitate decision making particularly where there is a dilemma. Relationships and length of time a professional has been working with someone in that setting can mean they advocate for that individual service user in MDT forums. However, Jack states it is not always possible to be sure whose perspective they might be speaking from sometimes. Risk is the reason for team to bring decisions to managers. Risk can be barrier to decision making, also in the context of a homicide inquiry, which has led to a focus turned in on team practice from number of external positions (including inquiry and newspapers). This can contribute to fear in team and risk aversion. Coroner's court mentioned in relation to inquiry in other team.

Interview straddles both Team A and Team B and adopts a more overarching perspective of the process – particularly in consideration of team decision making.

*“In the sense that well, let's call a mental health act assessment and that will prove that we are either right or we are wrong. That's not the case because an assessment and the outcome can be particular to that set of circumstances at that particular time. There will be occasions in the review*

*when somebody is reluctant for whatever reason to call for a mental health act assessment. That's sometimes can be about their own view about whether or not the law should be used I suppose or whether or not that for somebody to be in hospital or beneficial for them to be in hospital so that's particularly where they are kind of coming from. They are probably thinking that that person could be assessed they could well be detained and actually what value will that be so they are kind of thinking beyond the assessment".*

### Keywords

Following are the keywords consistently identified in the assertive outreach setting.

- Structure of decision making
- Risk
- Relationships
- Context (social)
- Responsibility
- Blame
- Power
- Dilemmas identified related to these areas; medication, admission, CTO, when to intervene, medication. Specific access to service users house, secure setting step down, engagement, appointeeship, education/goals, personal hygiene and lifestyle choices, family, homelessness, drug taking, discharge, depot injection, and relapse

#### **4.1.7 Theme Summaries**

Reviewing and summarising each transcript led to the identification of key themes in the data from Lawrence ward (outlined in the methodology section). Keywords identified from the interview summaries contributed to minor themes that have been collapsed into the thematic categories below. A brief summary of these themes is outlined.

##### 4.1.7.1 Lawrence Ward

##### Decision Making Process

Decisions were identified as taking place in team forums such as ward round, handover, and informal office discussions. Decisions tend to be made physically and structurally away from the service user and those who are described as close to the service user, families and health care assistants (due to the time spent with patients). Decisions were made by the multidisciplinary team and led by the Consultant. Possible options were discussed between staff in the office and attempts are made to seek service users' views. However, barriers are described as to why this is difficult, in particular resources. The consultant was recognised as holding ultimate decision making power.

There's an escalation process for decisions structured by the level of risk a person is perceived to present. Decision making individually or shared with each other is acceptable or desirable for the nursing staff where the level of risk is not perceived as significant. Where risks are larger, decisions are deferred to medical staff. This position is reinforced by structural arrangements; for example a consultant decides on discharge, section leave has to be agreed by medical staff. Amongst nursing staff there was some frustration at the power of the consultant but also acknowledgment of the benefits of someone else taking ultimate responsibility, especially if things go wrong.

## Risk

Risk was discussed by all participants and identified as an influence on decision making. Risk was defined as being the behaviour of service users, either in terms of aggression and violence or self-harm, suicide and vulnerability. Participants' relationship with service users impacted on how risk was perceived, knowing the person well was identified as enabling some practitioners to support positive risk taking. Their own experience and values was also identified to impact on assessment and management of risk.

Risk was outlined as the factor which governed whether someone would be admitted or discharged from the ward and a significant influence on decision making. Level of observation was associated with risk, the higher the risk the more frequent the observations. Some suggested that it was easier to increase rather than reduce the level of observations which is reflected in ward policy for this intervention. Medication was a key response to risk through level or requirement for psychiatric drugs.

## Blame

Blame is discussed by all the participants in Lawrence ward. Cautious decision-making in relation to risks was associated with avoidance of being blamed (for example people staying on section until a tribunal removes them). Awareness of coroners court was present in the context of decision making, with participants identifying a fear of being exposed to this and blamed for a serious event (such as death) happening. Four out of the six participants interviewed had been involved in attending coroner's court or involved in internal investigations following incidents. Participants identified that their employing organisation may point the finger of blame towards them but that professional bodies and families may also hold them to account. The consultant interviewed suggested that responsibility is falsely shared with the organisation until things go wrong when the doctor is then presented as to blame. The nurses' abdicated

responsibility for decision making to doctors as they identified this afforded some protection from blame.

### Relationships

Nurses were able to discuss service users' views in one to one sessions. This was viewed as an opportunity to represent these views in decision making forums such as ward round which was supported by the recent introduction of the patients ward round sheet. Two nurses identified that their relationship and knowledge of an individual service user enabled them to feel more confident in their decision, particularly where this may involve for example time off the ward. It was highlighted that on the shifts observed that there was a limited time spent between the nurses and service users.

### Dilemmas

Dilemmas were acknowledged as frequently occurring in mental health practice. There were a number of areas where a lack of consensus or difficulty associated with making a decision were narrated or observed. These included differences in perceptions about the risk a person poses in using the Mental Health Act, reducing levels of observations, disclosure of information in a safeguarding situation, prescription of medication for rapid tranquillisation and the use of restraint for taking bloods. The level of risk that a person was perceived to present was a feature of some of these dilemmas. The person's autonomy, recovery or choice was not mentioned.

#### 4.1.7.2 Assertive Outreach Team

### Decision Making Process

Decisions were identified as being made with the service user during a visit, in MDT meetings and CPA reviews. There was an escalation of decision making with the most straightforward (such as when to visit) being made with the service user and the more complicated deferred to the multi-disciplinary forums. Decision making

responsibility is geared towards the care coordinator though there is a complex interaction with the doctors in relation to this. From the doctors point of view there is a desire to share decision making but a suggestion that external influences on their role make this difficult. From the care coordinators there is a desire to ensure agreement with the consultants as a protective mechanism (see blame theme), though there are one or two exceptions to this. A number of participants raised the issue of how the service was perceived in the eyes of others such as neighbours, family and society. These perceptions were related to a desire for services to provide a solution to a range of problems and therefore take responsibility for the individual.

### Risk

Risk is identified as a key influence on decision making and is linked to the occurrence of negative incidents, such as homicide or suicide. A number of participants acknowledged that this means risk can dominate mental health practice. It was identified as a means of prioritising work with service users and the teams employ a communication system to draw attention to changes in the level of service users' risk. High risk levels associated with service users would prompt the involvement of the teams' managers in decision making. The role of acute wards was described as one of risk management with the level of risk ever increasing before an admission will take place. Participants described how their perceptions of risk may be influenced by how well they know a person. On the whole risk was linked with increased interventions in terms of medication and visits, though two interviews gave an alternative perspective to this and a further two adopted a critical perspective of the role of risk in health care.

### Blame

There was fairly frequent reference to desires to do 'the right thing' and avoid doing 'the wrong thing'. The right thing was often linked with duty of care and documentation whilst mental health legislation

was seen as providing a guide on this. The wrong thing was associated with significant incidents and inquiries. Thorough documentation provides a means to defend against investigation if incidents occur as well as a marker of the quality of care. Both of these assumptions are linked to issues of blame and responsibility particularly when things do go wrong and a fear the responsibility for this will rest with an individual staff member. Participants expressed fears of repercussions from their employing organisation, professional bodies and the media. The NHS Trust that the teams were part of were seen to drive priorities, establish targets and through this impact on decision making. This is influenced by a desire to protect themselves potentially from blame, litigation and damage to their reputation. These issues were discussed in the light of a homicide inquiry taking place in another assertive outreach team in the organisation.

### Relationships

Engagement with service users was identified as important to enable contribution to decisions but a lack of capacity could act as a barrier. The nature of assertive outreach service facilitated long term work with service users and this work depended on the engagement that professionals and service users built. There was some discussion that the length of this relationship could be a barrier and that staff could find it difficult to “let go” and enable people to move on. Although relationships were identified as important in relation to decision making the service user was rarely mentioned as having a voice or any influence in ‘complex’ decisions that impacted on their own care.

### Dilemmas

Participants acknowledged that they experienced dilemmas and difficulty reaching decisions. Specific examples were narrated around a wide variety of scenarios including the use of therapeutic funds, appointeeship, use of the team base and facilities, Mental Health Act and when to admit someone to hospital. There was one



dilemma that was discussed from different perspectives by four of the participants. It related to a service user who was admitted to hospital involuntarily, following this he refused to talk to members of the team. When he was admitted some of his clothes were in the washing machine and his lack of contact with the team meant they were unable to gain permission to enter his property to remove the clothes from the machine and save them from being thrown away. The dilemma was presented in relation to his capacity to make that decision and concern regarding the lost items. Two of the participants favoured going into his house to remove the clothes and two didn't.

#### **4.1.8 Cross-Case Interpretation and Reflection**

The data and theme summaries suggest analysis has provided insight into decision making, the dominance of risk in mental health practice and participants fears surrounding blame. What are much less visible are notions of recovery, involvement and service users' rights to make choices, the relationships themes were by far the smallest in terms of representation in the data. It is clear at this point that dilemmas exist for participants in their daily practice. It also appears that participants feel risk management, organisational and public perceptions influence decision making and a desire to avoid getting things wrong. The dominance of these influences within the data at the cost of the service user voice to a degree contradicts the position presented in the literature review. Risk management and the exertion of control appear to prevail, though there are some exceptions to this seen within the data. Primarily there are two interviews from the assertive outreach team that narrate examples of shared decision making. These participants appear aware of but less influenced by forces of expectation from the organisation and public. There are some further examples in the interviews, particularly in the community of questioning the current dominance of risk.

The data summaries highlighted that decision making is structured away from service users. Within the themes specific processes appear to reinforce this distance such as medical hierarchies, organisational targets and decision making structures. This suggests that there is a wedge which seems to distance staff from the person and enable them to take control in decision making.

These reflections led on to a series of explanatory propositions. These are presented below as brief summary statements. This provides evidence of the analytical process that resulted in the development of the final explanatory model. Comparison of these propositions with the data led to these being further refined to create the explanatory model on p.157, which reflects the main findings of this thesis.

#### **4.1.9 Explanatory Propositions Version 1**

- Decisions – risk comes into existence when a decision is made or retrospectively through the existence of a ‘negative’ event
- In the data risk is a complex concept – participants’ interpretation is influenced by a number of factors such as how long they have been qualified, how well they know the person, risk shifts in relation to these factors
- Risk comes into existence when “actioned” by service user, always linked to the actions of this group. For example, what isn’t there is risk to service users from services or society.

*Because ...*

- Distancing – service users are constructed as ‘objects of risk’ (is this a relational position?). They are always seen in the context of risk.

- Mechanisms that act to construct this position are paperwork & decision making structures, happening away from service users and acting to reinforce a position of controlling objects of risk
- Decisions where risk is focus relate to;
  - Discharge and admission
  - Medication – PRN, Increasing or stopping
  - Surveillance – observations

This process is influenced by:

- Expectations

*Social* – Mental health services responsible for service users (responsible for controlling and for their conduct) in eyes of others in wider society.

*Professional* – Has responsibility for negative consequences

- Expectations held by professional body and organisation but also influenced by society

*Organisational* - Responsible for service users

- Protect organisation from consequences of failure in social role (or fear of failure)
- Influenced by expectations of society

This may lead to;

- Blame

Product of the expectations and expressed as a fear, when expectations not met. Could be linked with mechanisms of distancing?

- Professional Role

Hierarchy of responsibility for decisions and risk which ends with the doctors and is perpetuated by society's, nurses, doctors and organisations expectations

- Power/Knowledge construct

When risk comes into existence it is at the hands of professionals which links back to the ways in which risk is defined and shifts depending on certain factors. Professionals are experts on risk

It is suggested that the definition of service users as risk objects is created through social, organisational and professional expectations, is maintained by structures for decision making, distancing and professional role. This position is mediated against by the therapeutic relationship and shared decision making which represents an attempt to expose and align expectations.

#### **4.1.10 Explanatory Propositions, Version 2**

Following further comparison of the data in relation to the propositions the explanatory model was amended to suggest that;

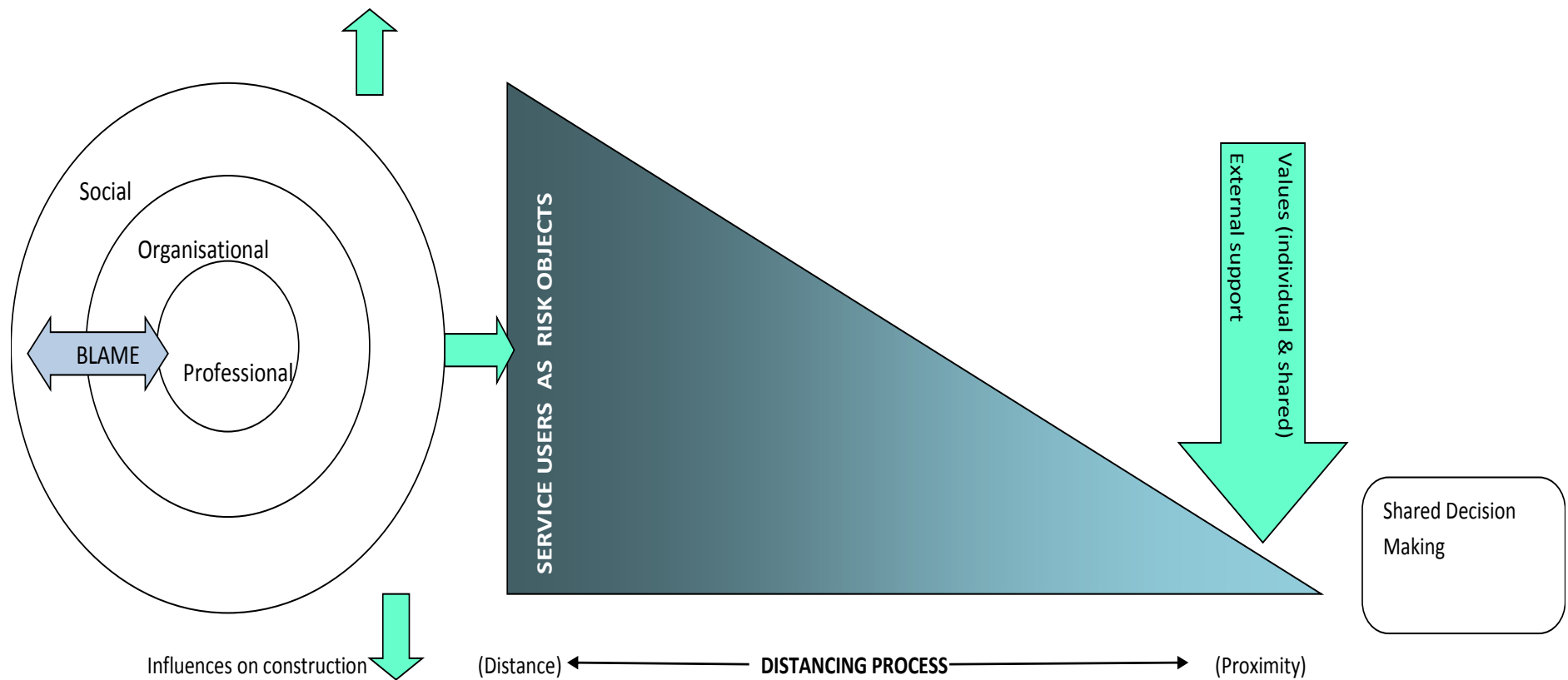
A distant relationship between professionals and service users enables them to be constructed as objects of risk. A process of construction is created by the influences of mental health professionals, the organisations delivering mental health care and society, underpinned by a fear of being blamed for negative events. A proximal relationship between professionals and service users mediates against their construction as risk objects and supports shared decision making.

This explanation provided the foundation for further comparison with the literature and is examined in depth in the discussion section of this thesis (see Fig 4.0).

#### **4.1.11 Summary**

The findings chapter has provided a descriptive summary of the interpretations made during data analysis. This has outlined sample evidence for key stages of the theory building analytical approach adopted; including evolution from the search for patterns to the development of an explanatory framework for the study.

Figure 4.0 Explanatory Model



## 5.0 Discussion

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## **5.1 Chapter 9: Risk Objects**

### **5.1.2 Overview of Explanatory Model**

The explanatory framework for the research findings is related to the work of Stephen Hilgartner. Hilgartner (1992) offers an analysis of the relationship between risk and technology. His work poses the question as to why some people view a technology as risky and others view it as safe. To examine this query he claims that the conceptual processes underpinning social definitions of risk need to be given more attention. “The Social Construction of Risk Objects; or How to Pry Open Networks of Risk” (Hilgartner 1992) presents a framework grounded in a social constructivist position on risk. Here he argues that definitions of what constitutes a risk are based on understanding something as an object with the capacity for harm, claiming that there is a link between the two. Construction of risk objects entails their emplacement in sociotechnical networks and is accompanied by a struggle to control the risk objects. Displacement from these networks is also possible as the definition of a risk object is open to reconstruction and change.

Hilgartner’s (1992) work has received some though not extensive attention in the literature on risk. His theoretical framework has been extended by Boholm and Corvellec (2011) to argue that risk objects need to be understood through a relational position. Where there is an object ‘of risk’ there is also an object ‘at risk’ with something of value under threat. Kendra (2007) applies Hilgartner’s (1992) work to examine the construction of merchant mariners as risk objects in the shipping industry. Significantly, unlike Hilgartner (1992) his work examines the application of power in the construction process.

An explanatory framework has been developed following analysis of the research data. Within this framework it is suggested that people with mental health problems are constructed as risk objects (Hilgartner 1992). The process of construction is achieved by



characterising service users as objects. Four aspects of objectification are explored within the data; including treating service users as lacking in agency and denying their subjective experiences (Nussbaum 1995). Construction as a risk object additionally entails linking of this object with harm. People with mental health problems are linked with risk by the participants. Risk is understood as the capacity to cause harm to either themselves or the public.

Objectification is a key part of constructing risk objects. Objectification within this study was contingent upon a distal relationship between mental health professionals and service users. Spatial distance was created and maintained via the structures used for making decisions that excluded service users. Spatial arrangements within the physical environment acted to distance staff and service users. Physical distance gave way to narrative and moral distance (Malone 2003), in which people's individual subjective experience was less known and therefore less visible in the decision making process. Psychological defences employed by mental health professionals to avoid anxiety and manage fears created by the risky unknown 'other' contribute to these distal relationships (Menzies-Lyth 1960, Kearney 2003). These conditions enable service users to be constructed as objects of risk.

The construction process develops within a socio-political context. Boholm and Corvellec (2011) argue that once defined as risk objects the process of construction becomes invisible. However, within this study professional, organisational and social influences have been identified as important powers in the definition of people with mental health problems as risk objects.

Risk is presented as a central aspect of mental health professional practice by participants. It is defined as a negative force, synonymous with harm and treated as a quantifiable notion with objective existence. The predominance of risk within mental health practice contributes to a focus on risk at the cost of other aspects of a person's

experience therefore perpetuating their status as risk objects. People with mental health problems being defined as risk objects exposes mental health professionals to being blamed if harm occurs. The potential loss of the professionals' social and moral standing through blame relationally positions them as objects at risk.

Professionals and organisations are powerful forces that can emplace risk objects (Hilgartner 1992). Organisational mechanisms such as standardised documentation systems were discussed by participants. These influence the construction of service users as risk objects. They concurrently link service users with harm and facilitate objectification as they limit professionals' opportunity to communicate people's subjective experiences. Effective risk assessment and management is an important indicator of a successful organisation (Power 2004). Risk is therefore not only the core business of mental health professionals but also the health service. Catastrophes can threaten an organisation (Power 2004). Catastrophes were observed within this study in relation to suicides and in the case of the community teams a homicide committed by someone under the care of the trust. Organisational responses to this serve to reinforce a link between people with mental health problems and extreme harm. Organisational reputation is threatened by a catastrophe which undermines the position of organisations as being able to control uncertainty. Service users' definition as risk object positions the organisation as 'at risk' as they are faced with damage to their reputation.

The responses of local communities were identified by participants to impact on how they worked with risk in relation to service users. These responses were seen to instigate a more controlling intervention resulting in containment or increased surveillance. Medication was identified in the in-patient setting as being used for behavioural management. These reactions served to reinforce people with mental health problems as having the capacity for harm, therefore contributing to their construction as objects of risk. Additionally, the

role of professionals in this situation is presented as one of governance enacted through the discourse of risk management (Crowe and Carlyle 2003).

The construction of service users as risk objects was seen as dominant though not consistently within the data. Some participants, most significantly two professionals from the community team displaced service users from their status as risk objects. This was achieved through maintaining narrative and moral proximity with service users and avoiding objectifying them. The link between an object and harm is therefore severed as the object no longer exists as such (Hilgartner 1992). Participants indicated that both their own values and working with colleagues with similar values aided the approach they adopted in practice. Support from experts outside the team was recognised as valuable to enable them to examine alternative perspectives.

### **5.1.3 Summary**

Distal relationships between staff and service users create the conditions where objectification can take place. Risk is the predominant concern of mental health professionals and mental health services. This position is influenced by a social concern regarding the dangers posed by people with mental health problems. These perspectives interact to enplace service users as objects of risk subject to increased surveillance and mechanisms of control.

### **5.1.4 Construction of Risk Objects**

Service users were consistently associated with the concept of risk within interviews and observations, with risk being viewed as the most significant influence on decision making in relation to their care. Within this study, I suggest service users have been constructed as risk objects through the influences of professionals, organisations and society. In order to begin to understand this process of construction it is important to draw on the data to explore both what constitutes a risk object and what the implications of this identity are.

#### *5.1.4.1 What is a risk object?*

The construction of an object of risk consists of two components, the definition of an object and the association of that object with harm (Hilgartner 1992).

Objectification, or the treating of a person as an object, constitutes certain key principles according to Nussbaum's (1995) analysis. She argues, not all these features need to be present for objectification to take place. It is four of these notions that have particular relevance for the construction of service users as objects.

- 1) Denial of autonomy; here the object is treated as having no self-determination.
- 2) Inertness in which the agency of the object is denied.
- 3) Denial of subjectivity occurs when the object is treated as something whose experience and feelings are not relevant.
- 4) Fungibility is defined as when the object is treated as though it can be substituted for other objects.

In each of these features it is the objectifier that acts to treat the object in these ways (Nussbaum 1995). Using examples from the data, in the following section I will examine how service users have been objectified and what comprises an object. Three of these principles

can be examined in relation to Peter's experience. Peter was admitted to Lawrence ward during the time of the study.

*Observation, Day 2 Lawrence ward, ward review meeting*

*Peter, History given briefly; before Peter came in to the ward his depot was reduced due to side effects. He was changed to oral meds but had not been compliant and was taking illegal drugs. He is now back on his depot and is accepting it despite the side effects. He is on section 3. Peter attended the ward round and commented on how many people there were there, we were introduced but he was not encouraged to ask us to leave. He stated he had been dreading ward round. He was told by the consultant that he needed his depot to stay well. He said he wanted more leave and said he didn't like taking medication, didn't like that he was woken up in the morning and told to take a tablet. There was some negotiation (with the consultant and the consultant informing the nurse) on how the meds were taken but he was told to take them. Peter said in the ward round that he wasn't happy and felt manipulated but there was nothing he could do. All this was based on a conversation between Peter and the consultant and a brief discussion afterwards between the doctors in the ward round. The consultant also commented that perhaps he could reduce his depot when back in the community (interesting given rationale for re-admission and possible perceptions of risk). Nurse from crisis team commented that he has a very violent past, that she felt he was a psychopath and it was very difficult to manage his violence. Peter looked like he was shaking in the review, could this have been nerves or medication side effects?*

Denial of Autonomy

Peter describes his dislike of taking medication, this statement is not acknowledged by the professionals within the meeting as Peter is

given no opportunities to exercise his autonomy in choosing whether to take the medication or not. The consultant adopts a paternalistic stance by informing Peter that his injection is necessary for the maintenance of his health, justifying the denial of his autonomy through this process. This undermines Peter's own self-determination to make decisions regarding his health and his body. Peter's autonomy was marginalised throughout the decision-making process itself as his opportunity to contribute was controlled by the chair of the meeting, the consultant. Ultimately, the decision to continue with the depot whilst Peter was in hospital was made by the doctors with no explicit reference or consideration of Peter's experiences.

#### Inertness

Peter's treatment as a passive being, lacking in agency is reinforced within the decision-making process itself, discussion about Peter's life is initiated before Peter enters the room and the decision is ratified after he leaves. Inertness is also evidenced through Peter's perception that he has been manipulated. Within this statement Peter signifies his experience of being seen as unable to contribute to the decision. Additionally, his inertness is viewed in his description of the action associated with medication; for example in the act of receiving the tablet and injection as a passive one. His lack of agency is expressed by Peter directly in his recognition that he doesn't agree with and is unhappy about the decision made, yet is unable to do anything about this.

#### Denial of Subjectivity

Peter's emotional experiences of being in the ward round are ignored. He communicates his apprehension about being there and intimidation by the people present yet these remain invalidated. This denial of subjectivity connects with his lack of autonomy as his experiences of the medication, including side-effects are not seen as relevant to a decision as to whether he should continue to take it. A lack of his own feelings being taken into account up to this point may

be considered in relation to Peter's reflection that he is woken to be told to take a tablet. Peter's perceptions of the ward review are echoed as a common experience for patients by the professionals interviewed in the in-patient setting.

The observation of Peter's experience of the ward round provides an indication of the process of objectification within the in-patient setting. The next vignette is taken from observation of an informal discussion in the office of one of the community teams. It further demonstrates how Nussbaum's (1995) features of objectification provide insight into the identification of service users as risk objects within the data.

