

**On Being Human in Depersonalised Places:  
A Critical Analysis of Community Psychiatric Practice**

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## ABSTRACT

If you are someone affected by severe mental illness your personal identity may be invalidated as an inpatient on a psychiatric ward (Goffman, 1961; Rosenhan, 1973). This can also happen, however, and frequently does, in community psychiatric contexts such as outpatient settings and day services where one would expect a more personal approach to support. My dissertation presents a combination of four qualitative research studies, alongside theoretical analysis, to support this thesis and offer some alternative reflections on how we might reconceptualise community psychiatric services.

The first paper draws on my personal experience as both a voluntary and paid support worker for voluntary sector organisations to provide examples of how the *contract culture* has evolved in local authorities, and how the loyalties of the day-service providers have tended to shift from the actual service users to the funders instead. The fourth study returns to this issue and is based upon a case study analysis of a social inclusion day-service. It was found that the service users were being asked to fit their lives and identities into rigid services and intervention frameworks that were contractually driven, rather than led by their own needs.

Loss of identity and agency was found to occur in the more formal outpatient facilities. Study 2 presents a discourse analysis study of how the loss and the return of agency in therapeutic relationships are signalled by linguistic structures adopted in the narratives of psychiatric outreach service users. Study 3 incorporates thematic analysis to investigate the positive and negative experiences of compliantly ‘engaged’ community mental health team outpatients. These apparently compliant outpatients nevertheless often felt invalidated as human beings. They mainly attributed this sense of de-personalisation to brief contact with frequently changing psychiatrists, the rigid intervention frameworks, and practitioners showing a lack of courtesy and personal concern.

Study 5 presents further evidence of the failings of contemporary community intervention frameworks by contrasting the lives of two individuals affected with severe mental illness. Their narratives reveal the richness of their lives and aspirations and the systemic failure of community psychiatric services to address their personal needs. The final general discussion summarises the weaknesses in contemporary intervention

frameworks and draws on the work and thoughts of the early pragmatists (most notably George Herbert Mead and John Dewey) to propose a *pragmatic* way forward. Community practitioners need to move away from forcing service users' lives into fixed frameworks, and instead should acknowledge and accommodate the shifting personal complexities of *being a human* living with a mental illness.

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## **DECLARATION**

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

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## **ABBREVIATIONS**

AA, Administrating Authorities  
CLG, Communities and Local Government  
CMHT, Community Mental Health Team  
CPN, Community Psychiatric Nurse  
CSE, Certificate of Secondary Education  
DA, Discourse Analysis  
GP, General Practitioner  
NHS, National Health Service  
OED, Oxford English Dictionary  
PA, Positioning Analysis  
SIP, Social Inclusion Project

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## DISSEMINATION

### Publications

- Chase, M., Malden, A., Lansbury, L., Hansen, J., Ambrose, A., Thomas, C., Costall, A., Wilson, C., & Zinken, J. (in press). 'In sight, out of mind': The experiences of the compliantly engaged community psychiatric outpatient. *Community Mental Health Journal*.
- Chase, M., Thomas, C., & Costall, A. (2010). 'Bonding' or 'Bridging'? A case-study evaluation of the 311 Wellbeing & Recovery Service. [Internal Report for Portsmouth Health and Social Care Commissioners. Currently being used to inform local restructuring of psychiatric day-services].
- Chase, M., Zinken, J., Costall, A., Watts, J., & Priebe, S. (2010). 'These psychiatrists rate themselves as gods': Disengagement and engagement discourses of people living with severe mental illness. *Communication & Medicine*, 7(1), 43–53.
- Chase, M., Costall, A., Thomas, C., Zinken, J., & Wilson, C. (submitted). 'Bonding or bridging?' A case study of a social inclusion day-service. *British Journal of Psychiatry*.

### Conference presentations

- Chase, M., & Thomas, C. (2010). Taking shelter from the storm: A case study of a social inclusion service for people living with severe psychiatric illness. Oral presentation at the Neuropsychiatric, Psychological and Social Sciences Today conference, Athens Hilton, Athens (Greece), May, 2010.
- Chase, M. (2009). Digging beneath the service: A pragmatist approach to community psychiatric Services. Poster presentation at the Mental health & the issues facing society conference, Mersch (Luxemburg), September, 2009.
- Chase, M. (2008). "They don't listen because these men rate themselves as gods": Discourse and the psychiatric experience. Oral presentation at the 9th LSE-Cambridge Inter-University Graduate Conference, University of Cambridge, May, 2008.
- Chase, M., & Ogunremi, S. (2006). Promoting collaborative research to explore processes of engagement with mental health services. Poster presentation at the Innovations in Mental Health: Opportunities for Collaborative Research conference, University of Southampton, January, 2006.