*Assertive Outreach, Team B Day 2*

*Discussion in the office with three qualified nurses, one of the nurses reported back regarding a new group for anyone who wants to withdraw from medication – and she suggested a couple of people might be interested – there is a support group run by a psychologist and [service user organisation]. The responses from some of the other nurses in the office led to a discussion around the issue. One suggested that if you don't think they are taking it then it would be difficult to do a withdrawal plan, that there is a need for the person to be consistent. Another nurse stated it needs to be someone who is well and stable who has been taking medication for years and is really well, that they are the people who they are looking at for the group and suggested that there is no-one that consistent here in this team. The other nurse mentioned there is one person who has no voices and is stable but they are a forensic client on low doses – she said she had spoken to the consultant – and it's not worth the risk.*

*A nurse from the other team (A) comes in to ask for contact details and joins the conversation, they give the example of a service user whose visits are being reduced –been weekly*

*then monthly, he used to go to [day centre] but the courses have stopped. We could take them to the recovery college but he suggests but there is a need to be careful as there's a course for stopping medication there. It was stated by the person giving the example that no he can't do that he's been OK with meds. He states, they don't understand that he needs to be stable and for our clients if they come off meds and relapse they end up on a section.*

Within the example above the withdrawing from medication group is introduced by Louise. In this examination it is the remaining three members of staff who are defining service users as objects.

### Denial of Autonomy

The nurses are acting as gatekeepers for information regarding a support group for the safe reduction of medication. The discussion highlights that a decision has already been made as to whether the service users that they are working with should attend the group based on the nurses' perceptions as to whether they would be suitable. Autonomy relates to an individual's right to make choices free from coercive influences (Beauchamp and Childress 2001). By denying service users the information about the group the nurses are not recognising the rights of the client to make a decision for themselves regarding whether to attend. However, it is evident from the extract that the implications extend beyond involvement with the group. What appears is the position amongst the nurses that service users should not be able to make the choice to reduce or stop their medication and steps are taken to decrease the likelihood of this happening. Exclusion from the opportunity to make that choice is highlighted in the statement from one of the nurses that they had already discussed it with the consultant and between them reached a decision that it wouldn't be appropriate for the service user to reduce their drugs. Failing to acknowledge the person's autonomy to both stop the medication and participate in decision making as a result.



This process does not recognise and act upon the autonomy of service users, particularly to make choices regarding their treatment.

### Fungibility

The nurses suggest that reducing medication would not be appropriate for all of the people using the services of Team A and B. In this respect a tendency to view each service user as inter-changeable is revealed in which the preferences and responses of individuals' remains unacknowledged as all objects (who use the team's services) are presented as responding in the same way to a medication reduction. This is most evident in the last statement which suggests that for all those stopping medication, there is a uniform response that would lead to being treated under the Mental Health Act.

### Denial of Subjectivity

Through deprivation of the opportunity to make a decision whether to attend a medication support group and reduce medication, the individuals own subjectivity is being denied. Psychiatric medication can reduce the intensity of distressing experiences and positively influence people's emotional state yet the debilitating side effects of taking medication are widely acknowledged particularly by service users. Medication can have a damaging impact on their quality of life (Busfield 2004, Weinstein 2010,). The discussion in the extract does not include any reference to the actual perceptions of any people that they are working with who are taking medication and in particular who may have had negative experiences relating to this. Shared decision making emphasises the person's rights to make choices about their medication and highlights the need for professionals to take account of their individual experience (Coulter and Collins, 2011, National Institute for Health and Care Excellence (NICE) 2009). In this respect the professionals show no recognition that the service users have a subjective experience and that this experience may be different from their own.

#### 5.1.4.2 Implications

Using two extracts from the data, examples of the process by which service users are defined as objects have been shown. Objectification is not always viewed as a malignant process (Nussbaum 1995). It may even be a necessary element of healthcare relationships and treatment (Timmermans and Almeling 2009). The following section examines the association of objects (service users) with risk within this study demonstrating that the process of objectification here can be a damaging one due to the impact this has on the level of control service users are subject to.

It is important to note that there are inconsistencies within the data regarding objectification. Two interviews (Louise and Lilly) within the community team show very little indication of objectification and there are further examples of participants recognising the subjective experience and agency of service users, though not always consistently within the same interview. For example Jack outlines the importance of listening to service users' views in decision making, suggesting that the long term relationship with service users promotes insight into their subjective experience.

*“I think it’s primarily based on the teams knowledge of an individual that stretches back years and the discussions that have taken place, knowledge of their care, their particular circumstances, what’s worked well what they have objected to. So that team members should be able to articulate an individual’s views and opinions even if they are not particularly of themselves ...I think is important to our work that people’s views and opinions are articulated, particularly when they may be find that very hard to do that for sometimes and maybe have few if any other advocates.”*  
(Jack)

The implications of perspectives in Louise and Lilly’s interviews are examined in detail in chapter 15. Significantly, however, within all of

the interviews it appears the association between service users and risk is demonstrated, a relationship that is also evidenced through the observations.

### **5.1.5 Characteristics of Risk Objects**

I have proposed that within this study service users are constructed as risk objects through the creation of links between them and potential harm. This is demonstrated in a number of ways. Participants related concepts of risk, in particular aggression and violence to service users during the interviews; establishing a connection between someone using the services (or object) and potential danger (or risk). This reflects Hilgartner's (1992) theory on the construction of risk objects, which entails both the construction of something as an object but also as a risk. This association was embedded when participants discussed, and the researcher observed, specific scenarios from the case study areas in which service users' actions were frequently interpreted through the lens of risk. Risk, therefore, tended to dominate the identity of service users and was present in decision-making. Vignettes from the data will be used to examine the definition of service users as objects of risk and the establishing of a relationship between the two.

*“If you know your client very well, you know when they are a risk to others or a risk to themselves so it depends whether you need to act very quickly and you need to involve other teams like crisis teams and whether or not it would help us - whether you need to increase visits. It kind of forms your decision in terms of, if the worst happens, would you want to be standing in her house cold? Depending on your knowledge of the client and the risks involved, I think public protection comes first, more so in the situations we deal with. So if you know the client very well you kind of act immediately depending on how they're presenting and the risks. Because things like self-neglect, things like that we*

*don't think they are an immediate risk, compared to someone who is going out wielding a knife or something like that. So you know depending on the level of risk and your knowledge of the client, how they're presenting and you base your decisions on that whether you need to ring the police or act asap, get a Mental Health Act assessment, plan for admission or increase visits depending on that.” (Ife)*

Within this extract service users are described in terms of their potential to cause harm. Within each statement that ‘client’ is mentioned so is the concept of risk, creating an immediate and obvious relationship between the two. Within this extract the contemporary conceptualisation of risk as synonymous with harm and danger is evidenced (Beck 1992, Lupton 1999). The service user is presented as having the capacity and potential to cause harm to both themselves and to members of the public. The suggestion that service users specifically have this potential presents them as something that is harmful. The pervasiveness of this identity as a risk object is evident in Ife’s inference that unless knowledge of the person suggests otherwise they are to be considered and treated as if they were dangerous in particular to the professional.

The definition of a client in terms of risk is shown within this extract to influence perceptions of the response that is required from the health professional. The nature of the risk governs the interventions required, for example whether to increase visits or to arrange a Mental Health Act assessment. The example given in this quote situates service users’ capacity for risk within an extreme context “...someone who is going out wielding a knife or something”. In this respect, the notion of dangerousness is reinforced through the heightened consequences of risk. The reality of such events perpetrated by people with mental health problems is rare (Laurence 2003, James 2006, Appleby et al 2013).

Ife relates the risks posed by the client to the potential for harm to both themselves and the public, presenting the danger to the public as more immediate. Boholm and Corvellec (2011) argue that it is the construction of these relationships between ‘objects of risk’ and ‘objects at risk’ that are significant. Objects at risk are generally appointed as something of value, with objects of risk as something that is identified as dangerous. There are two examples of the relational theory of risk here. Firstly, service users as the objects of risk and the public (safety) as objects at risk. Secondly, service users as both objects of risk and objects at risk. This second relationship is an important feature of service users as risk objects and is therefore examined in detail further in this chapter.

According to Boholm and Corvellec (2011) these risk relationships are based on perceptions of potential rather than actual acts. So using the first risk relationship, here Ife describes a hypothetical response to a hypothetical situation regarding a risk of harm posed by service users to the public rather than specifically discussing a person she has worked with. Relationships of risk are described as causal (Boholm and Corvellec 2011), where a direct threat is created between the object of risk and the object at risk. Within this extract service users are linked with causing harm to the public using the potential for rather than actual events. Finally, these relationships are linked with decisions to act having established the risk posed by service users to the public here, Ife communicates that an active response is required to manage this in terms of planning for an admission and so on.

This extract from Team A in the community team has provided an example to illustrate the process of linking service users with risk to construct them as risk objects. Following is an example from the in-patient team; this will be used to consider how in defining service users as risk objects a process of selection is taking place. The participant is discussing the ward’s observation policy.

*“Well I think it’s ... just for new admissions, potentially we don’t know them, potentially they are an unknown risk. So you have got to have at least that time to kind of have a look at what’s going on really, but as I say I think often there are patients that you have in who come a few times, you know within a year or what have you and they always present in the same way, so for them, but it’s a blanket thing but I think it’s again it’s best to be safe than sorry really I would always go with that.” (Zoe)*

Constructing something as a risk object entails a process of definition, where the boundaries and characteristics of that object are used to create identity. This is a selective process where some characteristics are emphasised and others ignored (Boholm and Corvellec 2011). Using this position it is, therefore, valuable to consider what is selected out of the above extract in favour of underlining new patients’ risks.

Zoe describes a lack of subjective knowledge in relation to people who are admitted to the ward who aren’t known to services. However, similar to Ife this leads to a situation where risk is viewed as the dominant issue and therefore the potential for danger should govern responses to this, “it’s best to be safe rather than sorry”. Uncertainty is prefaced and what is not visible is any aspects of that person’s identity that relate to their distress, emotional being, illness, fear or need for safety that may be part of their experience of being admitted to an acute psychiatric ward (Mind 2011). Such an emphasis also overlooks the well documented harms a person may be exposed to as a result of their service use and experiencing a mental health problem (Langan and Lindow 2004, Muir–Cochrane 2006, Thornicroft 2011, Boardman and Roberts 2014). The attention to risk in the context of admission emphasises how this can engulf their identity as again there is a process of prejudgement of the dangers posed by the service user.

#### 5.1.5.1 Service users as risk objects AND objects of risk

Ife's description of the potential of service users for self-neglect suggests within the relational theory of risk that service users can be both risk objects and objects at risk. Service users may have been defined as risk objects through their potential to undertake risky actions and therefore cause harm. However, within both the interviews and observation data, service users are also considered as vulnerable, open to exploitation and in need of protection by the mental health system.

*“God knows what happens if some vulnerable patients went out and did something silly. It’s like a safety net it always worries you when you are upstairs because as well as there being 25 patients and especially cos you have got people on observations and you know you have got that open door. I mean sometimes up there you have people on observations, we’re having to sit right next to the door to make sure that the patients weren’t going cos they were that vulnerable and unwell. If you have got let’s say 8 patients on observations, it’s a lot upstairs because you’re forever walking round, finding them checking they are OK signing and then if you are doing that one of yours on observations could have gone and you wouldn’t know it only takes a split second...So when you have got that locked door there it can make a big difference... well obviously may be take their own life is a big worry, not necessarily a risk to society to people in society but more of a risk to themselves or if their emotions are all over the place they might go and do something impulsive that they wouldn’t usually do.”* (Kimberley)

Within this extract Kimberley highlights her fears regarding the potential consequences if a patient leaves the in-patient ward without the awareness of the staff. Within this a concern is expressed that harm could come to the person from a tendency to

act impulsively or from a desire to take their own life. Here the service user is described as something that will come to harm, particularly without the supervision of staff. Vulnerability is presented as an attribute of some patients and therefore something which is embodied. Boholm and Corvellec (2011) highlight that characteristics associated with objects at risk are loss, vulnerability and a need for protection, which is evident in Kimberley's identification of the benefits of a locked ward to maintain safety. Within this extract, service users are also the objects of risk as the danger originates from within them. Here this appears as the potential for making unwise or unsafe decisions, therefore exposing themselves to harm and taking their own lives. The embodiment of vulnerability becomes evident as the 'selection' of characteristics to focus on does not acknowledge the potential for harm to come to 'vulnerable' service users at the hands of others. In this respect attention is therefore directed away from other risk objects (Hilgartner 1992).

The potential for service users to be constructed as objects of risk and objects at risk creates tensions. Given, according to Boholm and Corvellec (2011) and Kendra (2007) the responses to both positions are slightly different this potential for conflict is exacerbated.

*"...an example with the nursing team and the medical team, where I wasn't on but it was told to me as soon as I came back, that a lady was refusing to have bloods taken, refusing to eat, refusing to drink and the medical team insisted despite the nursing team saying we are not happy with this, taking bloods from the lady under restraint and it felt very wrong. The nursing staff that were on and I think, there were all males in there and the female present was the female doctor taking bloods. I think it all felt a bit wrong, that we should be doing that and when they reported that to me I wouldn't have done that because, I think they had followed all the proper channels, doing the mental capacity act assessment and kind*



*of covering themselves by that but I just think it .. it the nursing staff weren't comfortable with it and didn't think it was ...I can't remember whether it was that day or the day after the doctor said again he wanted bloods and he wanted to restrain her to take bloods. And I said I'm not happy with that and he was a bit well why and I said because she only had them two days ago, the results are normal, she is slightly improving and we have kind of lost all therapeutic relationship with her; she had started to come out of her room she had started to have a tiny bit of fluids and we have lost all that because now she just thinks we are going to restrain her..." (Emma)*

Within this vignette, as described by the participant, the woman is recognised as a risk object by the medical team. Here she is a danger to her health through her refusal to eat and allow monitoring of her bloods and therefore there is a need to control this risk, as is the response to risk objects (Hilgartner 1992). This appears within this vignette in both an implicit way through attempts to define and control the harm through measuring blood levels but also in a direct way through the use of restraint. From Emma's description of the nursing team, the woman becomes an object at risk, acknowledging the losses associated with the restraint both in terms of her experience of this but also in the relationships developed between her and the nursing team. This reflects Boholm and Corvellec's (2011) suggested characteristics of an object at risk associated with vulnerability, loss and need for protection. This difference in construction of the service user's role contributes to tension in decision making.

### **5.1.6 Summary**

The process of defining a risk object involves treating them as an object and making a link between this object and harm. Within this chapter examples from the data have been examined to explore how people with mental health problems have been objectified. Their

capacity for harm has been established as service users are associated with risk and therefore the potential to harm others or themselves. The dangers posed to themselves also positions service users as objects at risk within a relational risk framework. Through this construction people's other experiences and characteristics become less visible.

## 5.2 Chapter 10: Implications of Being a Risk Object

Within the data the capacity for service users to be understood as risk objects and objects at risk has been explored. Whilst the differences in the characteristics of both these objects has been considered, there is a similarity which is significant for this analysis; risk objects are seen to need to be controlled and objects at risk require protection (Hilgartner 1992, Boholm and Corvellec 2011, Kendra 2007). In the following section, I consider how this response is interpreted within the data. This includes the implications of being defined as risk objects for monitoring and control.

### 5.2.1 Observation

Being recognised as a risk object contributes to staff perceiving a need for service users to be observed and monitored. Within the community team this was expressed through increased contact with service users that enabled this monitoring to take place, as highlighted in the extract from Andrew below.

*“Risk, you know how whether someone is going to comply with their oral medication if you like and you know that’s going to lead towards them becoming unwell and all the risks which might go with that. I think having worked with other teams, I think because we can monitor people more closely we can see people every day or even for longer visits, we can flag so we can get an idea of whether things are deteriorating and assess the risks on an ongoing basis.” (Andrew)*

Observation brings risk objects into a mode of surveillance. Castel (1991) describes this surveillance process as systematic pre-detection where the aim of observation is to predict and therefore prevent an event occurring. Increased surveillance has been perceived as a response to risk within both mental health services and the wider community setting (Szmukler and Rose 2013, Crowe and Carlyle 2003). This intense observation may be indicative of networks of

surveillance discussed in Chapter 5 (Rose 1999). Such networks serve the purpose of protecting the community from risks posed by spoiled citizens and are maintained by mental health professionals. Within the extract from the interview with Andrew, close observation is justified as it is perceived to provide the opportunity to better understand the level of the risk the object presents. A link between risk, medication and monitoring is also espoused. The introduction of assertive outreach teams themselves has been linked with the purpose of monitoring by engaging those people with mental health problems who have distanced themselves from services (Priebe and Turner 2003). The potential for mental health professionals to enact a role in social control as part of this system has been acknowledged, though the tensions that this creates for practitioners are recognised (McAdam and Wright 2005).

The significance of observation in association with risk is reflected in the decision making structures of the community team itself. Team A and B had two weekly multi-disciplinary team meetings, these were observed by the researcher. The meetings that took place in the first half of the week lasted one hour and were attended by the team managers, consultants, nurses and healthcare assistants on during that day. The aim of these meetings was to talk about each service user, a requirement of this meeting was also to identify and record when each person was last seen.

*“It was about trying to at least make sure that we are touching base and trying to capture that group as well is my sense of why it happens. The problem is the time and the numbers it just doesn’t work out really. We really struggle and there are lots of other imperatives that have been put on us since, I think it’s probably come out of the [initials of service user] case in AO. There is a new system where we have to say when the person was last seen and who they were last seen by and when you have only got 50 seconds per patient actually trying to fiddle around, working out whether*

*did so and so see them when they were supposed to on that day and getting the data, actually you spend an inordinate amount of time, you know crossing the t's and dotting the i's and not talking about patients. That's come out of trying to be safer and certainly I don't want to speak for the rest of the team but I get a sense that some people share this view and I think it's almost being seen to be doing things properly."*  
(Lilly)

Lilly identifies that the review of service users becomes dominated by a need to record and assign responsibility to the time of their last observation. Within this, Lilly describes the contextual factors that have influenced the process which recognises that the construction and response to risk objects occurs within an organisational and social situation (see Chapter 13 and 14). In this respect it is not only the act of observation itself that has significance but also the act of recording it. Each team has a whiteboard in their office on which the *"Information recorded on the board is the name, date of planned visit, date last seen, location (MH including section and CTO), risk zone, medication and depot due date"* (Team B day 2 observation notes).

Such formalisation of surveillance is evident within the in-patient setting where local policy requires service users to be on intermittent observations for their first day in the ward. According to descriptions provided by participants in interviews the level of observations following this is clearly associated with their perception of the service user as risky.

*"At the moment we have a policy on the ward where we have patients when they are admitted go on 10 minute observations for the first 24 hours. That doesn't mean to say that they are necessarily re-graded to general observations after 24 hours but its that decision at that point where the dilemma is for me. I've nursed this patient for maybe 8 hours; do I know them well enough? Does the documentation give*

*me enough information to say yes we can take them off observations now? But also I wouldn't just let that dilemma rest with me, I would make it a team decision as to whether or not that person comes off or stays on observations.*

*(I)What kind of factors might influence the decision either way?*

*Whether I have known the patient from previous admissions, whether the risks had increased this admission, whether the presentation was different and more risky, the reasons for admission if particularly there had been self-harm or anything like that, the settledness of the ward, whether they were on a locked ward or not, that could influence the decision as well” (Charlotte)*

Here the consequences of being constructed as a risk object on the ward are evident in the use of the observation policy, based on the presumption of the person's behaviour as having the potential for harm. Placing patients directly under the regular or continuous observation of staff is a commonly used intervention in response to perceived risk within in-patient care (Neilson and Brennan 2001, Whitehead and Mason 2006). Observation has been criticised for perpetuating an over-emphasis on risk within this environment (Mullen 2009). Observations increase controls that patients are subject to, whilst according to Bowles (2000) demonstrating the organisation is efficiently managing safety. Surveillance in this respect is perceived as part of a well-established mechanism for institutions to identify and manage risk with nurses occupying a key role within this. According to Alaszewski (2006) this response functions as part of the panopticon in which 'inmates' are always observable. Within this vignette, Charlotte's individual response to decision making is evident but this is also located in the organisational context as the ward policy of placing everyone on observations on admission is highlighted. This further demonstrates

the notion of risk objects based on hypothetical dangers as the policy is applied to all admitted to the ward, despite individual experiences.

The notion that observations solely serve a purpose of surveillance and containment has been challenged (MacKay, Paterson and Cassells 2005). Mental health nurses have identified that observing can be an important opportunity for therapeutic interactions, the development of a relationship, assessment and responding to a person's individual needs (Mackay et al 2005, Hamilton and Manias 2007). Charlotte does bring other influences into the consideration of a change to the level of observations.

*“ ...talking to the patient as well I mean particularly if its around the example of observation levels some patients will know that they are not ready to come off observations, even after 24 hours I think in that instance I would definitely go with what the patient is saying they know how they feel.”*  
(Charlotte)

Within this statement, Charlotte also indicates that she would pay attention to the person's subjective experiences providing further alternative evidence to objectification. Though it is interesting to note this is stated in relation to whether the decision was to remain on observations rather than to reduce them.

### **5.2.2 Medication**

Being compliant with taking psychiatric medication is raised within the data and I would suggest appears as one of the consequences associated with being constructed as a risk object. This has already been evidenced through a number of the vignettes examining objectification of service users and their association as risk objects.

In the community team medication was recognised as a key intervention when risks were seen to increase, emphasising a relationship between a need to take psychiatric drugs and posing a danger. However, as indicated by vignette 2, in the previous chapter

the perspectives around the role of medication for those defined as risk object are more ingrained than that. Outlined below are two extracts that explore these issues.

*“ like the lady I was telling you about who has been, who has been terrorising her neighbours she's always been known to be very - when she's manic cause she's bipolar disorder, when she is elated and not sleeping she's been known to exhibit risky behaviours so at that point you know you have to act ... It's not something that's going to happen overnight, you know, you can see her mood getting worse and worse and then you try and get her extra medication but because you know her she's not going to take the full dose she will take part of the dose. Then you kind of increase visits and then at some point she'll probably refuse to see you, so that kind of informs what you need to do next you know that either she's going to be picked up by police which is not always good.”*  
(Ife)

This extract emphasises that the response to risk is to increase medication, suggesting that medication is perceived as a mechanism that acts as a means to control the risk (and the object of risk). Within this example, there is an absence of discussing any other therapeutic strategies that may help the person deal with the consequences of their distress. Moncrieff (2003) argues that the role of psychiatric drugs act to strengthen coercion within mental health practice. The emphasis on medication is seen to perpetuate a view that mental health problems would be controlled if service users were compliant with their drugs. This is a process which is recognisable within this extract in which the potential dangers posed by clients with 'risky behaviours' could be avoided with extra medication consequently here the problem lies with the risk object for not complying with this measure.



As has previously been highlighted, it is suggested the relationship between risk objects and medication extends beyond the perception that medication is only part of increasing risk or relapse. Following on from the discussion about a medication reduction group in Team B (outlined at the start of this chapter), the clinical psychologist who is external to the team but facilitates group supervision raises the issue with Team A. This produces a similar response from the other team. This vignette is taken from observation of Team A's team meeting where the reducing medication group was introduced.

*Team A observation, Final Day*

*Team meeting facilitated by clinical psychologist (Stuart). Part of the meeting is focussed on discussing team objectives around Recovery. The psychologist raises the coming off medication group*

*Nurse from team; Coming off medication, is not that successful.*

*Stuart shares an example of someone coming off meds in a staged way and of one person on anti-psychotic medication that is below the minimum recommended dose. Stuart suggested that part of the process might be informal talking about the possible consequences of reducing medication such as problems with mood, and then to consider with people whether they have looked at alternatives including resources and social support...He says that I know its difficult as people don't always make decisions in a planned way, maybe they could assume they wouldn't be supported.*

*Question from the team – do we have to support everyone with that decision? Especially people who become ill*

*Nurse - What about consultant involvement in discussion? Psychiatrist should be here but not here today. Junior doctors are more accessible but not willing to take this approach,*

*they feel it's too risky – they don't want to make decision without consultant. It needs to be considered, that our particular consultant is also more conservative.*

Within this extract, the mental health nurses in the meeting, present that being on medication is necessary to prevent illness; though it has been acknowledged that some people taking psychiatric medication do experience a relapse anyway (Moncrieff 2013). Concern is expressed that there is a risk to the professionals in supporting a service user with the decision, highlighted by the nurse in the suggestion that it was the consultant who should make that decision. This may be illustrative of a desire to avoid taking responsibility for a perceived increase in risk. This issue is explored more specifically in Chapter 12. As this example suggests, as a risk object service users are perceived to need to be on medication to maintain their well-being and safety. This reflects Szaz's (2007) view that psychiatric drugs are a form of chemical control.

Within the extract Stuart emphasises that the group entails talking with people regarding their choices about medication. It appears the responses of the team promote limited choice. This does not acknowledge that when shared decisions are made regarding medication, people are more likely to continue taking prescribed drugs (NICE 2009), recognising service users feel more able to take medication that enables them to continue activities they value (Deegan and Drake 2006). However, Jack, the manager of the assertive outreach team (with a social work background) does offer some insight into this perspective.

*“There are always dilemmas around medication typically - do we support people to be meds free or do we continue to plough on giving people medication? Encouraging them to take it when we know there is a kind of big down side in terms of people's health. And potentially its very toxic medication, which we don't know for people who take medication year*

*after year, if ultimately that could have a very serious effect on their physical health and we have not drawn them into that decision making that we have used our position to promote a course of action that people defer to.” (Jack)*

Power is integral to the definition of something as risky (Jasanoff 1999, Kendra 2007) with the powerful being those designating risk objects. Risk objects lack the power to challenge their objectification (Kendra 2007). This may be applied in this instance to the consequences of objectification in relation to medication. The following extract from Lawrence ward highlights that as a risk object the service user is also marginalised within the decision making around medication and that they lack the power to challenge this.

*“It’s trying to get a balance between promoting their involvement in their care and their independence with what we feel therapeutically is beneficial for them. Often may be, because of their standpoint on medication, on [the] Mental Health Act that kind of thing, it might differ quite a bit because of where they are in their mental health. You know they might be quite strongly opposed to medication now but in a few months’ time when it’s up to a therapeutic range and they’re well, they might be really grateful for it. Sometimes you feel you have got to make a decision that somebody, you know, they are not going to like and you almost feel you have kind of betrayed them.” (Zoe)*

Within this extract the service user’s own preference’s regarding medication can be overridden, particularly when under the Mental Health Act justified on the basis of the perceived benefit, demonstrating the service user’s lack of power in resisting medication and therefore the consequences of being defined as a risk object. Pilgrim and Rogers (2010) suggest that the importance of psychiatric drug treatment in relation to control is emphasised as it is easy to use via compulsion particularly compared to other treatments. Zoe does

however; clearly express the costs of not respecting service users' wishes for her.

There were some alternative views represented within the data. During interviews with Lilly and Louise, examples were given where service users were supported to come off their medication and Louise highlighted her personal views on the limitations of psychiatric drugs. The consultant with the community team suggested he would support people to come off medication particularly if this facilitated engagement. Additionally, Marcus expressed a more conflicted perspective on medication and the role of community nurses in promoting medication.

*"If it's to do with medication then the decisions ultimately in a way lie with the consultant, well I suppose that's not absolutely correct. The power of prescribing lies with the consultant, actually taking them lies with the service user so you know we are trying to provide a service and say to people, this is what we have got to offer and you can you know try this medication and that medication to some extent you know some clients may say well I want that one and the psychiatrists may say no so it's not a free for all.....My client said to me [own name], are you a drug pusher ? And I say yes! But the drugs that we sell to people that we promote they are no cure all, they are no wonder drug you know they have some very serious side effects and I don't think people should be forced to take them in the community." (Marcus)*

Risk objects are subject to networks of control, according to Hilgartner (1992). Within this research the use of observation and psychiatric medication has been examined as features of such a network of control. Once defined as a risk object the notion of risk dominates within that identity and consequently governs the responses to that risk object.

The extract below provides an example of how the status of risk object governs the responses towards service users, in particular by health services.

*“...there was a patient who was on a section. He has got a history of going AWOL but he had been on the ward for a while and he'd made no attempts or anything and we were contemplating whether to take him off obs or not. So we had a discussion and half of us were like yeah and half of us were like no and I was saying yeah so we took them off and he went AWOL (laughs). He went down to London but I said that there comes a point that you have got to risk take with somebody you can't keep someone on obs for ever ...*

*He went for about 2 days, and then everyone was going it's your fault. I thought oh god because in one to one time we had done some self-esteem work and increasing confidence. They went you gave him so much confidence he has gone down to London I thought oh god! In the past when he went AWOL he always went down London. He got off the coach the police were there and bought him straight back but he came on and he had a right grin on his face and he went oh yeah I really enjoyed it been for a walk and stuff, so he got no leave he had to be transferred down here [locked ward] as well*

*(I) Was he quite... distressed or was that because of the AWOL?*

*Because of the AWOL but he was happy about it. He actually said he doesn't mind coming down here, because down here he doesn't have to be on obs because we have got the locked door. What we do is we escort him off the ward for his cigarettes and a cup of tea and stuff and he goes off with a member of staff outside which he doesn't mind because he says he doesn't feel like he is being watched all the time cos*

*he can do freely as he would on the ward so it worked out OK.” (Kimberley)*

Kimberley reflects on some of the limitations of service users being subject to control through observations and how challenging this entails taking a risk. Within this vignette she also makes reference to the person’s subjective experience. Risk taking is associated with enhanced control and choice for the individual (Morgan 2000, Lupton and Tulloch 2002). However, the person in her description has limited power over his circumstance which is underpinned by his status as a section patient. For a risk object, lacking the authority to influence their situation is part of the definition of being risky (Kendra 2007). The person in this vignette contravenes the requirements of his section by leaving the ward without accompaniment by staff or in accordance with his section leave. According to Kimberley he reports his absence from the ward as a positive experience and from the ward’s perspective there is no narration of any harm that came to him during this experience. Yet the response to his absence is to increase the level of containment to which he is subjected. Interestingly, this is presented as preferable to the containment experienced by the patient in the form of observations (though Kimberley could have other reasons for identifying this such as that she feels guilty). Kimberley also highlights that increasing his confidence was a therapeutic goal, yet the response to the period of ‘AWOL’ is governed by the potential danger he may repeat this and the need to prevent a reoccurrence through an increase in containment and consequently control. This reflects Szmukler and Holloway’s (2000) arguments that people with mental health problems are subject to controls based on their potential for risk in ways that other groups are not, a situation that is legitimised by the Mental Health Act. Within this vignette the service user’s identity as a risk object influences the actions taken following his return to the ward rather than the actual consequences (possibly confidence and enjoyment) of him being away.

The description outlined by Emma provides further insight into the impact of defining service users as risky and the implications for reactions towards the risk object.

*“I think that sometimes it’s tricky whether to put I think observations is a big thing with regards to decisions ...for example... a patient was informal who was on general observations who wanted to go to a church service on a Sunday morning. When he came in he was very confused his short term memory was shocking you wouldn’t have wanted him to go off the ward or anything. On that particular day [he] presented as very rational; could tell me exactly where to go to go to the church, told me what time he was going, left me his mobile number, everything to suggest that he was perfectly fine. But it was all going round and round in my head, it just didn’t sit easy there was something that just didn’t sit easy that I was convinced that he could be alright. I ended saying to him yeah yeah you can go but literally 2 minutes afterwards, it was all a bit no I’m sure he’s going to be fine. 99% of me is sure he is going to be fine but there is a little niggle that’s saying he’s not. So I ended up running after him to bring him back to the ward and a member of staff taking him to the church service and giving him the number to ring up. We went to collect him which is not really part of our job role, but it was it was just something to make me feel better I think. He wanted to go, there was no reason why he couldn’t in his notes, in his section status information there was nothing. But there was just that little niggle of I am not entirely happy with this, so sometimes you get situations like that where you are a little bit and you kind of go with your gut feeling.” (Emma)*

The intuitive approach to risk assessment narrated by Emma is seen to be valued by professionals, facilitating the management of uncertainty and enabling complex decisions to be made (Godin 2004, Zinn 2008).

However, similar to the previous vignette the response to this intuitive perception was to increase the level of control via observation that the person was subject to. Being defined as a risk object, with the potential for danger, contributes to a level of concern that appears to justify the increased surveillance. Consideration of this person's rationality becomes excluded in favour of the more visible "risky" characteristics that have been associated with the service user in their construction as a risk object (Boholm and Corvellec 2011). Alongside the direct consequence for the service user there appears to be an implication for the mental health professionals too (see chapter 11 for more detail). Within these two examples both the nurses share a difficulty associated with the decision to reduce the level of observations that the service users were on. In this respect the consequences of being designated a risk object to the exclusion of other characteristics and the resultant increased controls serve to perpetuate that these controls are necessary.

Containment as a response to risk objects is less evident within the community. However, participants highlighted the barrier that being associated with risk can pose for individuals trying to access resources, even within mental health services. More evident within this case study was a brief reference to awareness amongst service users of being subject to control measures at the hands of mental health services.

*"I have got another client who says I am a police officer you know a community police nurse is what a CPN stands for. And we are a form of social control and policing, we police people's behaviour so although it sounds quite "oh god he's mad and psychotic and delusional it's not far off the truth in that kind of alternative way of thinking" (Marcus)*

### **5.2.3 Summary**

Within both the in-patient and community setting it is proposed service users were pre-dominantly constructed as risk objects.



Service users are defined as both objects devoid of autonomy and also as beings seen to pose a danger through the linking of objectification with risk. The implications of this construction interpreted within the data have been considered in terms of the controls risk objects are subject to, in particular observation and medication. To suggest that this was an unconscious process instigated by mental health professionals would be an over-simplification. During the interviews some participants were explicit about the dominance of risk in mental health services and the influences contributing to this position. Risk objects are part of a network according to Hilgartner (1992), the following chapters will proceed to explore the impact of professional, organisational and social influences on constructing service users as risk objects as part of this network.

## 5.3 Chapter 11: Distancing

The construction of service users as risk objects has been examined. Identifying and treating people with mental health problems as an object has been considered an important part of this mechanism. This chapter explores the conditions by which objectification is created and maintained in the case study settings. In this discussion I focus on a spatial and relational distancing process interpreted in the data which is expressed through the structures of decision making and professional roles.

### 5.3.1 Decision Making Structures

The relationship between health professionals and service users is spatially located and as such examining the constitution of this spatial component can give insights into the nature of the relationship (Liaschenko 1994). Using extracts from the data in this section I consider how mental health professionals in Lawrence ward and the community teams are physically distanced from service users. The implications this has for creating the conditions for the construction of service users as risk objects will be examined.

*“ I mean we tend to sort of on a shift by shift basis, we kind of discuss as a team, you know whose on, more so between qualified I think than with HCA's. Though partly because up here there does seem to be, as a qualified you do seem to struggle to get out of the office a bit but we do try and involve HCA's as well. Because obviously they're on the shop floor quite often, more than us and see things that we don't. So they'll be informal decisions like that, ward round, if the SHO's are often up a couple of times a week so we'll have a chat with them in the office, sometimes with the pharmacists if it's a particular meds related thing, supervision and then if you are just speaking to people's community teams as well.*

*Obviously you have got tribunals and managers panels and what have you but that is not a day to day type thing where we make decisions.” (Zoe)*

Zoe identifies that as a registered nurse the majority of her time is spent in the office where as those located within the ward on ‘the shop floor’ are health care assistants. This reflects my own experiences when observing discussions of individuals’ care as these tended to take place within the office, ward round or handover. In terms of decision making all references to interpersonal interactions in this extract, concern professionals and none recognise the service user. As such their presence is not visible or acknowledged here. Malone (2003) distinguishes three spatial types between nurses and patients which are essential notions within hospital nursing; physical proximity, narrative proximity and moral proximity. Physical proximity incorporates nurses’ practical closeness to patients, their role in caring for the person including the ‘diseased’ mind and body. Within this extract Zoe’s physical closeness to service users is not expressed. This is evident through her spatial occupation of the office, an area of the ward that is not open to service users and whose access to the space is controlled by those professionals inside the office. The ward office is described by Andes and Shattell (2006) as a fortress that patients need to breach in order to speak with a nurse. Proximity has been threatened through social, cultural and organisational changes in healthcare (Malone 2003). Nursing work has been reorganised so that they have become coordinators rather than deliverers of care (Flaskerud, Halloran, Janke, Lund and Zetterlund 1979, Malone 2003). This reflects Zoe’s description of the healthcare assistants as being located physically on the ward and therefore in closer proximity to service users. The value of such proximity is implied in her recognition that there is some benefit in this reduced distance *‘they are on the shop floor more than us and see things we don’t see’*. This reference to frequency mirrors Malone’s (2003) assertion that proximity is temporally as well as spatially

located. Unqualified members of staff are most commonly those involved in direct interaction with service users within in-patient settings (Bee, Richards, Loftus et al 2006). This closeness does not necessarily translate into input from healthcare assistants during decision making. They did not attend decision making forums such as ward round and on the only two occasions that I observed on Lawrence ward where a healthcare assistant shared their views in relation to a person's care, these views were overridden by the nursing staff.

The spatial distance is further emphasised when considering the relation between psychiatrists and service users in the context of decision making.

*"I think if a patient wants leave, let's say section 17 leave; the nursing staff will go into ward round, hand over how that patient has been over the past week, hand over what they think over whether a patient should have leave or not, have a bit of a discussion about it and then the consultant will either agree or disagree to leave. He will write the section 17 form or kind of document it in the notes the plans for leave. Then I suppose decisions after that would be if the patient deteriorated and we kind of thought, from leave being agreed Monday for the weekend and it was Friday and the patient was deteriorating, mental health or whatever, we'd discuss it and make the decision of no you're not doing well enough, especially with a section it can be rescinded by nursing staff." (Emma)*

Emma acts between the consultant and service user. The person becomes doubly distant from the medical staff both in terms of physical proximity and distance from decisions being made. The decision itself regards the person's liberty and notably the distancing here is taking place within the framework of the Mental Health Act. Alongside Zoe, Emma highlights the ward round as the forum for

discussing and making decisions in relation to people's care. It is this ward review that provides the boundaries for Emma, acting between the doctor and service user. Ward rounds are the most common place for consultants to meet with their patients within acute wards (Hodgson, Jamal and Gaythri 2005) yet are not valued by service users (Rose 2001). Spatially, on Lawrence ward these were located within a setting at the end of the ward away from service users with professionals acting as gate-keepers to participation. Participants on Lawrence ward identified the consultants as having the most power within decision making whilst service users and health care assistants have minimal influence. This suggests an emergent inverse power relationship between proximity to service users and influence in decision making.

Within the community team, decision making forums most frequently occurred in the team office base. These forums were reported as regular discussions between different members of the multi-disciplinary team, primarily nursing and social work staff, team managers, consultants and the psychologist.

*“There are shift leads who you would expect to lead that process and ensure those decisions are made and then there will be the twice weekly MDT decision making sessions where everybody's care is reviewed. Medics are present there as well so there will be decisions about whether or not somebody's medication needs to be altered, whether or not we make bigger decisions about whether or not mental health act assessments are going to be called for example. But quite kind of significant changes to somebody's care but also minor tweaks and nudges as well and then there is the CPA meetings which are meant to take place at least annually but we attempt to do more often than that in AO where service users themselves and carers should be present and other people who are involved in people's care so it's more of a collective response. But even though individuals aren't*

*present on a weekly or even daily basis their views and opinions should always be taken into account in terms of decisions about somebody's care.” (Jack)*

Jack refers to significant decisions being made within these team meetings. This is a common theme in the interviews in the community setting where complex decision making was clearly located within weekly discussions between mental health professionals. Whilst Jack's extract makes more visible the voice of service users, spatially they are not present within the regular decision making structures (with the exception of the annual CPA review) supporting Malone's (2003) assertions regarding the erosion of physical proximity. Other references were provided in the interview data from the community case study of straightforward decisions that would be made with a service user. Examples included arrangements for a visit but the more significant the decision was perceived to be the greater the spatial distance there was from the service user as the situations were brought to the multidisciplinary forums for discussion.

The spatial distance between professionals within the community team setting and service users was also influenced by the role of administrators (associated with the team or the building).

*Team B observation notes, day 1*

*Administrator comes into the office to report they had taken a message from Luke's mother, he's hearing voices, these are getting worse, she's worried about him. Luke's key worker is on the next day – it was decided by the nurses in the office for the message to be deferred to Luke's key worker. Green dot placed on board, directly by nurse, not really any discussion (Interpretation at time – interesting how much administrator gate keeps as 3rd message from client or carer that is passed on today). There has been discussion during the morning with other agencies, wards and professionals regarding decision making on the phone.*

Within this extract it is the team's administrator who has direct contact with service users or family members over the telephone when they initiate contact with the service. The decision in terms of how to respond to this contact (in the short term) is taken by the mental health professionals present in the office who have not had the direct interaction with the service user or family member at that point. This could reflect an inverse power relationship between proximity and authority in decision making. Here Luke's mother is spatially the closest but has minimal influence in the response to her son.

The psychiatrists within the community setting placed greater emphasis on developing relationships with service users though there were other factors that influenced the extent of the distance between them and service users. This difference is examined in Chapter 12 and 15.

The home as the place of care can promote different and in some cases more equal power relationships between health professionals and patients (Peter 2002). Liaschenko (1994) highlights that the extension of healthcare into people's homes threatens individual agency, traditionally expressed within this privately bounded space. The capacity of people with mental health problems to express this agency is even more limited through the legislation that they are subject to which can define their use of place and extend into their home.

*“Well more recently there's a client who is actually in hospital at the moment, but it probably got to, we were putting in a lot of support you know at least 3 visits a week sometimes more. I think it got to a point where I had to move towards a mental health act assessment because (pause) of family and police, housing patch managers all kind of you know communicating with me one thing or another and I guess all those things together kind of added up but I did try*

*and manage that for as long as I could before I called for a mental health act assessment.” (Andrew)*

Within this extract, extensions of healthcare into the persons own environment is evident alongside the impact of the Mental Health Act in altering the place of the service user from home to hospital. This reinforces the perspectives outline in Chapter 3 that Mental Health Legislation means people with mental health problems are subject to compulsion in ways others are not (Szasz 1989, Vassilev and Pilgrim 2007).

Though the concept of Liaschenko’s (1994) home as a space where agency can be respected is challenged by the many difficulties faced by people using assertive outreach services, that may include those without a home or living in transient housing environments (Wharne 2005). Assertive outreach models have been commended for holistic strengths based approaches to care alongside the provision of practical support to people who due to the complexity of their needs can miss out on help provided by statutory services (Sainsbury Centre for Mental Health 1998, Meaden, Nithsdale, Rose et al 2004, Morgan and Felton 2013). However, concerns have been expressed that the concept of ‘assertively’ engaging with service users can be coercive with pressures to comply with treatment and service driven agenda’s; consequently undermining an individual’s agency (Williamson 2002, Davidson and Campbell 2007).

Decision making structures evident within the case study settings may promote a distance between service users and professionals. This inhibits insight into people’s subjective experience, contributing to the conditions where objectification is possible. Treating a person as an object is part of the process of being defined as a risk object.

### **5.3.2 Environment**

Control of and access to the environment within the case study settings is related to the spatial distancing between service users,



mental health professionals and wider society. Within Lawrence ward, a decision had recently been taken by the organisation for the ward door to remain locked, though the mechanism for this had yet to be fitted.

*Extract from observation Lawrence ward, Day 1 and 2*

*The ward is currently open but will be being turned into a locked ward, with a fob system being introduced. The nurses talked about being worried that the people on the ward may be feeling trapped, that they wouldn't be allowed out for a bit of "quiet" time. They were also worried that staff time will forever be taken up by being at the door.*

*More conversation about the locked door. Nurses felt this was about the abscontion risks of having an open door which would mean they would have less need to transfer people to [other locked ward]. It's unclear why there has been a decision to go to the locked door. Some staff don't agree with but suggest it's not ours as to question why.*

The implications of a locked door for service users freedom of access to and from the ward is recognised by one of the nurses during their discussion, which was compared to the potential within unlocked environments for people to leave the ward without permission and therefore abscond. This was despite evidence to suggest that abscontion is associated with a broader range of factors such as service users experience on the ward and personal responsibilities (Bowers et al 2003). Historically, locked asylums have been recognised as a mechanism of segregation and containment, spatially and ideologically separating the mentally distressed from the general population (Scull 1979, Philo 1987). Locked doors on Lawrence ward enable a clear spatial distinction to be drawn between those inside the ward and those outside (them and us) with access between the two being governed by the staff on the ward via the fob access.

However, Foucault (1977) notes hospitals carefully designed their openings and means of access, developing a system of surveillance as a form of disciplinary power. In this respect the introduction of the locked door may be replacing a containing system of surveillance with a mechanical one, reflective of a general trend within acute psychiatric environments towards locked doors (Ashmore 2008). A comparison of the currently unlocked Lawrence ward with the locked acute ward located in the same building was made by some of the participants, particularly due to their rotation between the wards. The locked door was seen to provide some security for staff in terms of decision making, particularly in relation to reducing observation level (and therefore surveillance).

The configuration of space is different for service users using community mental health teams. Team A & B were based at Acorn centre. Here access to the space was also tightly controlled by mental health services.

This extract is taken from field notes of the second day of observations at Team A. Carl had a red dot against his name on the board as he didn't have a permanent home. He had arrived at the reception of the building where the team is based that morning. His key worker Tim was talking about the situation with Carl in the morning handover

*He [Carl] has arrived in reception not sure what he wants, he has been coming every day. He should be encouraged to go to housing advice but not sure – depends on why he has come. It's probably for money or cigarettes. He's asking for coffee- is it a good idea it might keep him quiet (there is no communal coffee). Different member of staff (Mike, HCA) – it would be better not to start that [giving him coffee] or it will never stop. Tim says he has rung housing aid. Tim offered*

*to drop him off but not sure if he will go as he has sabotaged the placement already.*

*Mike says - we'll just have to ring the police to ask him to leave. He used to do this in the previous team base and has damaged furniture in the past. Carl asked to speak to Tim, to chat with him. Tim said that the dilemma was whether to give him coffee or not, it helped to calm him but don't want to reinforce him to expect this or encourage him to come down.*

*Conversation returned to Carl later that morning*

*Tim took coffee to him outside, coffee worked though he won't go to housing aid on his own but will beg for food. Need to deal with as worried about whether he will come back over the weekend. More concern about Carl– Don't want him in here at the weekend with minimal staff, adjusting arrangements for opening up building to avoid access.*

The ways in which people with mental health problems have access to and use different spaces within an urban setting is seen to reflect their status as a marginal group (Pinfold 2000). Within the context of community care mental health centres can provide a place where the expression of distressing symptoms is permitted, in a way it would not be in other places such as the city centre (Parr 1997). Yet the references to Carl's use of the building where the team was based in this vignette are focused on moving him away from the building or preventing him accessing it. The debate amongst the staff about whether to offer him a drink highlights a concern that there could be a cost (him returning) in making him too comfortable in those surroundings. Contrary to Parr's (1997) suggestion the community centre is not providing an environment where his distress is accepted, instead there is a move towards excluding service users from the space.

Difference can be spatially situated. Here is an example of a space utilised by professionals where complex and important decisions are made. The boundaries of this space are protected from the inclusion of service users. Demonstrating a separation of the ‘us’, who aim to protect our space and prevent the ‘them’ from entering or remaining in it (Wolch and Philo 2000). This utilisation of the community building was represented in further examples during the interviews and observations. A spatial segregation reflective of the position of people with mental health problems in the wider community is observed within the team base whereas the locking of the ward mirrors the spatial segregation of the total institution. Such spatial segregation according to Philo (1997) results from an understanding of ‘madness’ as difference.

This section has considered a physical distance evident between service users and mental health professionals in the case study settings and how this is framed through decision making structures. Power to influence the decision making process appears inversely related to the proximity that a person or professional group has with the service user. The construction of spatial relationships and the use of space within Lawrence ward and the community team begins to illustrate a separation between people with mental health problems, mental health professionals and society. The following discussion will consider the implications of this separation and how this links with service users being defined as risk objects.

### **5.3.3 Relational**

The distance between qualified mental health professionals and service users extends beyond a physical one to include distance within the relationship between the two.

*“You don’t get that opportunity up here the same. You have got 25 patients and you have got on average of 2 or 3 staff nurses a shift and you just don’t get the opportunity to do it; it’s a shame, you do depend a lot on your care staff who do*

*... speak to the patients a lot more. You're obviously watching how somebody is presenting, if you can see someone becoming more agitated, anxious then you can say to them come and have a chat with me and make a decision from there .. it's sad more than anything."* (Natalie)

Within this extract Natalie communicates a lack of interaction with patients on the ward. Instead, informal observation is again highlighted as a means of relating to service users, identifying when conversing directly with a service user would need to take priority. According to Malone (2003) narrative proximity within nursing is characterised by getting to know the person's life story and sharing this knowledge with others who have a caring role for them. Within this extract the only reference to the person's possible subjective experience is viewed in the context of a medicalised expression of emotion rather than consideration of the person's own narrative. The arrangement of staffing is highlighted by Natalie as a barrier to relating directly to the person. Problems created by nurses role as coordinator of care and the increased use of temporary staff are recognised by Malone (2003) as hindering the physical and therefore narrative proximity in nursing. Nurses are prevented from spending time with service users and getting to know their story. This process is reflected in the extract from Natalie's interview. However, alternative perspectives have been promoted to suggest that nurses do actively avoid developing relationships with service users (Flaskerud et al 1979, Moyle 2003).

Within the community setting there was less frequent evidence of distancing from the narratives of service users. However, where this did occur this was often surrounding choices regarding medication

*"I suppose one of the slightly different examples would be when there are slight differences of opinion amongst say for example me and our doctor. I have got another client who is got a diagnosis of schizophrenia but isn't on any medication.*

*He was visited by a junior doctor who felt she wasn't ill enough for him to prescribe anything and that was something that I brought to the MDT for lots of other people to discuss. Really because both me and the support worker who sees her a lot feel that she might benefit from medication. She is in residential care so it would be quite easy for people there to help administer that; she is a bit ambivalent herself.” (Eric)*

Eric's description provides limited insight into the perceptions associated with medication for the woman he is working with and what this means in relation to her own narrative. Here her experience is understood in terms of her diagnosis and how this diagnosis relates to a need for her to take medication. Discussion regarding this decision is something that was taken to the MDT and therefore distanced from the woman involved. Malone (2003) identifies that “standardised systems” can promote distance; here Eric focuses on her diagnosis which may act as such a standardised system. A further, though isolated example of insight into distancing from the person's narrative was provided by Tanisha, a healthcare assistant working in Team B.

*Don't really know sometimes you can have it with certain clients, not everyone knows all the clients in the team. I have clients who are African-Caribbean's they don't like medication, think been putting things in it, phoney names we don't understand it. They could manage as they are in Jamaica but not in England. If they do anything outside the house in England, they're seen as odd/ill in Jamaica it's OK, people chat and talk in the garden to themselves. Here you tell the person to take their medication because of this.... Not understanding background and culture, once understand culture and background able to understand people and there are no barriers. (Tanisha, not recorded)*

Tanisha describes how as a service, there is potential for professionals to be distanced from individuals' narratives due to a lack of cultural understanding. This is located in a social context, as the country and dominant culture is seen to medicalise experiences which may be accepted in Afro-Caribbean cultures. Mental health services in the UK have commonly been criticised for cultural bias in diagnoses and misinterpreting cultural expressions as symptoms of illness (Fernando 2005). The increased incidence of people from Black African and Afro-Caribbean populations receiving physical treatments and being subject to compulsory care is well documented (Fernando 2005, CQC 2011).

Participants distance from interaction with service users in the in-patient ward and examples of distance from their subjective experiences in the community suggest a relational distance between mental health professionals and service users in this study. These processes are closely related to the features identified as part of objectification in Chapter 9 that enable people to be constructed as risk objects as they entail moving away from the subjective experience of service users. For Malone (2003) moral proximity is dependent on narrative proximity, moral proximity incorporates the actions of being there for *this* patient, of distinguishing their experiences as unique. Using the vignettes from Natalie and Eric a lack of moral proximity through either not being there or failing to consider the individuality of the person's experience becomes evident. The objectification characteristic of 'fungibility', treating everyone as the same (Nussbaum 1995) can be recognised here.

Moral proximity is characterised by professionals being closely exposed to an individuals' distress. Yet conversely it is the potential consequences of such close interaction with others vulnerability and pain that provides further reason for a distal relationship (Menzie's Lyth 1960, Williams 2001). This paradox creates the potential for tension for healthcare professionals. Within the data a number of the nurses interviewed within the in-patient setting referred to a difficulty

in managing tensions in certain scenarios. These tensions were often narrated as incongruence between what was perceived as a service user's preference and what the professional viewed as the gains of that action for the person.

*"...they might be quite strongly opposed to medication now but in a few months time when it's up to a therapeutic range and they're well they might be really grateful for it. Sometimes you feel you have got to make a decision that somebody, you know they are not going to like. And you almost feel you have kind of betrayed them, because you have built up a therapeutic rapport and they see you as doing something that they don't want so much. But you kind of just have to see the bigger picture I suppose and say you know it's going to benefit you in the long run but it doesn't always feel very nice." (Zoe)*

According to Menzies Lyth (1960) part of the system that develops to manage such anxiety experienced by nurses is to repress or deny these troubling feelings. Within this example, whilst Zoe does acknowledge that these tensions result in an unpleasant feeling, these are rationalised and therefore undermined as a necessary part of delivering care in a person's best interests. The consequence of such tension would be to avoid the situations that create the anxiety, which is relating to patients. According to Menzies Lyth (1960) this is achieved at a systems level through the organisation of healthcare work and tasks. The spatial and relational distancing identified within the case study settings may be a function of managing tension as ultimately 'closeness' to service users is avoided to manage these uncomfortable feelings. This avoidance is viewed in the distancing from those associated with risk (service users), therefore spatial and relational distancing functions to both create and maintain the conditions for the construction of service users as risk objects. Professionals avoid the distress caused by working with risk objects



which creates the very conditions that enable them to be constructed as objects of risk in the first place.

*“I think time can be, I think we can sometimes get distracted by other things. I think it can be kind of work can be very intense and sometimes by the end of the week if you have been working all week people are pretty worn out. And by Friday afternoon you are thinking, you know you have got your fingers crossed that nothing is going to come in that is too sort of disturbing. But at the same time you are going to be conscious of that; thinking keep focussing keep looking out for what’s going on. Perhaps on a Monday morning as well, equally is that when you are new to the week you are not warmed up yet, you are not in the swing of it yet, there are dangers that you might kind of miss things for whatever reason. There is stuff there about people not feeling confident about their decisions because they may feel they might be criticised for that or be scared of the ramifications.” (Jack)*

Jack identifies the demanding nature of a role working in mental health services suggesting that this might mean for some there is a difficulty coping with such complexity and being able to make clear decisions. Decisions also create anxiety; Menzies Lyth’s (1960) work identifies a number of mechanisms used by nurses to reduce the anxiety associated with decisions. Her work examined the personal costs of nursing and the associated responsibility. Jack’s description here alludes to the personal costs and tensions of remaining vigilant for ‘difficulty’ but wishing to avoid it. According to Menzies Lyth (1960) responses such as those outlined by Jack represent part of a defence mechanism characterised by avoidance of the emotional experiences associated with guilt and uncertainty which are created by healthcare work. A successful defence is achieved by avoidance or removal of those tasks and relationships that cause anxiety. These anxieties for Menzies Lyth (1960) are grounded in a psychodynamic defence mechanism arising from interaction of primitive instincts.

Such defence mechanisms are important for understanding the role of distancing, as interpreted within the data for enabling the construction of service users as risk objects.

The issue of risk appeared to create such an anxiety for some of the participants.

*“I think going back to what I have said is within mental health it is hard. I think people do find therapeutic risk taking hard and this sounds awful but let’s be honest if everyone was on a section everything would be easier but they are not and that’s not a good idea. Because you do get voluntary patients which is good, that they think I need to come to hospital to get well but I do think people think if everyone was on a section it would be a lot easier because then you have a lot more control.” (Kimberley)*

Within this extract from Kimberley on Lawrence ward she highlights the area of decision making around risk, in particular therapeutic risk taking and reducing the controls placed on people by mental health services as creating difficulty. The Mental Health Act is perceived as a mechanism to help manage this as it creates a degree of certainty and control for the professional. Risk is related to uncertainty and has been defined as, both the threat posed by uncertainty and the response to this threat (Alaszewski and Coxon 2009). Kimberley’s reaction to this uncertainty and the threat that it causes in the extract above is to appeal to a situation where it is perceived more certainty is created by the boundaries of legislation.

Unease about risk was also expressed by professionals in the community team. Here Louise explains that it is something that is ever present,

*“So but I think weighed against that there is all this thing about risk and I think it does affect our practice definitely. It is always in the back of your mind and I think we have all got*

*that mentality of in certain situ... well maybe all the time but certainly in certain situations.” (Louise)*

Perceptions of risk can create concern as expressed by Louise; Hawkes et al (2009) discovered that the terms ‘risk’ and ‘worry’ were used interchangeably by participants in their research examining risk awareness. In this respect, risk creates feelings of anxiety for participants. Returning to the work of Menzies Lyth (1960), defences are instigated by professionals to avoid the experience of such feelings, promoting a distal relationship from those perceived to be associated with risk and therefore such distress. Godin (2006) highlights how such perceptions of risk in mental health services can interfere with the ‘caring’ function of mental health nursing. Identification of a concern regarding risk has been suggested in itself to create an experience of unease for participants. However, it is in the association of this risk with service users that acts to create and perpetuate a desire for distance.

Risk is associated with both negative feelings for participants and the notion of ‘uncertainty’. An aspect associated with uncertainty is the unknown. Within the study knowledge of the patient was identified by participants as significant in relation to decision making. Here not knowing the person was generally viewed as problematic.

*“I think on a daily basis dilemmas occur I don’t think me personally that a dilemma doesn’t occur daily. It could be something that’s what might be simple to some people as reviewing a patient’s observation levels. For me it wouldn’t just be oh they’ve been fine for 24 hours let’s do it, it would be a much bigger decision I think that’s probably part of my insecurities rather than anything else about doing the right thing....Are we doing it at the right time ? Do we know the patient well enough to be doing this at the moment? ...But it’s that decision at that point where the dilemma for me I’ve nursed this patient for maybe 8 hours, do I know them well*

*enough? Does the documentation give me enough information to say yes we can take them off observations now?" (Charlotte)*

Initially, this vignette could be viewed as challenging the interpretation that there was a physical and relational distancing between service users and staff in the case study settings, as Charlotte expresses a desire to have narrative proximity. However, it is the identification of patients as unknown that creates feelings of anxiety here. This perpetuates both a perception of the person as a risk and, a need to maintain a distance in order to defend against such feelings created by the uncertainty of risk. Being unknown in the form of stranger is also a feature of otherness. From a psychoanalytic perspective the most hidden part of our unconscious (which is not known to ourselves) becomes so distressing that it is something that is externalised onto others. According to this perspective, projection onto strangers enables us to act out the hostility towards them that we really feel towards what is unknown within (Kearney 2003). In this respect, the unknown other becomes a threatening stranger, who is defined as different from self and therefore needs to be kept at a distance. Otherness is significant to risk and the fears projected onto different social groups (Douglas and Wildavsky 1982, Lupton 1999). That which is seen as different from self and therefore strange is the focus of concern and potential danger, a risk (Lupton 1999, Warner and Gabe 2004). This contributes to a dual process for some participants, one of distancing due to protection of self from dangerous other and also distancing as defence against the anxiety created by this conceptualisation.

Uncertainty, in healthcare staff is created where there are these expectations of difference in patients. This can impact on their experiences of care and create the potential that they become overlooked or treated differently (Myhrvold 2006). This is discussed by Louise, as she identifies that some of her colleagues perceive

people with mental health problems in a way that means they are treated unequally.

*“...there can be some dreadful attitudes sometimes; I think really I’m sure if this is risk or whatever. Recently they were talking about having some sort of weekend break with some clients and they were talking about where they can go. I think Skeggy was mentioned and someone said, I think centre parcs and then there was an attitude, oh well you couldn’t take them there kind of like, well they don’t behave themselves or they’re not, they are not good enough to go there. I mean that’s appalling, absolutely appalling really. And you can get that a little bit with some of the supported, I don’t know how much you know the supported accommodation but my favourite is [name of unit] because it’s homely and it’s nice. Sometimes when supported accommodation has been discussed for some of the clients and I’ll say “oh what about [name of unit]?” and they’re like oh they can’t go there. It’s almost too nice for them and you’ll like of course they can and you know people live up to their environment as well; you know if you are in a nice environment you are more likely to behave nice and that sort of thing so they can be a few kind of judgements like that which aren’t too healthy really.”*  
(Louise)

Louise’s suggestion that certain spaces may not be perceived as appropriate or accessible for service users reinforces a notion of spatial distancing. It also highlights the position of people with mental health problems as ‘other’ (perpetuating moral distancing) who need to be kept separate from ‘us’.

The strongest and most consistent evidence that challenges this position on distancing, is provided by the interviews with Lilly and Louise. Exploring data from these participants provided insight into how proximity may be promoted which is considered fully in Chapter

15. However, where participants discussed their work with specific service users, there were instances where this included some reference to the persons own narrative though these were rare. Within the extract below discussed by Prima, Malone's (2003) notion of a temporal component to proximity is again highlighted. Here Prima draws on her knowledge of the person developed through her initial work with him when she was training to be a nurse.

*"I kept arguing it because I have known him since I was a student on the ward and kicking off, you know and really kicking off on the ward because he can't deal with closed areas. And you know around staff dominating on him, it's just he can't deal with it. He can't deal with being on the ward in hospital and all sorts and I kept saying he was never going to have any bloods taken off him so how would we? You know because clozapine is quite personal if you get the bloods and you have to start with the weekly bloods and if somebody is saying I am not having them how can you?"*  
(Prima)

Both Edward and Sebastian the other consultants interviewed highlighted the importance of their relationship with service users and the need to listen to them.

*"I actually find it surprisingly easy because say in terms of their relationship with me they find it quite easy to forget who I am actually. They are happy just having a relationship with another individual; that's part of how it works as I guess a more extreme example of that was a sort of a chap one of our afro-Caribbean clients who when unwell believes that I am black as well as a way of allowing me to be safe . And so its kind of thinking that a big part of the skills set, I think its probably true, across the team that maybe and from a medical perspective, as we are seen as one of the purveyors of authority, is being able to divest yourself and I see doing*

*that in the context of having a reasonably friendly relationship with someone.” (Sebastian)*

Within this extract Sebastian expresses a desire to reduce the distance between himself and service users, providing an example of when perhaps this has been successful. Sebastian expresses a perception that the power associated with his role may have the potential to exacerbate a distance from service users and therefore investment in the relationship is needed to challenge this.

An awareness of the impact of spatial distance as a result of the decision making structures on the wards is narrated by Natalie. She discusses an example of a complaint being made by a service user who requested that the minimal number of people be present in ward round, Natalie supports the persons request (though doesn't highlight how this was advocated) but this is ignored by the consultant chairing the meeting. Within the narration Natalie refers to the person's emotional experience. Through this example the inverse power relationship between proximity and authority in decision making is perhaps expressed.

#### **5.3.4 Summary**

Spatial distancing results in a separation from service users own experiences and an understanding of those experiences as unique to an individual. Being removed from the person's subjective state creates the conditions where it is possible to act to treat a person as an object, denying their subjectivity, individuality and autonomy (as outlined in Chapter 9). The distancing process itself may be an act of protection by mental health professionals to manage the distress and anxiety created by working within health services with people who are unwell and traumatised. However, it may also be an expression of a deeper desire for personal protection against the strange, dangerous and therefore 'risky' other. Distancing contributes to creating conditions in which people with mental health problems can be

constructed as risk objects as well as a consequence of this construction.

#### **5.4 Chapter 12: Professional Influences on the construction of risk objects**

Risk objects are constructed as part of a network with professionals acting as powerful agents in emplacing these objects according to Hilgartner (1992). Within this study it is proposed that central features of the network that act to emplace service users as risk objects are the influences of mental health professionals, the influences of the healthcare organisation and the influence of society. In this chapter I examine how the perceptions and actions of mental health professionals may contribute to constructing service users as risk objects.

Professionals' perceptions are clearly shaped as part of a professional, organisational, political and social system. This chapter touches on these influences; though it specifically focuses on my interpretations of the nature of professionals' expectations and how these may act to construct service users as objects of risk. Chapter 13 and 14 deal more fully with the wider influences on professionals' views and the



participants account of the constraints that was perceived to be placed on their decision making.

#### **5.4.1 Mental health professionals' perspectives on risk**

Risk was identified in the majority of interviews as a dominant part of the role of mental health professionals.

*“I think for an acute ward, risk is the key influence, in the whole reason why someone is admitted. Whether they be on a section or not the risks are obviously classed as great enough to warrant an in-patient admission...I genuinely think that risk assessment is continuous it's ongoing, it's an everyday, every minute part of the role and it's probably the most important thing as to what influences decisions. For me personally it is and I think as an acute ward, that's probably how an acute ward is run. It's all about continuous risk assessment for each patient...” (Natalie)*

Risk appears increasingly present in the work of professionals, in particular those employed in health care. Managing risks associated with service users is a core competence for mental health professionals as highlighted by Natalie (DH 2006, NMC 2010, British Association of Social Workers 2012, Szmukler and Rose 2013). Within this vignette risk is presented as the reason the service is needed. Risk is commonly perceived as a rationale for admission to acute mental health care (Bowers, Simpson, Alexander et al 2005); a position that was echoed by some of the respondents in the community team. As Natalie describes, risk becomes fore-grounded in relation to the person with mental health problems on the ward, as it is perceived as the reason for them needing to be there. This reveals that there is a potential association between a service user and the concept of risk. Such an association is reinforced by the position that risk assessment is a constant and important part of nursing work. Drawing these factors together, the expectation that service users will

be a risk is set up contributing to the construction of people with mental health problems as objects of risk.

Natalie expresses that an increase in risk is characteristic of the reasons why a service user may be admitted to hospital. As highlighted in Chapter 5, Rose (1999, 2000) claims that the assessment and management of risk are fundamental aspects of mental health professionals' work, enacted as part of a network of control. Through surveillance professionals undertake a role to protect the community by identifying those individuals of such high risk that they need to be managed through containment. These arguments may be reflected in the assertions of those participants who identified risk as the main reason for admission to in-patient care settings.

Natalie's descriptions focus on both the importance and invariability of risk. Identifying risk in this way creates the potential for it to dominate responses to a person with mental health problems as it lacks any specificity to that persons' own situation and their individual need for safety or potential for harm. Such a position could contribute to creating a situation where all people with mental health problems are constructed as "risky" and as such responses to the person can be governed by this view.

The precedence of risk within daily practice was recognised within the community team setting and was identified as a key influence on decision making by the majority of participants in both case studies;

*"Well, I think that obviously people can be governed by risk; that it can influence the decision you make or perhaps make you err on the side of safety rather than taking particular risks really. Some of the paperwork is geared up to towards that isn't it? These risk assessments we have to do, I think you can get things where someone's maybe has done something about 20 years ago and it still comes up to haunt them doesn't it? Time and time again and I think things*

*around taking risk with medication as well ... well what happened last time you stopped and all the rest of it.”*

*(Louise)*

Research into community mental health nurses reflections on risk assessment mirrors the position that is articulated by Louise here in that it is perceived as integral to their role and an important influence within decision making (Godin 2004). Within this extract, being defined as a risk, becomes inescapable as the expectation from professionals that this person has the potential for harm is presented as constant, embedding their status as a risk object. The focus on risk as an influence within decision making resonates with challenges as to whether the caring therapeutic relationship is really the essential focus of nursing care (Flaskerud et al 1979, Moyle 2003). Though Godin (2006) highlights how nurses have objected to this increase in focusing on measures, such as risk assessment, introduced to aim to control ‘dangerous’ people with mental health problems. Three participants Louise, Lilly and Sebastian within the community setting reflected Godin’s (2006) findings by questioning the validity of the focus on risk in mental health practice. His research targeted nurses specifically and out of these three participants two are doctors.

Jack, however, challenges such a focus on risk, instead advocating that the person’s goals and wishes should be the centre of care, reflecting a recovery orientated approach (Repper and Perkins 2003). Whilst Ife shares examples regarding the dominance of risk in decision making, she also narrates a vignette where values of recovery and social inclusion have influenced her approach to enable a person take on more responsibility and autonomy within their life.

*“There is a danger of that making us kind of risk averse and again we have got to try and attend to that. I suppose for me I would always look to what is it that the service user wants really, what is it they are trying to achieve, where is it they want to go to, and is there any way possible to try and build*

*on that to ensure that our work is meaningful in a beneficial way to them really.” (Jack)*

Yet the association made by mental health professionals linking service users with risk could be reinforced through the risk communication system adopted within the assertive outreach service. A traffic light system was used in the form of highlighting on the team board where concerns were identified;

*“Sometimes if an individual is very worried about someone then they might individually decide that this person needs to have a dot. So if a care coordinator visits someone, for example and their mental health has deteriorated considerably, or they’re neglecting themselves, or there appears to be some sort of risk issues or something that needs attending to relatively quickly, then they might just put a dot on the board. Or sometimes after discussion in one of the team meetings, well actually things aren’t so good are they? Shall we put a dot? So it can be any concern on any level really it goes on until it’s decided that it’s not necessary. It’s normally a team decision that it comes off but it’s normally an individual one that it goes on.” (Lilly)*

The recording of the dot against the person’s name on the white board has the potential to immediately draw attention to the person in terms of their level of concern. Priority is then easily afforded to focussing on planning interventions for individuals in accordance with their risk as oppose to for example their needs or progress towards goals. At times participants did identify the significance of the structures and systems they worked within at shaping their focus and responses to risk; this influence is explored in depth in Chapters 13 and 14, though the ‘dot’ system was not recognised as part of this critique.

### 5.4.2 What does risk mean?

In order to understand the construction of service users as risk objects, the association of service users as the perpetrators (objects of risk) or victims (objects at risk) of harm have been examined. Significant to the development of this association is the expectation of professionals that the meaning of risk has negative connotations.

*“....At the moment because of the way she is presenting the risks would increase to others; as she has become more aggressive, she is quite threatening, she is verbally hostile. A risk to herself again because of the verbal hostility to other patients; there is a chance that they may react to that and respond to her, the fact that she is not sleeping is another major concern.” (Natalie)*

Here the discussion of risk is linked with aggression and hostility suggesting risk has been conceptualised as meaning something that results in damaging and unsafe consequences. At a societal level contemporary definitions of risk have become synonymous with harm or loss (Beck 1992, Douglas 1992, Lupton 1999,). This has been echoed by a process within mental health services where the concept of dangerousness has been subsumed by the notion of risk and associated risk factors (Castel 1991). As Castel (1991) argues a change that enables a potential danger to be displaced from an individual and instead understood as disembodied factors applied to all with a diagnosis of mental health problems. Through this, creating the ‘epidemiological clinic’ discussed in Chapter 5 in which service users are viewed by professionals in relation to their risks. One of the consequences of this shift is the loss of the relational focus of mental health practice (Godin 2006). This shift creates multiple opportunities for intervention to be instigated to control the risk, including through surveillance. Additionally, the association of factors with all rather than developing an understanding of the individual entails denying subjectivity and fungibility both characteristics of objectification.

Here a link is created between risk and an object contributing to the construction of service users as risk objects (Hilgartner 1992).

The concept of risk tended to be understood by participants as having an objective existence.

*“...sometimes the decisions to discharge a person out of the team, which is quite alright as well, you know to move on which is a good thing. Because I know usually we talk about when things are not good, they are also when things are at there best, clients get moved on. They get the number of clients who have got well and they have been discharged and that is how it goes and we move them on and get them to carry on with life ...so all those decisions we make as well based on the knowledge of the staff who have dealt with the client and they are not presenting with any risks any longer, no longer presenting with risk and we know that risk is unlikely at that point and we move them on.” (Prima)*

Within the vignette above Prima discusses the presence or absence of risks as a factor influencing whether an individual can be discharged from the community team. Both Natalie’s and Prima’s descriptions treat risk as a distinct entity which is something that is expressed by service users, that can be identified and categorised. Scientific explanations recognise risk as an objective fact that is quantifiable (Royal Society 1992), an approach that has been influential in the adoption of risk in mental health services as an entity that can be assessed, managed and controlled (Crowe and Carlyle 2003). Mental health professionals have been criticised for subjective and inaccurate judgments of risk in comparison to tools based on scientific statistical calculations (Doyle and Dolan 2002). A focus on the technical aspects of risk rather than the relational becomes reinforced. This serves to further exclude service users from having any authority to define or manage risk which could both reflect and reinforce their status as objects of (and at) risk.

Yet as this study emphasises the concept of risk in contemporary society is also viewed as something that is constructed. What is and isn't understood as a risk is interpreted in relation to a set of culturally defined norms and values (Douglas 1992). With the exception of one of the psychiatrists within the community team, who questioned the evidence base for risk predictions, risk as something which isn't fixed and quantifiable was not reflected in the data.

Natalie identified risk as the reason for admission to the acute ward; Prima suggests it is the absence of this risk that enables someone to be discharged from the community team. A person's risk is, therefore, presented as the primary reason for the input of mental health services which could act to further embed their status as a risk object. In this respect the conceptualisation of risk as a negative force enables risk to be used as a means of surveillance, for maintaining monitoring and contact with services.

Natalie and Prima's description of risk outlines a focus on the negative consequences understood as part of a normative experience of risk. The way in which we view risk in contemporary society, according to Douglas (1992) means avoiding risk and therefore loss is the accepted norm. There is an absence of the notion of 'good risk' and what can be gained by taking a risk. Acting outside of this norm; deliberately risk taking is seen as abnormal and pathological.

*"I think it's about risk taking and whether or not you are a risk taking person. I know that I'm not, so that might influence any decisions that I am part of around patients care. For me personally...I think it's just I never have been a risk taking person out of work I am just not. So I can't then just suddenly switch off and come to work and think, yeah that's a risk worth taking today that's just me." (Charlotte)*

Charlotte recognises the idea of taking a risk as problematic, it's value not equitable to the concern it would cause. Her description provides an indication of Douglas' (1992) perspective of risk as a

concept that is bound by group norms. Charlotte draws on her own values as a guiding force in her response to risk taking. This reflects the feelings of discomfort and unease prompted by risk examined in Chapter 11. Yet studies examining risk taking suggest that it can bring affirmation and positive social recognition, that it can have constructive implications for self-improvement, emotional engagement and control (Lupton and Tulloch 2002, Parker and Stanworth 2005). The struggles of professionals within this study around therapeutic risk taking are not only bound by a negative interpretation of risk but also fears associated with the professional damage that may be incurred by taking a risk.

*“...there is an interesting way in which resources kind of impact decision making because the more challenges that impacts on services, the less time there is to think about decisions, the more likely you’ll make the wrong decisions. Because of the pressures of risk management, the harder it becomes to do therapeutic risk taking and I think the more destructive you can become in responding to protect yourself rather than the client.” (Sebastian)*

Here whilst the risk itself remains grounded within the service user, the negative consequences of that risk for the professional may become what drive the response. The potential consequences for the service users themselves are much less visible.

Risk is largely described by participants within this study as an objective entity that is associated with harmful or negative consequences. It is understood as a feature of those using mental health services, in some cases defining the very need for those services. The notion of something bad happening or things going wrong was raised by 10 participants across the case studies and



observed in discussions on two occasions. This perspective was summarised by one participant from community team B;

*“Just the fact that, you have got people who have got complex mental health and serious sort of enduring mental health problems, paranoid schizophrenia for example. And then you have got at the same time people who are necessarily quite chaotic in their lifestyles, drug and alcohol and vulnerability, you know there is a lot sometimes with people. Which you just think this isn’t gonna end well, you know it’s just that feeling really but at the same time you are thinking well you know not everything is gonna end well you know I mean for our client group in particular you know you can only do so much.” (Andrew)*

Andrew’s reflections may reinforce service users’ status as risk objects as an expectation is created that supporting these clients is likely to have a negative outcome. Here working with individuals with serious mental health problems means that inevitably the situation won’t end well, that there is potential for harm to occur. The need to respond to service users in the anticipation of negative outcomes may therefore be created, reflecting Boholm and Corvellec’s (2011) claim that risk relationships are characterised by anticipated rather than actual accounts. Additionally, Andrew’s fears provide further evidence of anxiety in relation to his work as explored in Chapter 11.

#### **5.4.3 Risk and Blame**

Fears regarding the potential harmful consequences of decision making may be influenced by concerns that were shared by participants regarding blame. Anxieties about being blamed appear consistently within participants interviews from psychiatrists, managers and nurses. According to Boholm and Corvellec (2011) the interpretation of risk as danger posed by an object of risk to an object at risk introduces a moral notion of blame.

*“With him in particular, I suppose is often with.. with ..risks it’s kind of a lot about covering yourself really. I suppose the fear of backlash really and like you know a decision made wrongly; you are going to be held accountable for that. I mean psychiatry, is a risk kind of the risk business, in the sense of the nature of it. There are always going to be risks and it’s trying to manage that but I think especially because of the potential for how bad they can be, nobody wants to be the person that has said OK you can go and then ... he’s done this. Being held accountable, I mean obviously for the medics it would be GMC and for us the NMC, if we were involved in the decision, if there was an incident where he, you know, killed or killed himself, coroner that kind of thing. That just within the trust as well, obviously we could be sort of disciplined by them and publicly as well the newspapers, if it was that high profile”. (Zoe)*

An example of this emphasis on blame is drawn from within Zoe’s account of working with an individual on the ward that was defined by the team to pose a risk, particularly of violence towards others. She makes a link between the risk, harmful outcomes and the potential for mental health professionals to be seen as responsible for those outcomes. Notably, in her account risk is perceived as a persistent, yet normal part of mental health practice and is directly related to service users. Zoe implies there are consequences for the practitioner in being seen as responsible for harm that result in both a ‘fear’ and a need to respond to that by avoiding the consequences, in this case a decision that would result in less control of the person from mental health services (discharge).

Zoe’s account makes reference to a concern that should something go wrong, judgement would be made in relation to the role of mental health services in failing to prevent that event. The propensity for individual practitioners to be identified as part of this chain of responsibility is expressed. Blame has been explained as evaluation

in relation to someone, based on the belief that they have acted badly or displayed a bad character for which they have no valid excuse (Cohen 1977, Sher 2006) and as such have violated a moral code. Blame is often associated with anger, hostility and reproach motivated in part by a desire that the bad act or display of character should not have occurred (Williams 2003, Sher 2006,). Within the example from Zoe's account the fear of reproach is evident as she discusses potential reproach from professional registering bodies. According to Sher (2006) reproach also enables the public expression of the desire that the act should not have occurred which is reinforced by Zoe's concerns regarding the public response should professionals' actions be blamed for the bad act (the person killing themselves or harming someone else).

The extent to which people with mental health problems, particularly during times of distress, can be viewed as accountable for their actions is a complex and much debated issue. However, being 'insane', 'deranged' or 'abnormal' appear in theoretical discussions around blame and responsibility as valid excuses for the bad acts or bad character displayed (Halverson 2004, Wolf 2013). This justification not to be blamed for an act provides some indication of why that blame may be deferred to those who are perceived to be responsible for the 'insane' in the form of mental health professionals. This exclusion from responsibility of people with mental health problems may relate to a denial of a person's self-determination and agency. These are features of objectification (Nussbaum 1995). In this situation fears regarding bad acts are observed in the association of service users with risk, yet the distancing of responsibility may reflect being treated as an object. Both these processes could contribute to the construction of service users as risk objects.

Mental health professionals from the community setting discussed a concern about being blamed as illustrated by this example from a community nurse in Team A.

*“I think it’s... risk assessment cause there’s things that you learn and then your knowledge of risk assessment and probably not knowing the client very well. I didn’t know this gentleman very well, I had visited him but then I’d known him just about nine to twelve months. I knew his risk assessment and that he’s impulsive. But this time he’s been voicing the thoughts and I thought well he didn’t have much to live for, he hasn’t got any family, no wife or kids or anything else around him, not many friends besides people who just want to come and get his money and buy alcohol, he had loads of physical health issues. You know so I think for me, it was a fear of doing the wrong thing so I kind of thought, well I’s safer to have him admitted than being sorry the next day that I could have done this and I didn’t and now he’s dead. The fear of standing in front of Mr [name of coroner] yeah and kind of really wanting to do the right thing. Hopefully it’s the right decision to do and I think when you’re a band five in the community, it is quite a big responsibility when you do lone working and place yourself in situations. You’ve got no one there but a phone call and at times you can’t get through to any one and at times you have to make a decision say this is how things are and this is my reasons why I want this done asap.” (Ife)*

Ife shares a worry regarding a decision she makes on whether to admit someone to hospital who may have been having thoughts to harm himself. Ife highlights that an assessment of his risk is important to making the decision which she also links with the ‘unknown’. Expressed within this example appear to be her fears that should she decide not to admit him that he may kill himself. Her decision would retrospectively be defined as wrong or bad (and therefore expose her to blame), potentially leading to reproach from the coroner. Ife’s discussion of risk may be significant in relation to

blame processes. Intentionality and foreseeability have been recognised as key concepts in the attribution of blame (Alicke, 2000, Lagnado and Channon 2008). Foreseeability refers to the likelihood of an event, how probable that person perceives it to be and what may be seen as reasonable for the person to expect (Lagnado and Channon 2008). If it is judged that a person should have expected the negative consequences then blame may be attributed (Alicke 2000). Parallels may be drawn between foreseeability and that of risk, notably as the definitions are distinctly similar. For example the Royal Society (1992:2) defines risk as ‘the probability that a particular adverse event occurs...’. Risk assessment undertaken as a core part of mental health professionals’ work may be acting to construct a situation where harmful events are perceived as foreseeable and predictable, therefore when they do occur professionals may be justifiably blamed for failing to see and act to prevent them. This is reinforced by the scientific approach to risk as a quantifiable entity which is reflected within some of the participants’ discussions of risk.

Foreseeability is a powerful stimulus in the attribution of blame. Lagnado and Channon’s (2008) research suggested it significantly impacted on people’s perceptions of blame; irrespective of whether the negative consequences were planned or not (intentionality). Constructing service users as risk objects may become perpetuated by the position that predicting negative outcomes associated with them is necessary for professionals to avoid blame. Yet paradoxically the more that the assessments of risk are presented as predictable, the more this exposes mental health professionals to being blamed.

Evident within Zoe’s and Ife’s fears regarding the links between their decision making and harm occurring is a perception that the event can be predicted and it is their role (the right decision) to do so. For example in Ife’s vignette a suicide would occur unless admission to hospital was decided upon. Blame is linked with the values and beliefs of contemporary Western society and as such is perpetuated by modernist mentality (Lau 2009). The attribution of blame in relation

to foreseeability is part of modernist thinking that defines tragic events as preventable and therefore predictable, holding individuals to blame for when this doesn't occur (Douglas 1992, Lau 2009). It is from such a position that a culture of blame can develop as individuals are seen as responsible for failing to act properly (Locke 2009). In this respect blame is inextricably linked with risk and perceived failures of risk management at the hands of professionals for neglecting to control tragic events. According to Douglas (1992) this forms part of a new blaming system linked with risk reduction in modern society.

These experiences may also be interpreted as associated with Rose's (1999) position on the role of mental health professionals in administering networks of control of 'non-citizens'. Mental health professionals are tasked with the role of protecting the community from such dangerous non-citizens. They are held accountable for any harm that may come to such a community as a result of failures in risk management.

In the example from Ife she makes reference to fear of doing the wrong thing and desire to do the right thing, as previously highlighted a number of participants in both settings referred to fear of doing the wrong thing. The definition of right action in this scenario was related to admission to hospital and consequently increased containment for the person. Whilst clearly hospitalisation may provide an environment that helps reduce distress and promote safety it can also result in a loss of freedom and reduction of autonomy (Goffman 1961, Glasby and Lester 2005). It is, therefore, important to note that the wrong thing wasn't constructed in terms of a person being exposed to these losses unnecessarily. This reflects concerns within the literature that mental health professionals may be more likely to predict 'false positives' (i.e. over predict the likelihood of a harmful event occurring) contributing to unnecessarily losses of freedom (Mcguire 2004, Morgan 2007). However, experience may impact on assessments of risk and Ife highlights how her experience and

seniority influence her concerns regarding responsibility which was also reflected by two participants in the inpatient case study.

Participants highlighted that their concerns regarding blame existed as part of their organisational and professional context.

*“I think sometimes there is, I don’t really want to, it sounds negative but I think a lot of the decisions you make you kind of think, is that going to stand up in coroners which sounds terrible but a lot of it’s back covering. I know before I have thought I don’t know whether to take them off observations, I think I should but what if something happened and I don’t want something to come back to me. So we’ll get the doctors to come back and see them and make a bit of a decision rather than cos they do get paid more (laugh). Anyway, the situation was a man, who was presenting well, used to enjoy the sunshine and lounging out in the garden. He was on a section but had unescorted leave. He wasn’t back in time and went AWOL. It had come up in team meeting that day that people weren’t always reporting AWOL straight away so they did that day. The police arrived later with his wallet, having found it on his body. We had to ID the body, we thought it was accidental but... there was an inquiry and they were looking at his notes, makes you feel like you were to blame, they started looking at his notes and making out it was your fault. There was an internal inquiry- didn’t get called myself but went to support a staff nurse. It’s negative, it sounds bad but it’s about blame, they want to blame the staff. I knew it was the right decision after reflecting back on it but it makes you feel like you should have done differently, we felt it was accidental.” (Emma)*

Blame is a relational concept in that it is expressed through affective or behavioural responses (Cohen 1977, Sher 2006) and therefore professionals would have to be attributed as blameworthy by an

individual or groups. Here Emma identifies that she experienced blame from the organisation she was employed by through an internal inquiry. Zoe and Ife identify that they were concerned about being blamed by their professional bodies, the coroner and the public. A fear of being blamed is a common experience for healthcare professionals and as highlighted by participants within this study has been described as being part of an organisational culture (Khatri, Brown and Hicks 2009, Kendall and Wiles 2010). A culture of blame has been widely recognised in health services and is largely seen as a negative force that undermines safe and effective care (Freeman 2009, Woodward, Lemer, Wu 2009). Emma highlights her experiences of feeling blamed, despite actually having limited involvement in the situation described as she was not on duty at the time of the person leaving. This was an experience that was common amongst participants in relation to fears regarding blame as expressed by Felix from Team A in the following example.

*“I haven’t experienced it myself, it’s a perception. Well, I’ve gone a bit once in an interview with someone I had worked with six months previously before the accidental death that was the result. But I think it’s from America really, where when something goes wrong it’s someone’s fault. So it’s always kind of the culture when I was training you always have to cover your back. You know documentation, it’s very important cus if it’s not documented, it’s not happened so you you’re always living in this culture where by someone’s always to blame even if you’re doing your best it doesn’t matter your best is never good enough. People always look for the smallest thing that you didn’t do, you know to find fault, I know I haven’t experienced myself but I wouldn’t want an experience of that nature.” (Felix)*

Out of the eleven interviews that discussed a fear regarding being blamed associated with appearance in coroners court, five had actually been to coroners court and out of those five none had been



identified as acting at fault. This could suggest that the professionals' anxiety anticipating being blamed for a tragic event is more dominant than actual attributions of error. Gorini, Miglioretti and Pravettoni (2012) showed that a fear of being blamed was much more prevalent than a fear of being punished amongst nurses and doctors, taken as indication that a culture of blame persists.

Andrew provided an alternative perspective when discussing his experiences of attending coroner's court; suggesting this confirmed that all actions that could have been taken were, reassuring family members and professionals that such tragic deaths aren't necessarily 'preventable' by individuals.

*"I came away from that having written the report feeling even before it went to coroner's court, we couldn't really have done, that you would do little things differently but you know ultimately you wouldn't really change an awful lot. And a relief, there in the coroners court was that in her summing up she basically said this is an accident, there is nothing, it was directed towards family mainly but you know there is nothing else which could have been done to prevent it. You know it's a tragedy and you know, didn't want anyone to go away feeling they could have prevented it. Anyway so that was quite reassuring but yeah it does focus in on your care, what we try to do with people and what we are trying to achieve."* (Andrew)

Emma, Zoe, Ife and Felix's vignettes indicate how professionals have experienced blame and a fear of blame from their organisation. Blame according to Williams (2003) acts to distance those who attribute judgement (in these examples the NHS, professional bodies and the public) from the person defined as blameworthy, which can represent an act of self-preservation. Additionally, when blame is targeted towards individuals, Williams (2003) suggests this can function to overshadow responsibility held within the broader context.

In this respect the role of the person with mental health problems, where relevant the victim but also the NHS organisation and wider society become invisible. This is expressed directly by Edward, the consultant from the in-patient setting.

*“And there is a greater explicit enthusiasm for distributed responsibility and the “empowerment” in inverted commas and the enablement if you like of others employed by the organisation. But it’s amazing how rapidly the lightening comes back down to the doctor when something goes wrong yeah? And the extent to which that actually mirrors, in an interesting way, the wider dynamic about the role of the doctor in maintaining social order is interesting. The extent to which and I think it does happen covertly and the extent to which trust boards actually hide behind the medics when issues of blame and accountability for clinical upsets are flying around is one worth exploring I think.” (Edward)*

In this respect professionals may become scapegoats enabling those pointing the finger (the NHS, professional bodies and the public) to focus attention away from any joint responsibility and adopt the role of judging and correcting those individuals at fault (Williams 2003). Correction is achieved through individual fitness to practice reviews or pressures to resign, which may reflect a state sponsored attempt by healthcare organisations to reduce professional power and autonomy; masking system errors (Freeman 2009, Traynor, Stone, Cook et al 2013). Being blamed therefore exposes professionals to loss of status, social, moral standing and potentially employment. Objects at risk represent those that have a value that may be threatened and are imbued with qualities such as loss and need for protection (Boholm and Corvellec 2011). In this context, professionals may be viewed as objects at risk in relation to service users as objects of risk.

The potential impact of such blaming process highlighted here by Edward may be reflected in the subjective experiences of Emma,

Felix, Ife and Zoe (amongst others). Charlotte from the in-patient setting reflects on the painful experience of attending a coroner's court and being exposed to a position of being blamed, drawing attention to the impact it had on her future work with service users.

*"But it's a very uncomfortable situation and its you have got it hanging over you a long time before it actually happens and then it never goes away. I think that episode has, it has influenced how I nurse since then. I think it's like I said earlier I think it's made me more cautious and more wary and it encourages you to think more about what the things... I think when you get a patient in who is similar, you know you just have a gut feeling there is something not right but you can't put your finger on it; you can't explain it because nobody else has gone through what you have gone through to make you think those things, does that make sense?"*  
(Charlotte)

This emphasises the affective experience of being blamed, judged as acting badly or having a bad character, contravening a moral code. Blame, according to Woodward et al (2009) provides the mechanism through which shame is assigned and it is this experience of shame that is damaging to both professionals and safety within healthcare systems. It is an experience that individuals would seek to avoid. This is highlighted by Louise who refers to her own experience of feeling to blame for a situation where a service user had set fire to their flat. She highlights how other mental health professionals may act to avoid blame.

*"And kind of at the meetings and stuff, I would say I don't think, you know I don't things are quite right and the feedback was like oh he's like that, he's fine don't worry about it. But when it happened all of this lovely collective responsibility flies out of the window and the finger is very*

*much on the care coordinator really. I think that's what a lot of care coordinators have in their minds when they are covering every, when they are ticking every little box really. I think in certain circumstances, people do tend to maybe to practice within safety limits, rather than stretch that a little bit which I think is a real shame really and it can maybe stop, sometimes stop people progressing or following certain paths in their lives.” (Louise)*

Blame and responsibility according to O'Connor, Kotze, Wright (2011) are deeply frightening, in part due to the associated implication that we exist in a social and physical environment that is difficult to predict and impossible to control (Lau 2009). This reinforces the position that blame should be avoided and control promoted through accurate predictions and careful management, notably as inaccurate judgements of risk are seen to expose mental health professionals to blame and shame (Undrill 2007). Service users' position as risk objects may be perpetuated through such an emphasis on the need for prediction of negative outcomes and control.

The avoidance of exposure to blame may have some bearing on who was perceived as responsible for decisions, particularly in relation to risk. This issue was highlighted in both case study settings. Some nurses within the in-patient setting made reference to a desire to defer decisions regarding risk to doctors due to their status and wage (as seen within the statement about blame from Emma). This also highlights that the nurses actively sought to pass responsibility back to the doctors. This perception was reflected from the in-patient psychiatrist;

*“.... I think we do tend to see medication as what we do when other interventions aren't sufficient to either contain the clients distress, or aren't sufficient to contain our own anxieties about the client. So whether a request for a medication review is actually code for something else, I think*

*is an interesting question to address. Well I mean we get into the whole business, don't we about corporate responsibility for clients and our collective and separate roles in managing the anxieties that our clients provoke. And then we get into the whole business of what particular part the doctor plays in that process; whether that particular part is a clear and legitimate reflection of the doctors, if you like particular training and skills which are only differentiated from everybody else by their medical or bio-medical background. Or whether in fact that is used as a code for, I want the most expensive senior person to take some responsibility for what's going on here."* (Edward)

One nurse did express frustration that they lacked power in decision making when doctors were perceived to be averse to taking risks. Within the community setting psychiatrists were presented by some as needing to be responsible for complex decision making, notably when risks were defined as high.

*"It was for the doctor to assess his mental state and to assess the risk of other risks I guess you know, risks to the public, risks to staff, risks to himself, you know will all be thought about. I think our doctor generally is usually led by us and so he's not going to know the clients as well as we do and well because he's paid more, you know he has to go along and be part of that decision making process. I think that probably he is more, is probably better at assessing somebody's mental state, he'd do that in a more formal way"* (Eric)

Though there was also a sense that authority for decision making was held in different ways within the community teams. Power was ascribed based on individual characteristics and not just status, both the manager and the psychiatrists identify a desire to share

responsibility for decisions, yet team members acknowledged that authority for decisions was prompted by a desire to avoid '*getting your tail stung*' (Marcus). Kendall and Wiles (2010) research highlighted that GP's engaged in strategies aimed to promote self-protection and avoid blame within a blame culture. It is possible that the deferring of complex decisions to those with authority (hierarchical or otherwise) may be a strategy to avoid blame should something bad happen. Traditionally, nurses have lacked power and status to collectively resist increases in management and governance in the NHS in a way that medicine has been more successful at (Traynor et al 2013). This may provide insight into the tendency for nurses to perceive psychiatrists as responsible for complex decisions that may pose a risk of being blamed, particularly as according to Kendra (2007) the more power possessed the less likely of being blamed for a negative event.

#### **5.4.4.Summary**

Risk occupies a central focus within the expectations of mental health professionals' role and as the participants of the study have highlighted is perceived as an influential force in decision making. The dominance of risk within mental health practice may act to reinforce the status of service users as risk objects as it is an anticipated centre of care delivered.

Professionals may be viewed as the objects *at* risk in relation to service users' objects of risk. However, rather than the relationship characterised by a danger of physical or emotional harm from the service user, the value that may be lost to a professional is their social and moral standing as they could be exposed to the shame of becoming a blame worthy agent. This process may act to reinforce service users as objects of risk; not only due to the relation between objects of risk and objects at risk but also as a result of the action to avoid blame which emphasises

the need to become more effective at predicting and preventing harmful events.

## **5.5 Chapter 13: Organisational influences on the construction of risk objects**

Organisations are key domains for emplacing risk objects and developing networks to manage them (Hilgartner 1992). In this chapter I explore how organisations may have influenced the construction of service users as risk objects and therefore participants' perceptions of how organisational factors may shape decision making. Within this study organisations relate to either the NHS or the local NHS trust where the research took place.

### **5.5.1 Organisational mechanisms linking service users with risk**

The frameworks for documentation that the mental health professionals are required to use were highlighted by some participants as prioritising a focus on risk. This was raised in relation to statutory documents such as CPA, Health of the Nation Outcome Scale (HoNos) and written risk assessments. Within the in-patient setting the focus on risk was related to the new clustering system, linked to payment by results.

*In patient observation, day 2*

*Clustering – new system – seen as increased admin work by nurses. Looked at and have a copy of the mental health clusters booklet for guiding decisions. Here risk level is articulated by diagnosis and linked with the clusters. Aggregated risk issues-defining clustering system. Perception of nurses on shift in discussion was that it was lots of paperwork, more increases in admin workload, suggested no-one interested in what doing - just interested in meeting targets.*

*Further discussion in office by the nurses on shift about clustering – not perceived as helpful. Cluster governs the resources allocated to patients. Nurses clustering, not comfortable with making decision especially on admission – in terms of doing the clusters it's– best to err on side of caution when clustering patients. Suggestion that it's linked with diagnosis therefore should be doctor's decision.*

Clustering groups provides a mechanism to organise resource allocation within a payment by results system (Dixon 2004, Fairbairn 2007). Within clusters developed for mental health, risk level is a key descriptor marking the differences between each group (DH 2012a). The framework adopts risk categories that define the harms caused by the person or to them in the case of vulnerability. These narrow conceptualisations are observed in risk assessment forms in mental health settings (Crowe and Carlyle 2003). Categorisations of risk based on aggression/violence, self-harm, suicide, safeguarding of children and vulnerability reinforce the service user as the source of risk, therefore contributing to their status as an object of or at risk. It belies an organisational perspective that represents a 'scientific' view on risk (Royal Society 1992, Lupton 1999). Here risk is presented as measurable, knowable (by professionals); an objective entity inherently linked with the conduct of service users. This focus on risk within the organisational documentation system may therefore serve to associate service users with the potential for harm.

The construction of risk objects is dependent on their definition as both an object and a source of harm (Hilgartner 1992). Within this extract from observations on the acute ward it is highlighted that clustering entails the grouping of people according to diagnosis and risk level. As noted in chapter 10, denial of subjectivity and fungibility (treating an object as though it can be substituted for another object) has been defined as features of objectification (Nussbaum 1995). Clustering requires mental health professionals to rate behaviours on the basis of predefined categories. Consequently it



has the potential to perpetuate the objectification of service users as there is no opportunity for the inclusion of subjective experience. Service users' position as objects with the potential to cause harm is reinforced.

Prioritisation of risk within such documentation was recognised by some of the participants in the community teams as problematic.

*"...yet all the paper work that is put in front of us, all the risk assessments we have to tick and the HoNOs, PBR we need to score everyone on their psychopathology there is nothing about the strengths in their at all. So on the one hand there is this message recovery and also this underlying that there is this other world that doesn't match. The assertive outreach team is a fantastic team I think they really do genuinely work very flexibly with patients and really do genuinely care but sometimes that is held back by the system and other people's systems as well."* (Lilly)

Lilly's observation highlights how once service users have been defined as risky, this can become a dominant feature of their identity and care. Within this example she draws on the documentation systems as a mechanism which encourages professionals to focus on the problems posed by service users. This is acknowledged as at odds with recovery and she therefore alludes to the potential for tension between the two. Development towards recovery working is restricted by 'the system'. These barriers are recognised in the literature as challenges to developing recovery orientated practice (Tickle et al 2012, Barker and Buchanan Barker 2011).

The requirement for mental health professionals to gather and document the data discussed by Lilly is influenced by a new definition of professional expertise (Castel 1991, Le Bianic 2011). Here professionalism is based on the production of assessments and documentation primarily in order to deal with risk. Castel (1991) claims that within a bureaucratic system professionals no longer have

responsibility for the processing and management of this collated risk information instead the manager within organisations becomes the decision maker, a function of control in a post modern society. Within these theories the influence of the organisation on professionals' constructions of service users as risk objects can in part be understood. The emplacement of people with mental health problems as risk objects is developed through the focus on risk within required documentation completed as part of professionals' role.

This position is reflected by some participants in both settings who identified the importance of completed risk assessments and documentation to ensuring that they have done a good job. Through such an emphasis, other indicators of care provided by health services (such as the person's views, the quality of relationships or recovery journey) are less visible. However, the report investigating homicides committed by Daniel Gonzales, who had severe mental health problems, highlights that this approach to risk assessment could contribute to compromises to safety (Scott-Moncrieff, Briscoe, Daniels 2009). Instead assessment based on a meaningful relationship with the person, providing insight into their subjective experiences is likely to lead to a more accurate insight into potential harms. The collection of data is defined by Hilgartner (1992) as part of the efforts to emplace risk objects.

*"I think sometimes you do training which reminds you the importance of documentation, if it's not in there, it's not happened. I think it reminds you to write down every little thing and give examples of things, so that you can come back to them so that everybody who then gets to read it understands" (Emma)*

Hawley, Gale and Sivakumaran, Littlechild (2010) suggest it is commonplace for mental health professionals to perceive that filling in a risk assessment tool denotes a completed risk assessment. These pro-forma's provide auditable evidence that the risk assessment has

taken place and as such demonstrate good performance for the professional and the organisation. Yet the utility of such tools has consistently been called into question (McGuire 2004, Fazel et al 2012). Beck (1992) claims that risk assessment is an institutionalised attempt to control the actions of individuals. This process serves organisational and social agendas to manage people with mental health problems (Crowe and Carlyle 2003). However, there is research that suggests a more nuanced approach to risk assessment by mental health professionals which relies further on intuition and relationships (McGuire 2004, Doctor 2004, Boardman and Roberts 2014). These issues are considered in more detail in chapter 15. One participant in the community team offered an alternative to the claim that risk assessment promotes control

*“You know it’s not like that at all, I mean having perfect paperwork doesn’t stop people doing things” (Louise).*

For other participants from the community team, notably those with senior hierarchical roles, the focus on risk orientated auditable documentation systems were seen to serve organisational interests.

*“Well for me CPA actually embodies that conflict as well; as you have a document which purports to be caring but there are elements within in it which are there to protect the service. They provide medical legal back up for if something goes wrong, you could pretend I did everything I could ...” (Sebastian)*

A successful organisation is characterised by effective systems for assessment and management of risk (Power 2004). Within this context risks can be identified and governed, contributing to the perception that the organisations are in control and able to manage uncertainty. Power (2004) highlights this occurs in the face of catastrophes that threaten the existence of organisations and undermine the myth of controllability. Yet this myth is perpetuated by the systems of risk management and the requirements of stakeholders.

This state of the 'risk management of everything' with the need for robust auditable risk governance strategies undermines the role of professional judgement (Power 2004). Defensible mechanisms of allocating responsibility are also conceived within this organisational system. Here, Sebastian highlights that statutory documentation such as the CPA demonstrates such an auditable, defensible process. He locates this as providing protection for the service but also potentially for himself as a professional in the completion of such documents. This can be linked to the discussions of blame within the last chapter.

Organisations have a key role for the conceptualisation, creation and management of risk (Hutter and Power 2005). Risk is therefore presented as core business not only for the professionals working within the mental health service but also for the service itself. The link between risk and the people the service is set up for is reinforced, helping to construct service users as risk objects. The service and the professionals employed in it also represent a powerful network that is in the position to emplace service users as risk objects (Hilgartner 1992, Kendra 2007).

Power's (2004) reference to the impact of catastrophes on the perception of management and control can be related to the case study settings. Within the in-patient area a number of participants made reference to internal inquiries and coroner's court following the suicide or accidental death of a patient from the ward. In the community setting, participants related similar experiences. Within this team professionals talked about an ongoing homicide inquiry taking place in the organisation. The homicide was committed by a person being cared for by another assertive outreach team in the same Trust. The murder received local and national press attention as well as according to one participant being raised in the House of Commons by the local MP. The internal inquiry had been going on for two years at the time of data collection. The case study identified that this had impacted directly on the team and its structures.

*“Other imperatives that have been put on us, so since the, I think it’s probably come out of the [name of person] case in [name of team]. You know there is a new system where we have to say when the person was last seen and who they were last seen by. When you have only got 50 seconds per patient actually trying to fiddle around working out whether, did so and so see them when they were supposed to, on that day and getting the data actually you spend an inordinate amount of time you know crossing the T’s and dotting the I’s and you know not talking about patients. That’s come out of trying to be safer and ... I get a sense that some people share this view and I think its almost being seen to be doing things properly but actually it’s detracting from safety because we have less time to think about a person but it looks good on paper because we have dotted everything. I am not sure it’s a very useful process for the others to think about their longer term recovery and what their needs are and what they want for themselves thinking about them as people really.”(Lilly)*

Events which have a significant impact but are rare can lead to ‘extreme precautionary attention’ within organisations (Hutter and Power 2005). Within the vignette Lilly highlights how the team’s weekly multidisciplinary meeting has been restructured as part of an organisational directive to ensure that the last time a person was seen is checked. With the 75 service users that the team support this occupies the majority of the meeting. Beck (1992) notes how organisations contribute to the manufacture of risk which is alluded to in Lilly’s reflections as she suggest that being prevented from exercising professional judgement as to what the team should be discussing could compromise safety.

Homicides committed by people with mental health problems, particularly that experience psychosis are a rare event (Goldacre 2006). The rate has consistently fallen since 2006 whilst the number of suicides has risen (Appleby et al 2013). A murder will clearly have

a devastating impact on the families involved but as highlighted by the participants can have far reaching consequences in terms of media and government attention. The restructuring of the team meeting and the extensive internal inquiry reflect, Hutter and Power's (2005) intense precautionary focus by the organisation. Through this, all service users are linked with the potential for extreme danger and the level of surveillance increased. Service users are constructed as risk objects as this process serves to create a link between people diagnosed with mental health problems and extreme harm. This is underpinned by Lilly's last comment which points to the impact of focussing on surveillance of service users detracting from their experience '*as people really*' and therefore further objectifying them.

Through the mechanisms of inquiries, homicides perpetrated by people using mental health services are presented as preventable and therefore predictable (Szmukler 2000, Munro and Rumgay 2000). Events are viewed as resulting from a professional error or system breakdown (Revill 2006) which feeds into Power's (2004) notion of the myth of control within organisations. This perspective serves to justify the consequences of being designated risk objects through increased surveillance and control which is demonstrated in Lilly's example. Such a focus may be influenced by the historical perspective of the role of mental health services to control a moral and social threat (Morall and Hazelton 2000, Foucault 2006).

Szmukler (2000) criticises this approach within homicide inquiries which ignores the role of other people involved and presents the service user as without agency (another feature of objectification). The link between mental illness and violence has also been questioned (Langan 2010) with the majority of violence (and murders) committed by people without mental health problems (Szmukler and Holloway 2000, Laurence 2003). Hutter and Power (2005) highlight how encounters with 'risk' in organisations can be translated into institutional facts that shape practices.

*“... it’s also about sort of defensive ways of working, is to making sure that the documentation stuff is done that risk assessments are as thorough as possible. So if we were to be investigated in that way that our defences could be as robust as perhaps we could make them.” (Jack)*

Within this extract from Jack taken from his discussion of the ongoing homicide inquiry, development of institutional defensive practices in relation to the risk (i.e. inquiry resulting from service users violence) can be seen. These practices may therefore serve to create risk objects through construction of the link between service users and harm. The construction process itself becomes less visible as objects are seen independent of this context (Boholm and Corvellec 2011) and the risk becomes institutional fact. Jack and Emma’s comments provide further evidence of Power’s (2004) arguments. In a culture in which organisations must be made responsible, through the legal or compensation system, documented records are developed to provide a rationale for decisions in hindsight, created for legal and defensive benefit (Power 2004). Providing a record of care useful for service users is therefore redundant.

Directives to complete risk assessments and documentation could be serving an additional purpose.

*“You always have a duty to protect the public and mental health act is protecting the public and harm to self, so it always plays a big part. Cause you know the media are going to pick up that and they’ll blow everything out of proportion, you know and it’s not going to look nice. To start with you don’t want AO to have a bad reputation; you don’t want the Trust to have a bad reputation so you have a duty to protect everyone”. (Ife)*

Ife suggests that the reputation of the service and the trust needs protecting. Reputational risk is a key concern for organisations (Power 2004). Events which pose a threat to public safety, such as

homicide, threaten the organisations reputation and those that involve death have the most significant impact (Hutter and Power 2005). This process can be observed in the media and public responses to the homicide the participants referred to.

*"In sentencing {names of judge removed} was highly critical of (name of organisation) mental health services.*

*He said: "It's clear there had been numerous opportunities to send [him] to hospital and it is a matter of grave concern that these opportunities were missed repeatedly."*

*He added that those responsible for his care should be "examining their consciences".*"

*(BBC News 2010)*

Pre-occupation with risk to reputation is part of a new social context characterised by public loss of faith in expertise (Beck 1992) and trust in government (Power 2004). Here tragedies result in the search for responsibility and right to hold people to account (Lupton 1999, Power 2004). Public perceptions of organisations have been shown to threaten the survival of those organisations. Coupled with risk being presented as the new framework for questioning the quality of public services (Power 2004), risks to reputation could be a significant issue for a healthcare organisation. The loss of reputation becomes a deep rooted fear. Participants within the community made reference to the reputation of the NHS trust and a belief that certain decisions and processes (particularly documentation) were undertaken as a mechanism to protect its reputation. For Jack, the team manager, this extended to questioning whether in current commissioning arrangements the organisation would continue to invest in the assertive outreach service at all in the face of public criticism following the homicide.

The risk to reputation becomes of primary importance driving people to focus more on these risks than any others (Power 2004). According



to Boholm and Corvellec (2011) a risk object is created in relation to an object at risk. The object at risk is threatened with losing something of value. The trust is threatened with the loss of reputation as a consequence of violence perpetrated by service users. A relationship between the object at risk (the organisation) and the object of risk (people with mental health problems) is established.

Despite the apparent emphasis on risk, two participants in the community team and one within the in-patient setting highlighted that organisational targets reflected a slightly wider focus with requirements to support service users' physical health, occupation and other aspects of their identity such as sexuality. In the discussion of these targets participants did question whether these were really developed to serve the interests of service users or the organisation. However, access to opportunities through employment, enhanced physical health and relationships are important aspects of social inclusion and may promote recovery (ODPM 2004, Tew 2013) offering an alternative focus to risk. During day two of the observations in Lawrence ward, a discussion between a senior nurse from the intensive care unit and one of the nurses from the ward was noted. The discussion related to targets for reducing length of stay in hospital. Within the discussion the senior nurse noted that the Doctor's at times tried to avoid having beds filled if a person was on leave and not discharged. This perhaps provides an example of how professionals may try to challenge or subvert organisational agenda's which could be of interest when considering the impact of organisational directives on professionals' practice.

### **5.5.2 Summary**

Within both case study settings participants discussed organisational processes that created and maintained a focus on risk. Completion of these processes was considered by mental health professionals as an important part of their role. Risk as the central concern of mental health services (and their employees) is established, reinforcing the

link between service users and harm. The focus on risk is compounded by a homicide inquiry taking place within the organisation, positioning the trust's reputation as threatened by the risk objects it provides a service for.

## **5.6 Chapter 14: Social influences on the construction of risk objects**

Within social theories of risk, shared cultural values, norms and social processes are recognised as selectively influencing the definition of risks and hazards (Douglas and Wilavsky 1982, Douglas 1992, Lupton 2013). As discussed in the literature review people with mental health problems have been constructed as deviants, identifying them as different from mainstream society (Rose 1999, Morrall and Muir-Cochrane 2002, Foucault 2006). This chapter examines participants' accounts of the influence of social context on their responses to risk. Through this the impact of social perspectives on the construction of service users as risk objects will be considered.

### **5.6.1 Influences of the public on participants' decision making**

Within Team A and B participants identified that local communities could be a powerful influence in determining a decision to admit a person to hospital.

*"...it led to a mental health act assessment and he did go into hospital. So that was something that was discussed but it wasn't necessarily the fact that he wasn't taking medication, it was more to do with his behaviour within the community and things which you know led to us becoming more concerned that things were possibly going to get worse before they get better....There was an incident with a shop keeper where he was quite threatening towards the shopkeeper and reported incidents of people being shoved and pushed by him". (Andrew)*

Within this extract the person's conduct towards other members of the community is recognised as an indicator of deterioration and potentially linked to the need for a Mental Health Act assessment. Assertive outreach services have acknowledged that the needs of the community can feature in compromises to a person's autonomy

(Williamson 2002). Criticisms of the model highlight its approach as a form of coercion (Gormory 2002). Within the vignette Andrew and the team are concerned with the behaviour of the person using their service. As examined within Chapter 5, it is claimed that a core function of community mental health teams is surveillance of the mental ill, particularly of their conduct in relation to social norms (Moon 2000, Vassilev and Pilgrim 2007). This is managed in the name of the 'risks' posed by people with mental health problems (Crowe and Carlyle 2003). Fears of the general public that their safety is threatened by this risky group have influenced the development of community services (Coid 1996, DH 1998, Szmukler 1999). This has led to criticism that structures within community teams serve political rather than therapeutic purposes. Szmukler (1999) highlights that services responding to reports from members of the community to deal with 'disturbed' people contribute to labelling. The behaviour is defined as a feature of the mentally ill, therefore perpetuating the link between mental health problems and harm. This process may be observed in the situation narrated by Andrew and contributes to the construction of service users as risk objects as a link with harm is reinforced (Hilgartner 1992).

Such a scenario identifies mental health services as responsible for managing behaviour outside of social norms. Within observations on the in-patient ward members of nursing staff briefly discussed how their role sometimes entailed behaviour management.

#### *Inpatient observation, day 3*

*There was a discussion in office between a 136 band 6 nurse and a staff nurse on ward. Discussion of violence after incident where person from [locked ward] was transferred to Lawrence ward, stating he would hit someone in order to get back to [locked ward] which he did and was then returned to [Locked Ward]. Staff – it's not right but how else is it*

*managed if the behaviour is not due to mental illness? It's difficult for the victim to suffer.*

*Protocol on the ward is to IM an individual after an aggressive incident so they are given rapid tranquillisation to calm them down – the problem is then treating it as an illness even though its not – then you are treating the behaviour – but it's the only way to manage here but it's not the illness that's being managed.*

Within the extract it is identified that following any act of violence on the ward the legitimate response (protocol) is to provide medication, the implication here is that it is against the persons will. Focus is concentrated on the actions undertaken by the service user that lead to medication rather than framed in terms of therapeutic benefit for the person's mental health problem. Such interventions have been described by some nurses as part of the process of discouraging unwanted behaviour (Bjorkdahl et al 2010) whilst a custodial role for inpatient services has been widely recognised (Gournay 2005, Rogers and Pilgrim 2010). Chapter 9 outlined the need to be medicated was a consequence of being defined as a risk object. Within this extract medication is more explicitly identified as a mechanism of control for actions that could be harmful. Associating medication as a treatment for aggression or violence poses the danger of medicalising these actions. In doing so the link between experiencing mental health problems and having the capacity for harm is further embedded.

Participants from the community team identified that in the eyes of the public they were responsible for the conduct of the people they were supporting. They felt an expectation that they should 'do something' to manage the risk.

*"I suppose to a certain degree we are influenced by society, I mean you know when neighbours or relatives start expressing concerns we rightly or wrongly people are more likely to have kind of control measures used against them. We know*

*things aren't wonderful but we kind of feel maybe we can work with them a bit and they don't need to be in hospital just yet, if kind of relatives ,neighbours start expressing concern you can almost suspect that they are going to end up in hospital sooner rather than later. And I think when other agencies as well start to get involved sort of like housing, police, maybe draconian measures tend to be taken than if they are not. I think it's because we need to be seen to be doing something I think its because the expectation is that we should be doing something I think its because more likely someone's going to say why didn't you do something ..."*  
(Louise)

Louise's discussion highlights that the regulatory role of mental health services is more likely to be instigated when concerns are raised by people's families, their local communities or other agencies. This supports the myth outlined by Power (2004) that in the eyes of the public and stakeholders it is the role of organisations, in this case services, to enact control and manage uncertainty i.e. risk.

Social and political values of contemporary Western society are characterised by an emphasis on rights and responsibilities. Citizens enact self-regulation through the maintenance of these roles and responsibilities (Rose 2000, Morrall and Muir-Cochrane 2002) which has been viewed as part of the governance system in modern society (Rose and Miller 1992). Those who do not adhere to these boundaries are subject to increased state intervention in their lives. The mental health professional is positioned as responsible for enacting governance of these 'spoiled citizens'. Risk assessment and management is one of the mechanisms through which this is achieved, which according to Crowe and Carlyle (2003) means it functions as a form of discipline. Within this extract from Louise, when service users are identified as contravening these expectations further intervention from professionals is justified. The expression of being seen to do something could reflect this expectation that mental

health professionals are responsible for intervening which supports Rose's (1999) position that control professionals are perceived as accountable for any harm that comes to the community. Being viewed as responsible for governing the actions of service users also exposes them to being blamed when this is judged to have failed.

Some participants make explicit reference to their perceived role as agents of social control (Morrall 1998).

*"Do you see what I mean? Is a reflection of that and I do feel that psychiatrists and psychiatry is used by society to do this dirty job. What it does is it trades upon the social seniority of the medical profession to legitimise or do to you see what I mean? To legitimise the part psychiatry plays in maintaining social order right? That's basically how I understand what's going on and all the bits that happen within the service itself actually reflect that larger external dynamic."* (Edward)

Emphasis is placed by Edward on the expectation that mental health services have a role for maintaining order. This reflects the arguments presented in the literature review that mental health services form part of a system of discipline and control for members of society defined as deviant (Morrall and Hazelton 2000, Foucault 2006). The construction of service users as objects of risk with the potential for harm provides a justifiable mechanism for the enactment of control. Amendments to the Mental Health Act and the introduction of CTOs provide a clear example as these changes were justified on the basis of risk (Chan 2002, Laurence 2003, DH 2000). This situation was recognised by one of the participants, Sebastian who cited community treatment orders as part of *"society's fantasy of control"*

Participants within both the in-patient and the community linked reactions of the media, in particular newspapers, with their concerns regarding risk. This was either in relation to anticipated responses of the press or actual reporting of incidents related to service users.

*“Very negatively at a time when actually work needs to carry on, even if something dreadful has taken place, you can’t just suddenly stop and not do it. Then you kind of get a sense that you know if every family that were attached that we are supporting, read the [name of local newspaper] from that day what are they thinking about the quality of the work that we are doing? So that it could lead to sort of doubt in their practice and losing their confidence.” (Jack)*

Jack shares his concerns regarding the impact of the reporting of the homicide perpetrated by someone under the care of assertive outreach services. He suggests this could impact on both families’ perceptions of the service but also professionals’ perceptions of their work. Media representations may therefore contribute to organisational concerns regarding reputation risk and professionals’ concerns regarding blame. Risk is understood in relation to shared social norms and values (Douglas 1992) and situated within social institutions (Boholm and Corvellec 2011). The media was seen in this study to provide negative representations of people with mental health problems and services, in particular the failure of those services to control the actions of service users. This failure is often reported as failure to care. The media has been recognised as a powerful influence in linking mental illness with danger and violence (Paterson and Stark 2001, Sieff 2003). Within this study, the media was mentioned by a minority of participants, yet there was a consistent view regarding its negative influence on mental health services and the experiences of people with mental health problems. Participants identified its influence through the focus on harm related to service users. The media is therefore a potential source to contribute to constructing service users as risk objects.

Hilgartner (1992) actually suggests that the public and the media lack the influence to construct risk objects, emphasising instead the power of professionals and organisations. Boholm and Corvellec (2003) recognise Hilgartner’s lack of focus on the cultural dimension of risk



as a limitation of the theory. However, the publication of Hilgartner's work coincides with the release of the British translation of Beck's 'Risk Society' (1992) and Mary Douglas (1992) risk and blame essays. Recognition of the powerful contribution of public and the media to affirm or deny risks has grown since, in the light of this seminal work. Models such as the Social Amplification of risk (Kasperson, Kasperson, Pidgeon and Slovic 2003) identify individual experience alongside social organisations as interacting to mediate the extent to which a risk is recognised. Social organisations include voluntary groups and the media. This reflects the issues raised by participants in this study who noted the reactions of organisations such as housing, the police and the media as impacting on how they responded to risk linked to service users.

Through this the association of people with mental health problems with harm contributes to their construction as risk objects. The potential for these public perceptions to have a powerful impact on influencing the reactions of professionals to service users' status as risk objects is seen in a vignette discussed by Edward.

*"If for instance somebody is making a fuss in A&E and you have got 2 casualty consultants, 3 dogs, 4 policemen and all the relatives demanding that this person be sectioned right and actually I am sort of reluctant to do that because I don't think that in the strictest sense of the word appropriate. I would take into account that pressure of public opinion that this person is high risk and needs to be contained even though I would perhaps silently or quietly wish that I was in a different culture in a different time in history where... you know and those pressures weren't upon me..."(Edward)*

### **5.6.2 Summary**

Mental Health professionals identified that responses to service users within the community could influence the timing and level of intervention from services. This was reflected within the in-patient

setting by recognition of a role for services in managing behaviour. A function of control and governance for mental health services is articulated. Social control as a responsibility of mental health services reinforces the position of service users as 'dangerous' risk objects in need of control.

## **5.7 Chapter 15: Displacement of Risk Objects**

The previous section has examined the emplacement of service users as risk objects. According to Hilgartner (1992) there are frequent tensions between efforts to emplace risk objects and efforts to *displace* them. Displacement can occur through two main mechanisms, deconstruction and absolute control. The former involves dissolving the relationship between the object and harm or undermining the existence of the object. Displacement through control entails the total enclosure of objects within a network to exert control.

This chapter examines scenarios from the research data where construction of service users as risk objects was destabilised. This was most evident in two interviews within the community team, Louise and Lilly. Displacement within these examples was observed in their recognition of a person's subjectivity; challenging the creation of service users as objects. This chapter draws heavily on these two interviews as the most consistent examples.

However there was evidence of isolated vignettes within other interviews where subjectivity was acknowledged, a number of these have been highlighted throughout the discussion. Additionally some participants, particularly Jack, Sebastian and Edward (all of whom had senior positions) questioned the predominance of risk within mental health practice, perhaps representing an effort to undermine the link between service users and harm. This has potential to also displace service users as risk objects.

### **5.7.1 Proximity**

I have argued that the distance between mental health professionals and service users creates the conditions where objectification can occur. Objectification contributes to the construction of service users as risk objects. Malone (2003) argues that physical, narrative and

moral proximity are essential components of nursing work. Chapter 11 used these notions to demonstrate a physical, narrative and moral distance between service users and mental health professionals. However, data from interviews with Louise and Lilly suggested that they had achieved these proximal relationships enabling the subjectivity of service users to be recognised within decision making. This serves to undermine the service user as an object.

#### 5.7.1.1 Narrative Proximity

Narrative proximity involves both knowing the person and using this knowledge to share with others who contribute to their care (Malone 2003).

*“Another guy who isn’t really risky in classical terms, his physical health is pretty bad, he doesn’t look after himself very well and I suspect his quality of life isn’t great. He wears headphones even inside the house, he can’t bear any kind of noise, he can’t have the windows open or anything and he has been like that for about 10 years. Again he says as long as I’m not, you know, pressure isn’t put on me, I can manage this, it’s when people try and get me, people have classically tried to do the graded exposure stuff and its just not worked at all. But there is also, it keeps getting thrown into the mix, why isn’t this guy being detained and being put in hospital? But that feels you know as though it would be quite tormenting for him and he is very clearly saying if you just leave me be, I am ok. ... [the team] have been just trying to work with him where he is now and just trying to improve his quality of life. Instead of bringing things to him I think he has got a personalised budget now, so he has got someone who can do the housework and things because that was getting on top of him..” (Lilly)*

Within this extract Lilly demonstrates her knowledge of the person through recognising their perspective on their own situation. During

this discussion Lilly identified tensions in the team around how best to support him, particularly in light of concerns regarding the quality of life he may have. Rather than making a judgement about this person's living standard from her perspective, Lilly accepts his position. This involves recognising that the interventions of mental health services could cause him more distress and means really listening to his voice.

Objectification in chapter 9 was described as developed through four notions; denial of autonomy, denial of agency (inertness), denial of subjectivity and fungibility (Nussbaum 1995). Within this extract Lilly demonstrates her insight into this client's subjective experience as she highlights how admission to hospital could have been experienced as tormenting for him. He is able to exercise autonomy through having his desire not to be pressured recognised in the work the team are doing with him. Additionally, she suggests his agency has been shown through having a personal budget supporting him to make choices about his life. Sharing knowledge of this person's experience with other team members enables care to be individualised and helps distinguish between each person (Malone 2003). This sharing therefore guards against fungibility. These processes are demonstrated within Lilly's narration of the situation. Here the person is recognised as such and the idea of objectification displaced. The construction of service users as risk objects is therefore undermined according to Hilgartner's (1992) description, despite a link with risk being evident in the vignette.

Louise highlighted that insight into the person's narrative, developed through the therapeutic relationship, can influence how risk is understood.

*"...you are care coordinator, you can feel safer with people than if you are not because you have got that relationship with people and you know them a bit better. Because I know one of mine, it was a while ago but he was unwell and I took*

*someone from the team with me to go and see him and he was very kind of ... in your face and a bit kind of intimidating, a little bit threatening but when you know him, when you know him it's OK. But the worker I took with, he asked us to go and get cigarettes for him and I said "yeah go on then give us some money" and so we went. And she said "oh I am glad you said yes" you know she was petrified. And I thought yeah I suppose there is kind of, you know a lot of it is about relationships and how well you know people so I can understand." (Louise)*

Knowing the person enabled Louise to feel like she could contextualise this person's emotional expression. As a result she identified a sense of being able to make judgements in relation to safety. This involved not automatically linking the person's behaviour with harm instead using knowledge of the person to respond to their individual reactions. Interestingly the language is also different within this description as she talks about safety rather than risk. Fear of the unknown was identified in chapter 11 as influential in creating concerns regarding risk and contributing to a desire for distance to protect against these fears. These arguments were linked to anxieties related to the dangerous 'other'. Louise demonstrates how narrative proximity could actually have the opposite impact, creating some sense of safety by making the unknown known. Kearney (2003) proposes that narrative understanding builds bridges between the self and other, enabling us to recognise the other in ourselves and vice versa. He describes this as a way to prevent strangeness from 'estranging us to the point of dehumanisation' (Kearney:231). Within Louise's description the narrative proximity enables these connections and reduces fear. The dehumanisation of Kearney's statement is reflected in the process of objectification which again is undermined in Louise's extract as she responds to the person's individuality. Service users are therefore displaced as risk objects

here through a lack of objectification and a fracturing of the link between people with mental health problems and harm.

#### 5.7.1.2 Moral Proximity

Moral proximity is generated through healthcare workers exposure to a person's distress which invokes a 'moral concern' to be there for the person and act on their behalf. Individuals' are recognised in their life context and the practitioner uses this understanding to inform their actions (Malone 2003; 2318).

*"...again his experience, sometimes with this particular patient if you spend enough time with him the barrier drops down and you can just sort of see the pain. He makes you feel very sad; he doesn't make you feel frightened, he makes you feel very sad that he is like a little boy that has to have this fantasy world because he is so horribly damaged that he can't be himself. I think when you touch, when you feel that experience you just want to you go into caring and wanting to nurture mode. He is very moving when you are with him for long enough you sort of forget all the other stuff and you see where it comes from the pain actually, a very fragile vulnerable man and all the rest of its just bravado really. But he can be very dangerous when the bravado is there really, so yeah that sort of connection can help you be brave, just as you would be about your children or whatever you know you want them to progress...It helps you care if you make those connections and you can with him .. " (Lilly)*

Lilly expresses her compassion for the person she is discussing through recognition of his own distress. Here Lilly has voiced her own experience of sadness in response to understanding this clients "florid delusional system" (her earlier words) in another way. His own life narrative becomes present through her description of working with him. This empathic view of the damage he has been exposed to particularly in his early life appears to evoke a moral

concern which openly expresses both his and her vulnerability. Moral proximity involves representing the person's narrative and life context when acting on their behalf (Malone 2003). Prior to this quote Lilly had spoken about how this man's medication had been reduced and he had been supported to go to the Recovery College. This was despite recognition that he was severely unwell and when admitted there are "*massive risk issues*". Yet the approaches introduced to support him were prompted by thinking about how he can be made to feel strong, in the context of his belief system, informed by his own personal narrative.

Narrative proximity is demonstrated within Lilly's discussion, her reference to spending a long time with him highlights that this is temporally as well as spatially located (Malone 2003). This narrative is used to inform decision making subsuming the influence of generalised categories such as high risk. The person's subjective experience and individuality are recognised. This displaces the service user as a risk object as there is no objectification despite some links with the vulnerable characteristics associated with objects at risk.

Lilly does still link this person with risk, though in her discussions of his experiences the language shifts to being dangerous. This may be reflective of how danger is given context in relation to his previous experiences. According to Castel (1991) dangerousness is an embodied notion whereas risk is disembodied which could be mirrored by Lilly's use of the terms.

Within Louise's interview moral proximity is also suggested.

*"I had a lady who she was fresh out of hospital actually and didn't want her depot basically. But the distress that, because when I went to kind of do her depot the first time, the distress it caused her just me offering her depot and I thought is this worth it? And I said OK I won't mention the depot again, you know I mean she did become unwell and she did end up*



*being admitted to hospital again. But just the distress the thought of the depot gave to her I mean you would have to be made of stone ...you know it would have to be her choice.”*  
(Louise)

Louise acknowledges the anguish that having a depot caused the person she was working with. Through being exposed to this emotion, she supported the woman to make a choice not to have her medication even when becoming unwell. This demonstrates recognition of the person's agency but also how this was linked with being with the person during her distress. Consequently, moral proximity is demonstrated. What is absent from this vignette is any discussion of the risks of not taking medication despite what may be seen as a negative consequence, highlighting that proximity enabled this person's own experience to be emphasised.

Within both this extract and the previous scenario described by Lilly, examples have been shared where service users have either not taken or reduced their medication. Chapter 10 examines the impact of being emplaced as risk objects for service users which includes an expectation that they need medication. Within these examples where this position as risk objects has been displaced there is a change in consequences for the individuals. Medication is not presented as a necessity to manage risk and service users have been able to exercise choice about whether they take it or not. Sebastian also identified that he supports service users to come off their medication and as previously identified Jack questions the position that medication should always be promoted.

#### 5.7.1.3 Physical Proximity

According to Malone (2003) the physical closeness between a nurse and patient is an important part of proximity, creating the opportunity for both narrative and moral proximity. However, her paper is related exclusively to hospital nursing. Spatial arrangements within a multidisciplinary community context may have different

interrelationships. This is reflected in the following example from Lilly;

*“..said very clearly when I am unwell you all come around and see me much more frequently and that makes me feel much worse. When I am unwell I need to sort of work through it and being near people is really hard for me. Of course that is really counter-intuitive because when people are more unwell, of course we want to check up and monitor more closely and check risk and all those sorts of things. But it was very clear and she was saying things repeatedly when she was well, that her experience, that her personal experience was that that wasn’t helpful for her. Us being more assertive when she was unwell wasn’t helpful for her and so we’ve done things quite differently with her on lots of levels really. So at one point she wanted to go on clozapine but she couldn’t bear the idea of people coming round everyday monitoring; so we gave her a blood pressure cuff so she monitored her own, so we didn’t have to come round all the time. Actually if anything went wrong goodness me heads probably would roll, letting the patient monitoring their own but of course people do, do their own blood pressure and we were happy she was competent and able to do that.” (Lilly )*

The service model of assertive outreach has been questioned on the basis that it is involved with people who have opted not to be part of services and may be under no legal obligation to do so (Williamson 2002). Such involvement has been seen as an infringement of their autonomy. Physical proximity may, therefore, represent the opposite of the values espoused by Malone (2003) in this context. Instead, frequent visits from the team could be seen as intrusive. The home is viewed as the private space of the individual and as Liaschenko (1994) claims the extension of healthcare in this setting could threaten individual agency. Within the vignette discussed by Lilly, the narrative proximity she has with this person actually enables her to

adopt a more distant spatial relationship. The individual exercises her autonomy in requesting for the team to be more distant and Lilly recognises her agency to do so. However, rather than the examples of spatial distance in the community, this vignette once again recognises this persons subjectivity and individuality. Rather than a distant spatial relationship providing the grounds for objectification, the narrative proximity between Lilly and the service user provides the grounds for her to adopt a distal spatial relationship. Any notion of being defined as a risk object is displaced from this relationship.

A link with risk is again evident within the discussion and Lilly is aware of her (and her colleagues) potential as blameworthy agents in relation to the risk, yet the narrative and moral proximity she has developed inform a less controlling approach and provide a rationale for the actions of the team. The investigation of the care received by Daniel Gonzales provides support for the approach adopted by Louise and Lilly. Daniel Gonzales perpetrated a multiple homicide before going on to take his own life. Here the provision of a service underpinned by recovery is advocated as a means to reduce the potential for harm by ensuring a complex client group are offered support actually valued by the service user (Scott-Moncrieff et al 2009). Consequently, the developments of meaningful relationships that enable insight into the person's narrative are essential. Through this, the report suggests that more effective assessment of potential risks to safety can be undertaken.

### **5.7.2 Maintaining Proximity**

Both Louise and Lilly have demonstrated how their insight into service users' subjective experiences has enabled them to make decisions that support people's autonomy and arguably work towards their recovery. As such emplacement of service users as risk objects is avoided. Yet they maintain a link between service users and harm or risk. As vignettes within the previous section testify they feel exposed to the same professional, organisational and social influences

as other participants which could draw them towards constructing service users as risk objects. This begs the question, what enabled them to resist these influences, maintain proximity and avoid objectification of service users? This resilience is not necessarily fully explained within the data. However, there are indicators of factors that they identified as helpful to their approach to practice. Some of these factors are recognised by others such as Sebastian who adopted a critical perspective on risk in mental health practice.

One of the ways that was identified as helpful for their practice was the input of professionals external to the team. For Lilly the forums chaired by a clinical psychologist were particularly valuable and enabled the exploration of alternative perspectives.

*“...we usually have [name] who is the team psychologist and that’s really useful actually because he is quite a good chair for that meeting and makes sure that everybody’s voice is heard. He is quite good at being the neutral sounding board, he gets ideas off people, he will also challenge ideas but not coming from any particular position; to make us think about all the aspects and coming from a psychologist, that’s useful cos he helps us step outside, you know medical model and not always thinking about you know just because someone has stopped their medication...He makes sure that we explore all aspects and that we sort of come to a definite team decision.” (Lilly)*

Here Lilly is referring to the team’s group supervision forum. Group supervision is recognised as supporting the development of compassion and creativity within practice (Proctor 2008). However, Proctor (2008) argues that there are certain skills and attitudes that participants need in order to gain the benefit from supervision which may highlight why Lilly identified this forum specifically. She identified that the chair encourages the team to examine perspectives other than those suggested by the biomedical model, as a psychiatrist

this could be particularly valuable to Lilly. The biomedical model and the development of medical experts have in itself been presented as a system of objectification (Foucault 1973). This critique has been levelled at diagnostic systems in psychiatry (Coles 2013). Therefore being encouraged to examine alternative perspectives could be an important component of avoiding objectifying service users and constructing them as risk objects. Perhaps group supervision also offers Power's (2004:63) notion of a 'safe haven' where honesty about uncertainty can thrive. Participation in such team forums by the psychiatrist from Team A was comparatively minimal according to the participants in the study. This group forum was also not available on Lawrence ward though one participant identified 1;1 supervision useful at enabling her to manage risk.

Within the organisation a forum has been convened to provide support for practice where ethical dilemmas arose. Sebastian discussed two situations where this committee external to the team had been helpful at enabling them to make a decision, in one of these situations it resulted in the person's autonomy being supported and her wish not to know the results of a Huntington's test respected.

Personally held values and beliefs were identified as influential in the decisions made by Louise and Lilly;

*"..I suppose I don't know they can be even individual things really, cos I suppose we all have our own views don't we on mental health and how to work with people. So potentially the way I might work with someone might be different to some extent to how someone else might work with someone. I mean possibly, I'm not a great one for medication, I mean I think it serves a purpose and I think its very useful for some people but I don't think it's the be all and end all and the answer to everybody's problems." (Louise)*

Louise's personal views of mental health problems and her practice as a nurse may have enabled her to maintain proximal relationships.

Values based practice according to Woodbridge and Fulford (2004) is about subjectivity and engaging with other people's perspectives. Acknowledging her subjective position may support the recognition of this in others and a move away from detached objectivity. Recovery involves people with mental health problems having the opportunity to exercise their own agency. Adopting a recovery philosophy within mental health practice involves applying specific values rather than working within certain models (Repper 2000, Lakeman 2013). Values can inform action and therefore represent an important intrinsic motivator for behaviour (Jambrak, Deane and Williams 2014). In this respect the personal beliefs and values suggested by Louise could be influential in her approach to practice.

*"... and also you know I guess having like-minded care coordinator. Again a team is made up of different personalities, some are more proactive in positive risk taking, others are more cautious and she happens to have somebody who is very good and pro-active in risk taking. So I think together we have got that strength really and because we felt competent doing that, it just naturally progressed that the team supported that approach with her but I think if perhaps I was away and the care coordinator was away and nobody had seen her for a while, it might easily have slipped back into knocking on the door and seeing her more frequently."*  
(Lilly)

Lilly suggests that sharing these values can be an important source of strength potentially helping the development of narrative and moral proximity. Here, she is discussing the scenario referred to previously where visits to a woman who was unwell were reduced. Narrative and moral proximity include components where the professional is able to share this viewpoint with others involved in a person's care (Malone 2003). Here Lilly highlights how combined with an ally she was able to secure the support of the team to adopt this approach.

Within this vignette Lilly discusses the therapeutic approach in the context of positive risk taking. Positive or therapeutic risk taking was identified as part of their practice by five participants (Kimberley, Sebastian, Jack, Lilly and Louise) with examples being provided by three of these. Positive risk taking still creates a link between service users and risk, perpetuating the view that being 'risky' is part of the experience of mental health problems. In this respect it has the potential to contribute to constructions of service users as objects of risk. However, within Kendra's (2007) analysis of the construction of mariners as risk objects, he argued that due to powerlessness the only strategy available to the mariners to resist their objectification was to focus on different forms of risk. Positive risk taking attempts to reintroduce the notion of possibility and gains in association with risk (Morgan 2000). Whilst the framework of risk remains problematic, it could be argued that this inclusion of a different 'form' of risk may support Louise and Lilly to resist emplacing service users as risk objects.

Displacement of risk objects has been evidenced in Team B and not in Team A or Lawrence ward. Community Team B adopted a one to one case management model where as in Team A these responsibilities were held by the team. As such Team B departed from an assertive outreach approach more closely aligned with the original model (Bond et al 2001). Time spent with service users is an important feature of developing narrative and moral proximity (Malone 2003). Interviews with Louise and Lilly have been highlighted as different to those with other members of the same team. However, it is possible that these case management structures may have supported the development of proximity for Louise and Lilly.

### **5.7.3 Summary**

The construction of risk objects is a dynamic process characterised by attempts to emplace and displace them (Hilgartner 1992). Whilst risk objects themselves lack much power to resist their emplacement

(Kendra 2007), this chapter has examined instances largely from two interviews where service users were displaced. It has explored how Lilly and Louise were able to maintain narrative and moral proximity with service users to avoid viewing and treating them as objects of or at risk. Personal values, allies within the team and aid from professionals external to the team have been explored as supports that may have enabled them to maintain this displacement.



# 6.0 Conclusion

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## **6.1 Chapter 16: Conclusion**

The concluding section of this thesis presents the key findings from the study and considers how these insights may inform mental health practice and further research.

### **6.1.1 Strengths and Limitations of the Study**

The strength of case study research according to Flyvbjerg (2006) rests in the generation of context-dependent knowledge that has intrinsic value. However, transferability is partially about the practical application of the findings, which is a genuine concern for the majority of nursing research including mine as I seek to inform understanding about this particular area of mental health practice (Ruddin 2006). In order to reach a position where it is possible to examine the potential practical implications of the study, it is essential to debate the merits and limitations of the case study research process I have undertaken.

Due to developments in the design of the case study, the research did not explore the perspectives of service users and their loved ones. The rationale for this decision has been provided within the methodology section. The omission of these perspectives could be defined as a limitation of the research, particularly in light of its concern with the autonomy of people with mental health problems and recovery orientated values.

Research that examines service users' experiences in relation to risk is limited. With the exception of the work of Joan Langan (Langan and Lindow 2004, Langan 2008, Langan 2010), literature relating to risk in mental health practice is dominated by professional views. The discussion highlighted that risk assessment and management has become an increasingly technical process which positions professionals as experts (Godin 2004). This narrow visibility of the service users' voice is therefore unsurprising. Such a discourse acts to

exclude service users, who lack the power to define and consequently manage risk (Kendra 2007). This study, conducted by a mental health professional and concerned with the issue of risk may inadvertently perpetuate this position through the lack of attention to the perspectives of service users on the topic of risk.

It has been acknowledged that atypical case studies can contribute valuable insights (Stake 2006). Difference in circumstance and participants can lead to theoretical assertions that may be relevant for a range of contexts (Sharp 1998, Flyvbjerg 2006,). Whilst the research intended to include an atypical case study this was not conducted, which may be viewed as a limitation of the research. Within this inquiry an atypical case was identified as a non-statutory peer led service. Such services are characterised by people with lived experience of mental health problems being in control of policy, as well as the provision of support, planning and evaluation of the service (Solomon 2004, Faulkner and Kalathil 2012). Mutual support from peers has been shown to enable service users to be more in control, experience a sense of empowerment, hold hope and have more social contacts (Repper and Carter 2011, Repper 2013). Services delivered by peers also perform well on service defined goals such as reduced hospital admissions (Solomon 2004, Tratenberg, Parsonage, Boardman and Shepard 2013). The positive impact of peer led services (and peer support) on recovery would suggest that including such an atypical study would have contributed to the development of richer and more rounded explanations. An atypical case study may have furthered understanding of how connections with service users' subjective experiences may mediate against an emphasis on their risk. This is a perspective which is limited within the current study as it only consistently appears in two interviews. Additionally, I would have been able to compare this with the impact of professional accountability and the statutory organisational directives that featured significantly in both the

instrumental case studies, since these influences would have been different in a peer led service.

Case study research involves the collection of detailed information from multiple sources (Yin 2003, Casey 2006, Gangess and Yurkovich 2006,). In order to fully immerse myself in a setting to support the development of rich interpretation, data collection was completed in one case study setting before the next case study was initiated. Conducting the research has therefore been a lengthy process complicated by the challenges of undertaking the study part-time. The complexity and depth of case study research suggests these issues are not unique. However, this may reflect a limitation of this research. Change is a constant feature of statutory healthcare provision, yet during the period of the study new service commissioning arrangements were introduced nationally (Health and Social Care Act 2012). It has also been noted that the organisation within which the study took place has a focus on the implementation of recovery at an organisational level. The organisation revised its recovery strategy in 2013, with specific goals related to risk assessment and management. There is potential that these factors could have had an impact on the teams that formed the case studies for this research, their organisation and practice, possibly undermining the relevance of these findings. However, literature published more than 10 years after health policy espoused a commitment to recovery has highlighted that adopting the recovery approach in mental health services is a cultural shift that has yet to be made (Barker and Buchanan-Barker 2011, Yates et al 2012). Therefore, there is potential that the changes noted here may take longer to have an impact than the period of this study.

All these limitations present opportunities for further research. Whilst a case study needs to be concluded, this doesn't necessarily mean that it is closed (Flyvbjerg 2006, Perry 2011). Exploring the research question in an 'atypical' peer led service is a direction for future research, the findings of which could be compared with those of this

study. In addition a broader range of perspectives on the experience of potential tensions that may arise from delivering care and enforcing control could be gathered, through the examination of service users' and carers' experiences. This could provide further insight into strategies that service users undertake to challenge definitions of risk. Whilst recognising risk objects as disempowered, Hilgartner's (1992), Boholm and Corvellec's (2011) and Kendra's (2007) work lacks a full analysis of how these definitions may be resisted by those constructed as risk objects. Such insight may be important to further consider how the position of service users as objects of risk could be challenged; particularly since mental health practice has a long history of people with mental health problems actively challenging the manner in which they have been treated and defined.

The association between service users and risk appeared frequently within the findings of the study, which was linked with professionals' distance from a person's subjective experience under the influence of social and organisational constraints. The consistency with which this was evidenced is a strength of the study. This was underpinned by the use of observations and interviews. The comparison of findings across the different methods of data collection and two case studies provided the opportunity for triangulation, strengthening the interpretation of such patterns (Darke, Shanks and Broadbent 1998, Yin 2014).

Stake (2006:87) notes that within case study 'interpretations are enriched by personal experience'. The professional experiences that inspired the study have provided an important foundation for the research. The personal reflections incorporated within this thesis present an account of the influences of my own values and actions on the research. Yet these reflections may also make a contribution to the depth achieved within the interpretative process, particularly in relation to revelations that tensions between delivering care and pressures to control did not appear in the manner that I anticipated or that reflected my own nursing practice. Personal influences of the

researcher on a study have traditionally been perceived as a negative force, even within case study research (Yin 2003). However, supported by an epistemological context that claims individual researchers' beliefs are an essential part of developing understanding (Habermas 1972, Stake 2006, Andrade 2009), these personal reflections may have assisted the development of rigour since they offered a further perspective for comparison. This is further emphasised by the discovery of findings that significantly challenged my pre-conceived ideas (Flyvbjerg 2006).

The exclusion of service users' and carers' perspectives, and an atypical case study from the research may be considered a limitation; but conversely, the focus on health professionals and statutory services could be viewed as an advantage. The majority of mental health care is delivered by statutory services led by professionals. Focusing on these areas may have enabled a more bounded case study, set in the context of mainstream services where care is delivered.

The strengths explored in this section reflect the well documented benefits of case study research that supports the development of rich and detailed interpretations in complex 'real world' situations (Stake 2000, Flyvbjerg 2006, Ruddin 2006, Watts 2007).

## **6.1.2 Implications of the Study**

### ***6.1.2.1 Summary of Key Findings***

A concern that mental health practitioners are likely to be frequently caught in a process of trying to strike a balance between promoting choice and exerting control has been regularly discussed within the literature, though it has rarely been explored empirically (Hopton 1996, Morrall and Hazleton 2000, Langan 2008, Tickle et al 2014). At the outset, this thesis presented an argument that there is a duality at the core of mental health service delivery. It considered how the historical development of institutional and community care has

shaped a concern for the need to control people with mental health problems alongside providing therapeutic care and support. Tensions between the rights of the individual to self determination and perceived threats to public safety in the development of mental health legislation have been examined. Within contemporary mental health practice it has been proposed that mental health professionals, through the assessment and management of risk, are positioned to control 'non-citizens' who do not conform to the roles and responsibilities demanded by a neo-liberal society. It has been argued that this function conflicts with the professionals' role to work alongside people with mental health problems to support their recovery. I, therefore, argued that mental health professionals could experience tension in making decisions due to these conflicting influences on their practice. The research set out to explore whether and how mental health practitioners perceive and experience the potential tensions that may arise from delivering care and enforcing control for people who experience mental health problems.

Within the case study sites, this research has claimed that the expression of such duality is limited. The notion of risk was seen to govern the practice of mental health professionals to such an extent that it defined how service users were understood and treated. The application of Hilgartner (1992) alongside Kendra (2007) and Boholm and Corvellec's (2011) work has offered new insight into the well-documented concern regarding the preoccupation with risk in mental health practice. The interpretations presented in this study suggest that the nature of the relationship between professionals and service users is pivotal to understanding how this dominance of risk is created and maintained. Distance between professionals and service users on a spatial, narrative and moral level enabled the subjective experience and individuality of that person to become lost. Through this, the conditions were developed whereby risk could come to dominate their identity in the eyes of mental health professionals. However, an examination of the perspectives of participants in this

study suggests that this relationship between a professional and service user (and ultimately their construction as a risk object) is significantly influenced by professional, organisational and social contexts. Documentation systems, incident inquiries, a fear of being blamed, alongside responses from local social agencies and community members were viewed as contributing to the construction of service users as a source of risk. These were also viewed as informing the response that a risk object should be subject to surveillance and control. All of which is supported by a social theoretical perspective of risk. This study has recognised a lack of visibility of the service user voice in decision making. These findings would suggest that principles of recovery have had a limited impact in the case study sites at the time of the research. Discovering how to move forward from this position and consider how it may be addressed is therefore complex.

#### 6.1.2.2 Duality

Developing insight into the expression of duality in contemporary mental health services may in itself be of value. The objectification of both patients and people with mental health problems has long been recognised (Menzies Lyth 1960, Foucault 2006). In light of the findings of this study which suggest these processes continue to be embedded in health care; as mental health professionals practicing in the context of humanistic and recovery orientated values we may be at risk of perpetuating a form of false consciousness. Such arguments reflect Hopton's (1996) assertions that mental health professionals' claims to be working in person-centred ways can serve to legitimise compromises to service users' rights. The justifications provided by participants on the basis of reified notions of risk, that mechanisms of control are always necessary may also perpetuate a false consciousness. Foucault's analysis of the forces that act to define and control madness (which are recognised in this thesis) have been criticised for presenting 'subjects' themselves as lacking agency



(McNay 2013). The apparent entrenchment of objectification, influenced by professional, organisational and social contexts could reinforce this position. However, understanding and raising awareness of the situation reflects the emancipatory knowledge interests of Habermas (1981) which provide the epistemological context for the thesis. This highlights that recognising that people with mental health problems are being objectified and that professionals may act as part of a process which reinforces this can make a contribution to creating the conditions to change the situation.

The pressures to construct service users as objects of risk did not overpower all the participants in the study. This may offer further hope that resisting influences to define and treat service users in terms of their risk is possible. These individuals were exposed to the same professional, organisational and social influences as other participants, yet they were able maintain their connection with service users' narratives. The reasons for this were not fully explained in the interviews. There could be significant value in gaining further insight into the factors that enable staff to develop practice that remains focused on that person's subjective experiences.

#### 6.1.2.3 Risk and Professional Practice

The development of a distal relationship between professionals and service users created the conditions whereby their construction as risk objects was possible. It also appeared to be reinforced by ideas of risk and uncertainty, perpetuating the view of people with mental health problems as 'unknown risky others'. Developing knowledge of the person using services through establishing a meaningful relationship could undermine the challenge posed by the unknown associated with the experience of risk and therefore emphasise what is familiar between the two, helping to reduce fear (Kearney 2003). These findings would support an approach to understanding and responding to risk that is situated in engagement with service users' individual experiences. The disconfirming evidence provided by the

interviews with Louise and Lilly underlines these claims as they were able to see risk in the context of the whole person, not as defining the whole person.

Situating an understanding of risk within the context of a relationship creates space for exploring threats to the person's own safety and well-being, such as victimisation, stigma or the physical effects of psychiatric medication (Muir-Cochrane 2006, Langen 2008). This presents an opportunity to move away from service users as the source of risk (therefore displacing their position as risk object) alongside recognition of the potential gains that may be achieved through the person taking more control. Yet developing a relationship that is valued by service users could also impact positively on risks. Scott-Moncrieff et al's (2009) report on the Gonzales inquiry stresses that developing a service that people with mental health problems value is essential and in itself could help to promote safety. Within the community setting this could entail re-evaluating opportunities for engagement in response to the service users experiences, such as that observed in relation to Carl (p166). Within an acute setting, promoting opportunities for individualised care such as involving service users in their decisions about observation levels could promote such an approach.

Emphasising a need for meaningful relationships reflects the claim that current approaches to risk undermine the relational emphasis of mental health care (Godin 2006). In many respects the arguments explored here underpin recommendations for good professional practice (DH 2006, South London and Maudsley NHS Trust, South West London and St Georges Trust 2010) and in some cases good practice for assessing risk (DH 2007), yet this may not be being achieved. Adapting the tools used to document risk assessments and management plans to create more emphasis on an individuals' experience, could be an area to further examine to support the formation of a relational approach to risk, particularly in the context of significant debate over existing tools (Langan 2010, Fazel et al

2012). Similar developments are considered by Boardman and Roberts (2014) in an IMrOc paper examining recovery and risk. Here the authors promote person centred safety planning as a means to redress the balance between risk and recovery. The paper argues that planning for safety enables a greater focus on individuals' self-determination, opportunity and responsibility. Additionally, a partnership between service users and professionals supports collaborative understanding of problems and the development of strategies and plans to deal with them and promote safety. This reflects the experiences of Louise and Lilly, therefore providing some evidence that Boardman and Roberts' (2014) recommendation for recovery orientated approaches to risk could have an impact.

#### 6.1.2.4 Risk and Language

Within this study practitioners tended to treat risk as an objective entity, associated with harm perpetuated by service users, which needed to be quantified and controlled. The process of construction examined in this thesis has highlighted how risk came to dominate the identity of people with mental health problems. As part of raising consciousness, it is essential to draw attention to the manner in which the term risk has come to represent such a narrow range of ideas in the mental health practice explored in this study. Risk is not a neutral concept. Yet accepting that risk is, supports a process of reification that may have enabled 'risk' to become the key issue that determines the support and treatment people receive from mental health services. Moving forward from these insights suggests that as mental health practitioners we need to be more attentive to language and perhaps subsequently more questioning of the ideas that it represents.

In the context of interpretations made in this study, this assertion implies that the language of risk may itself be perpetuating an association between service users and harm. A professionalised discourse of risk has been seen to act to exclude service users. The

association with predictability may serve to reinforce professionals' vulnerability to becoming objects at risk through a blame process (chapter 12). The use of the term risk in mental health services could be problematic. Boardman and Roberts' (2014) paper argues that to promote recovery whilst also maintaining safety requires a conceptual (and practical) shift in risk assessment and management practice. Notably within the paper the language used, particularly in relation to risk management shifts to a focus on 'safety'. The use of such language was more visible in the interviews with Louise and Lilly than other participants. I would argue that the use of concepts such as safety, threats to safety and opportunity, provide scope for more individualised means to understand the dangers that people may pose, or be exposed to. This could be reflected within assessment and planning frameworks, promoting a more focused, relational and contextual understanding of the person's circumstances. Such a semantic shift might challenge the displacement of individual experiences in favour of generalised disembodied risk factors applied to all people with mental health problems (Castel 1991).

#### 6.1.2.5 Organisational Influences

Chapters 11 and 13 discussed the capacity for structures and practices within the NHS organisation to act to promote distance between staff and service users, alongside identifying service users as the source of risk. Developing recommendations for the study has to therefore examine how these practices could be amended. Meeting structures were noted as promoting distance and excluding the service users' voice. This was compounded by a perception that complex and 'risky' decisions should be made in these forums away from the service user. Connection with subjective experiences, undermining the construction of service users as risk objects was promoted by proximity to the service user which was spatially and temporally located. Creating opportunities for mental health professionals and service users to engage in dialogue, particularly in the context of

decision making could promote proximity. These opportunities would also support a relational approach to understanding risk.

The open dialogue model provides one example of how care may be organised to facilitate close relationships between staff service users, families and networks of support. The approach grew from psychotherapeutic work with people with psychosis and their families (Seikkula and Olsen 2003). Informed by specific approaches to therapeutic dialogue, the model is a whole systems approach that centres on treatment meetings which aim to ‘make sense of the clients experience and find ways of coping with that experience’ (Seikkula 2003:232). Meetings are organised immediately following initial contact with services, involve all those in the persons support network and offer consistency of team support (Seikkula, Alakare, Aaltonen 2011). According to Seikkiula et al (2011) the role of the mental health team involves providing security and a safe space to hold uncertainty. Follow-up studies of those participating in the open dialogue approach, in Lapland where it developed, showed decreased use of medication, reduced hospital admission, reduced relapse and being more likely to be employed (Seikkula and Olsen 2003). Open dialogue meetings create the opportunity to engage with the meaning of the person’s psychotic experiences in the context of their life events and relationships. Seikkula (2003) notes that participating in the process as a professional means sharing the emotions of the clients. This assertion clearly expresses narrative and moral proximity with service users.

It is notable that the consistency and inclusiveness of the meetings is seen to contribute to an environment where uncertainty may be held. This is significant in light of the arguments explored in Chapter 11 where uncertainty becomes a source of anxiety for professionals, perpetuating distance from service users to protect against that anxiety. Power (2004:62) also advocates that a new ‘politics of uncertainty’ needs to be developed to tackle organisational

approaches to the risk management of everything. Spaces where uncertainty can thrive are perceived to be important for this to evolve.

Methodological criticisms of evaluation studies have led to some questioning of the claims made regarding the impact of Open Dialogue (Ross 2013). Yet the links with recovery approaches have been recognised and there is support for the development of the model within the UK (Developing Open Dialogue 2012). Open Dialogue has largely been tested in services supporting people with psychosis in which the majority of the workforce have undertaken education in psychotherapy, thus highlighting the complexity of translating the model into mental health services outside Lapland. However, the Open Dialogue principles of consistent support, regular meetings centred on an individual service user (as opposed to, for example, ward round structures) and empathic dialogue focusing on subjective meanings may offer some practical strategies to challenge structures that promote distancing. Additionally, the focus on dialogue as a means of sense making and bringing the individual with psychosis, their networks and professionals closer together reflects Habermas' emancipatory interests. Speech acts, according to Habermas, enable emancipatory communicative action when mutual understanding is achieved between two people who are capable of speech and action. Both individuals recognise the rights of the other to be engaged in dialogue and that participants can attain consensus (Giddens 1982).

This discussion has considered how supporting professionals to remain connected with service users' individual narratives may be where there is most potential to impact on practice. The study has however also noted how professionals themselves and the organisation may be positioned as objects *at risk*. Repositioning of these powerful groups is complex, yet it may be valuable to consider strategies which may reduce the threat of loss that has become associated with supporting people with mental health problems, acting to reinforce service users as risk objects. Debates concerning

empowerment of service users are useful to inform consideration of the impact of such power relationships on professionals and service users. This critical awareness shown by some participants of the influences of organisational systems on the actions of mental health professionals may be particularly significant. Practitioners are themselves subject to the influence of considerable power relationships in order to promote the maintenance of the status quo and compliance with the dominant norms and values of the current organisational and political systems (Ryles 1999). Yet they can lack awareness of such an influence on their practice (Masterson and Owen 2006). Through the development of consciousness regarding the impact of these power relationships, mental health professionals are enabled to consider their own role in oppressing rather than empowering people with mental health problems. Recognising the sources of control and dominance creates the scope for change (Habermas 1972). Reference to forums to support decision making, such as the ethics meeting and the identification of allies within a team, may provide indications of where those participants in the study identified a collective response that facilitated this critical perspective.

Within this research, the fear of being blamed by both their local organisation, professional bodies and in some cases wider society appeared as a key influence on mental health professionals that promoted the construction of service users as objects of risk. Shifting cultures of blame in healthcare services is a major challenge. However, this finding would emphasise the need for clear organisational processes that support reflection and learning following adverse events, rather than culpability. Shepherd, Boardman and Burns' (2010) vision for the development of recovery in mental health services underlines the importance of organisational commitment to ensuring that staff are supported rather than blamed. Through this, they suggest positive risk taking would be enabled.

Professional guidelines articulate a role for mental health professionals to support therapeutic risk taking, enabling people to exercise choices and rights, striking a balance between this and a duty of care (NMC 2010a, Health and Care Professionals Council 2012, Morgan 2007). This position is reflected in best practice guidelines (DH 2007). Participants in this study emphasised the perceived role of professional bodies in punishing bad practice following negative events. This highlighted that an emphasis within professional guidance which promoted the need to support people with mental health problems to make choices was not recognised. Whilst this expression from participants appeared to be influenced by social and organisational factors, it highlights the potential for a gap in knowledge of full professional and best practice guidelines; a perspective emphasised by Langan (2008). There may be a role for education and training bodies in promoting awareness of best practice in this area and the guidelines that inform it.

#### 6.1.2.6 Public

The potential influence of the media and public attitudes on policy development and mental health practice was acknowledged in the literature review. Chapter 14 highlighted those participants who perceived their decision making in relation to individual service users' care was influenced by these social contexts. Notably, all the examples identified in Chapter 14 narrated that the consequences were higher levels of containment for the service user. The importance of tackling prejudice and negative media portrays of people with mental health problems has long been recognised. Significant investment in changing public attitudes has been made. Despite many improvements, the percentage of people associating mental health problems with violence has actually increased (Time to Change 2013). Whilst this study is unable to offer any recommendations as to how these issues may be addressed, it emphasises the significance of tackling public perceptions through the



insight into the direct impact these had on the mental health professionals' everyday decision making. The study has highlighted that local media reporting was of particular concern, emphasising the potential to focus on positive relationships with the media at a local level. Open dialogue has been identified as an approach that supports meaningful relationships between people with mental health problems, their support network and mental health professionals. Seikkula et al (2011) note that this may have had a positive impact on the perception of mental health services in the local community. Participants from the community team highlighted that the reactions of community members, alongside local agencies, impacted on their decision making. Where these agencies are involved in the persons' support network (such as housing and the police) including them in dialogue meetings with the person could provide the opportunity for their concerns to be heard without necessarily compromising the service user's freedom.

### **6.1.3 Conclusion**

The thesis has contributed to knowledge through the new insights presented on the means through which risk has come to dominate perceptions of service users in mental health practice. Using Hilgartner's theory (1992) it has emphasised relationships as key to explaining how mental health professionals understand risk in relation to service users. The weight of the professional, organisational and social influences on this process is heavy, yet raising awareness of these processes provides opportunity for critical dialogue. There is also a need to maintain consciousness that definitions of risk objects are open to reconstruction and change. The concluding chapter to this thesis has explored approaches that may undermine the position that people with mental health problems are objects of risk.

The research has examined an area which has been much debated but lacked empirical investigation. Through undertaking and

disseminating the research it is hoped that it will inform development of strategies needed to enable individuals and organisations to move towards a position in which service users are able to make genuine choices about their lives, in a way that people without this label take for granted.

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# 8.0 Appendix

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## 8.1 Appendix I, Ethics Committee Approval

**Derbyshire  
Research Ethics  
Committee**

1 Standard Court  
Park Row  
Nottingham  
NG1 6GN

Telephone: 0115 8839435  
Facsimile: 0115 9123300

13 October 2010

Dr Julie Repper  
Associate Professor  
University of Nottingham  
Duncan Macmillan House  
Porchester Road  
Nottingham  
NG3 6AA  
Dear Dr Repper

**Full title of study:** An exploration of the meaning and practice of control in mental health settings from the perspectives of mental health workers and service users

**REC reference number:** 10/H0401/57

Thank you for your letter of 30/09/2010. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 15 June 2010. Please note these documents are for information only and have not been reviewed by the committee.

### Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		30 September 2010
Participant Information Sheet: Interviews	4.0	01 May 2010
Participant Information Sheet: Observations	4.1	01 May 2010
Participant Consent Form: Service Users - For Interviews with Digital Recording	3.0	01 May 2010
Participant Consent Form: Service Users - For Interviews without Digital Recording	4.0	01 May 2010

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

**10/H0401/57**

**Please quote this number on all  
correspondence**

Yours sincerely

**Mrs Lisa Gregory**

**Committee Co-ordinator**

E-mail: [lisa.gregory@nottspct.nhs.uk](mailto:lisa.gregory@nottspct.nhs.uk)

*Copy to:*

Anne Felton

Mr Paul Cartledge

R&D office for NHS care organisation at lead site –

Nottinghamshire Healthcare NHS Trust



## 8.2 Appendix II,

### **Participant Information Sheet (Observations)**

#### **An Exploration of the practice and meaning of control in mental health settings**

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

#### **What is the purpose of this study?**

The aim of this research is to explore the meaning and practice of control in mental health settings and examine it from the perspectives of mental health workers and service users. The research seeks to explore the potential for tensions that may arise associated with control and to examine how if at all these tensions are experienced and managed within mental health practice. The study is being conducted as part of a PhD program.

#### **Why have I been asked to take part in the study?**

You have been asked to take part in the study because you have you have experience of working within adult mental health services and are attending one of the meetings where an observation may take place.

#### **Do I have to take part?**

Deciding whether to take part or not is entirely up to you. You have been given this information sheet for information and the researcher will go through it with you in person if you show an interest in taking part and will be available to answer any further questions. . You are free to withdraw from the study at any time, without giving a reason. All attendees at the meeting must give their consent for the observation to take place.

#### **What does the study involve?**

If you decide you want to take part in the study, the researcher will observe a team discussion in which you may be part. The observation would be of an existing discussion forum such as team meeting or ward review and will last for a maximum of the duration of a meeting. The researcher will be observing the whole meeting and all members' discussion; you would not be singled out.

#### **What will I have to do?**

As the observation is of normal working practices, no additional action will be required from you though the researcher will be asking for your consent for these discussions to be observed. The research is being conducted in two phases so you may be invited to take part in a follow up interview. If this is the case you will be asked again at this point whether you consent to being involved.

#### **What will happen if I don't want to continue in the study?**

You are free to withdraw from the study at any time, without giving a reason and without consequence. If you decide to leave the study, information collected so far cannot be erased and this may still be used as part of the study analysis. If you decide to withdraw part way through the observation, the researcher will leave the room.

**What are the possible disadvantages and risks of taking part?**

There is a risk that you may feel uncomfortable knowing that the researcher is observing a discussion that you are part of. However, the researcher will aim to make their presence as unobtrusive as possible and the process of observation is to explore the potential tensions that may arise around care and control and not to judge team member's performance.

**What are the possible benefits of taking part?**

You will not directly benefit from taking part in the research study. However, the study is being conducted to help inform and develop mental health practice. Therefore taking part will provide the space to reflect on the issue of control in mental health and potentially input into the development of the evidence base for mental health practice.

**Will my taking part in the study be kept confidential?**

Yes. Ethical and legal practice will be followed and all information about you will be handled in confidence. The researcher will be making notes during the observation. Names and other personal information will not be recorded. Notes will be stored in a locked filing cabinet for the duration of the study. Non-identifiable data will be stored in a secure archive in accordance with the University of Nottingham policy after this point.

**What happens if I disclosed something that may need reporting?**

If you disclose something that may need reporting, such as unsafe practice or reporting harm to self or others the researcher may be required to take further action and has a duty to do so. If this is the case you will be fully informed. The action will depend on the nature of what has been disclosed. However, the action is likely to include informing your key worker or the nurse in charge of the shift if you are using services. In relation to members of staff this will be the senior member of staff present in your service area.

**What if there is a problem?**

The research is being supervised by the Dr Julie Repper and Professor Mark Avis at the Division of Nursing, University of Nottingham. If you have any immediate concerns supervisors can be contacted at the following address:

Dr Julie Repper  
Associate Professor  
Nursing, Midwifery and  
Physiotherapy  
University of Nottingham  
Duncan Macmillan House  
Porchester Road, Mapperley  
Nottingham NG3 6AA  
Email:  
Julie.Repper@nottingham.ac.uk  
0115 9691300 Via Extension: 11109

Professor Mark Avis  
Head of School of  
School of Nursing, Midwifery and Physiotherapy  
University of Nottingham  
A Floor Queens Medical Centre  
NG7 2HA  
Mark.Avis@nottingham.ac.ukEmail

If you remain unhappy and wish to complain formally you can do this through the Nottinghamshire Healthcare NHS Trust Complaints process by contacting the services liaison department on Tel: 0115 993 4542.

### **What will happen to the results of the study?**

The findings from this study will be written up into a report forming the researchers PhD thesis. The results may also be made more widely available to health professionals and mental health service users through journal publications and conference presentations. Individual participants will not be identified in any report or publication resulting from the study. A summary of the results can be sent to you at the end of the study if requested.

### **Who is organising and funding the research?**

The study is being carried out by a researcher from the Division of Nursing at the University of Nottingham. It is part of the researchers PhD course and is not funded

### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Derbyshire Research Ethics Proportionate Review Sub-Committee.

**Thank you for taking the time to read this.**

**If you have any questions or concerns about taking part in the research, or would like to discuss this further, please contact:**

Anne Felton  
Lecturer in Mental Health  
Division of Nursing  
University of Nottingham  
Duncan Macmillan House  
Porchester Road, Mapperley  
NG3 6AA [Anne.Felton@nottingham.ac.uk](mailto:Anne.Felton@nottingham.ac.uk)

Dr Julie Repper  
Associate Professor  
Division of Nursing  
University of Nottingham  
Duncan Macmillan House  
Porchester Road, Mapperley  
NG3 6AA  
[Julie.Repper@nottingham.ac.uk](mailto:Julie.Repper@nottingham.ac.uk)

0115 9691300 Ex 10560



## 8.3 Appendix III Participant Information

### Sheet (Interviews)

#### **An Exploration of the practice and meaning of control in mental health settings**

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

#### **What is the purpose of this study?**

The aim of this research is to explore the meaning and practice of control in mental health settings and examine it from the perspectives of mental health workers and service users. The research seeks to explore the potential for tensions that may arise associated with control and to examine how if at all these tensions are experienced and managed within mental health practice. The study is being conducted as part of a PhD program.

#### **Why have I been asked to take part in the study?**

You have been asked to take part in the study because you have current experience of either using or working within adult mental health services, or have had experience of having cared for someone who is using mental health services.

#### **Do I have to take part?**

No - deciding whether to take part or not is entirely up to you. You have been given this information sheet for information and the researcher will go through it with you in person if you show an interest in taking part and will be available to answer any further questions. If you are using services choosing to participate or not will have no impact on the care you receive. All participants are free to withdraw from the study at any time, without giving a reason. If you do agree to take part you will be asked to sign a consent form to indicate your agreement.

#### **What does the study involve?**

If you decide you want to take part in the study, you will be involved in a one to one interview with the researcher which will last for a maximum of 90 minutes.

#### **What will I have to do?**

The interviewer will ask a series of questions to explore your views and perspectives on the issue of control in mental health services. The research is being conducted in two phases so you may be invited to take part in a follow up observation. If this is the case you will be asked again at this point whether you consent to being involved.

#### **Where will the research take place?**

The interview will take place at a mutually convenient location to all participants involved. For mental health workers (NHS staff) this will probably be in your workplace or alternatively at a private meeting space. For service users and their family members arrangements can be made for this to take place at a location of your convenience such as a meeting room in the care setting. This could also be in your own home if this is preferable.

#### **What are the possible disadvantages and risks of taking part?**

Being involved in this interview creates the possibility that sensitive issues may arise for you as part of the discussion. These areas are not the specific

focus of interviews. However, given that the researcher will be exploring the issue of control and the potential for tensions within mental health practice and for service users how this relates to their care, individuals may disclose or discuss issues which may have caused them distress. However you will never be put under any pressure to talk about issues or reveal information about yourself that you prefer to keep private.

**What are the possible benefits of taking part?**

You will not directly benefit from taking part in the research study. However, the study is being conducted to help inform and develop mental health practice. Therefore taking part will provide the space to reflect on the issue of control in mental health and potentially input into the development of the evidence base for mental health practice.

**What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time and without giving any reason and without this affecting the care that you may be receiving. If you decide to leave the study, information collected so far cannot be erased and this may still be used as part of the study analysis.

**Will my taking part in this study be kept confidential?**

Ethical and legal practice will be followed and all information about you will be handled in confidence. Names and other personal information will be removed from the research data and records. With your permission, I will make an audio recording of the interview so that we can obtain an accurate record of what was said. However, this will not occur if you do not want it to be recorded. All personal information, such as your name and contact details, will be stored in a locked filing cabinet to which only the researcher will have access. Non-identifiable data will be retained in a secure archive within the University of Nottingham.

If permission for an audio-recording is given, this will be transcribed. However, any names and identifiable characteristics will be removed and your transcript will be allocated a code to which only the researcher will have access. If you do not wish to have the interview recorded the researcher will make some notes during discussion without making reference to personal details. Audio-recordings will be stored on a password protected computer and transcripts and notes secured in a locked filing cabinet for the duration of the study. After this date they will be stored in a secured archive in accordance with University of Nottingham policy.

**What happens if I disclosed something that may need reporting?**

If you disclose something that may need reporting, such as unsafe practice or reporting harm to self or others the researcher may be required to take further action and has a duty to do so. If this is the case you will be fully informed. The action will depend on the nature of what has been disclosed. However, the action is likely to include informing your key worker or the nurse in charge of the shift if you are using services. In relation to members of staff this will be the senior member of staff present in your service area.

**What if there is a problem?**

Contact numbers of support organisations including counselling service, advocacy groups and carer organisations have been included at the bottom of this information sheet. Team managers are aware the study is being conducted and therefore support can be arranged via managers. Key workers are also aware that the study is being conducted and that you have been invited to take part if additional support is required.

The research is being supervised by the Dr Julie Repper and Professor Mark Avis at the Division of Nursing, University of Nottingham. If you have any immediate concerns supervisors can be contacted at the following address:

Dr Julie Repper Avis Associate Professor Nursing, Midwifery and School of Nursing, Midwifery and Physiotherapy University of Nottingham Nottingham Duncan Macmillan House Medical Centre Porchester Road, Mapperley Nottingham NG3 6AA Mark.Avis@nottingham.ac.uk Email Julie.Repper@nottingham.ac.uk 0115 9691300 Via Extension: 11109	Professor Mark Head of School of Physiotherapy University of A Floor Queens NG7 2HA Email:
--	--

If you remain unhappy and wish to complain formally you can do this through the Nottinghamshire Healthcare NHS Trust Complaints process by contacting the services liaison department on Tel: 0115 993 4542. The patient advice and liaison (PALS) service may also be contacted on 0800 015 3367.

#### **What will happen to the results of the study?**

The findings from this study will be written up into a report forming the researchers PhD thesis. The results may also be made more widely available to health professionals and mental health service users through journal publications and conference presentations. Individual participants will not be identified in any report or publication resulting from the study. If requested a summary of the results can be sent to you at the end of the study.

#### **Who is organising and funding the research?**

The study is being carried out by a researcher from the Division of Nursing at the University of Nottingham. It is part of the researchers PhD course and is not funded.

#### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Derbyshire Research Ethics Proportionate Review Sub-Committee.

#### **Thank you for taking the time to read this.**

#### **If you have any questions or concerns about taking part in the research, or would like to discuss this further, please contact:**

Anne Felton Lecturer in Mental Health Division of Nursing University of Nottingham Duncan Macmillan House Porchester Road, Mapperley NG3 6AA	Or	Dr Julie Repper Associate Professor Division of Nursing University of Nottingham Duncan Macmillan House Porchester Road, Mapperley NG3 6AA
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[Anne.Felton@nottingham.ac.uk](mailto:Anne.Felton@nottingham.ac.uk)  
0115 9691300 Ex 10560

Julie.Repper@nottingham.ac.uk  
0115 9691300 Ex 11109

### **Contacts for Support**

#### **Nottingham Counselling Service**

32 Heathcoat Street  
Nottingham NG1 3AA  
Tel: 0115 950 1743  
Fax: 0115 988 1611  
Email: [info@nottinghamcounsellingcentre.org](mailto:info@nottinghamcounsellingcentre.org)

#### **Carers Federation**

Website: [www.carersfederation.co.uk](http://www.carersfederation.co.uk)  
Tel: 0115 985 8485

#### **Advocacy Partners Speaking Up**

3a First Avenue  
Sherwood Rise  
Nottingham  
NG7 6JL  
Tel: 0115 962 8270  
Email: [nottingham@speakingup.org](mailto:nottingham@speakingup.org)

## 8.4 Appendix IV Consent Form

**Version 3.0 May 2010**

(Form printed on local headed paper)

**Title of Study:** To explore the meaning and practice of control in mental health settings and examine it from the perspectives of mental health workers and service users

**REC ref:** 10/H0401/57

**Name of Researcher:** Anne Felton

**Name of Participant:** **Please initial box**

1. I confirm that I have read and understand the information sheet version number 3.0 dated May 2010 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis ☐
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that interviews will be recorded and that anonymous direct quotes From the interview may be used in the study report and may be used in subsequent publications. ☐
5. I agree to take part in the above study. ☐
6. (Optional) I would / would not like to receive a summary of results from this study (Please delete as appropriate) ☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent Date  
(if different from Principal Investigator)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Principal Investigator Date

\_\_\_\_\_  
Signature

2 copies: 1 for participant, 1 for the project notes

## 8.5 Appendix V Interview Questions

- Tell me a bit about the forums for decision making in your team
  - *Who is involved in these forums?*
- From your perspective what are some of the factors that influence this decision making process?
  - *Tell me about some times when you have seen these influence decision making*
  - *How are decisions about individuals' care reached within this service setting?*
- Have you ever experienced any dilemmas in relation to making decisions about an individual's care?
  - *What has informed this?*
  - *How was the decision reached? Was there any resolution?*
- Have there been any instances when you have felt like there was a lack of consensus or the team experienced difficulty in reaching a decision?
- What if any are the barriers to the decision making process?

Font in italics = prompts