## 1 GENERAL INTRODUCTION

### 1.1 On Being Human in Depersonalised Places: What's in a Title?

The title for my thesis stems from a radio programme I listened to in 2009, based on the classic study by David Rosenhan in the early 1970s: “On being sane in insane places.” In the study, Rosenhan and colleagues turned up at a number of psychiatric hospitals across the US and, in the hope they would be admitted, faked symptoms of schizophrenia. They need not have worried. They were admitted and, despite their attempts to act as ‘normal’ as possible when they were inside, it was between eight and 52 days before Rosenhan and his confederates were allowed out again (Rosenhan, 1973).

What I discovered in the programme was that, contrary to the emphasis on the misdiagnosis finding in his *Science* publication, Rosenhan’s original research aim had been to study the human experiences and behaviours of psychiatric patients and staff in hospital:

Indeed I had no intention on the outset to test diagnostic practices, and am quite sorry now that diagnosis looms so large in the paper I wrote for *Science*. The real purpose was to engage in a psycho-anthropological study of psychiatric hospitals. (Rosenhan, 2009)

My initial thought was that a more appropriate title for Rosenhan’s study would have been ‘On being human in insane places’. It then occurred to me that a similar title would pretty much encapsulate the essence of my thesis: the systemic loss of embodied human agency in community psychiatric settings. I settled for ‘On being human in depersonalised places’.

### 1.2 Embodied Human Agency

Heidegger proposed that we have agency from the moment we are born. We are “thrown” into the world at birth. From then, he said, our human existence was “futural”; a life story unfolding "between birth and death" (Heidegger, 1962, p. 425). This “futural momentum” (henceforth termed agency), as he and other eminent theorists

have said, is not however, an internal ‘life spirit’ that drives us to move from one context to another; it is embodied in the environment or context we find ourselves in at any given time. Whether it is manually working, ‘passively’ thinking, running, driving and so on, we are always ahead of ourselves in mini life projects nested within larger ones (e.g., Dewey, 1917; Heidegger, 1962; Mead, 1934; Taylor, 1993; Thurstone, 1923).

Generally our continual and active involvement with our environment is an embodied, seamless affair. We do not tend to reflect on who we are as ‘selves,’ what we are doing or what it is that goes in to the make-up of the environment that we are doing it in; our lives tend to be a flow of action and reaction in the milieu of day-to-day practices (Dewey, 1917; Heidegger, 1962; Mead, 1934). It is only when we choose to step out of our flow of life or when something goes wrong that we might reflect on our world and our position in it (Dreyfus, 1991; Heidegger, 1962; Taylor, 1993). It is the latter reflective experience that is important to this thesis.

The ‘something going wrong’ that can lead us into reflective modes of being comes in various forms in our daily interactions with objects and people. In relatively superficial instances, a tool or an object may not be ‘ready to hand’ even though you expect it to be so. Here, perhaps you would only very fleetingly reflect on what has gone wrong and adjust your behaviour accordingly (Heidegger, 1962). But loss of agency can also be severe and systemic. Take for example someone who lives with schizophrenia. Positive (psychotic) and negative (de-motivating) symptoms, overpowering medical professionals who systematically fail to listen to your views, prejudices and stigma of others or the disabling side effects of medication, can all lead to feelings of being dislodged from active participation in everyday life, and, as such, impinge on human identity (Goffman, 1961, 1963; Priebe, Watts, Chase, & Matanov, 2005; Rosenhan, 1973).

In this thesis, I argue that one does not need to be an inpatient on a psychiatric ward in order for someone affected by mental illness to feel that their human identity is invalidated. It can also happen, and frequently does, in less clinically oriented community psychiatric contexts such as outpatient settings and day-services. Through a combination of four qualitative research studies alongside theoretical analysis, I present a body of evidence which in my view strongly supports this thesis and offers some

reflections on how we might reconceptualise community psychiatric services into the future.

The current thesis consists of six papers. The first paper (chapter 2) is theoretical and draws on my personal reflections of working in the voluntary community care sector over two decades. The chapter is meant to serve two functions. First, it critically highlights how wider political policy and rhetoric directly impinges on the agency of people using community day-services. Second, it sets up the critical framework discussed in the following chapters.

The second paper (chapter 3) is a discourse analysis study. Here I describe how people describing 'troubled' relationships with psychiatric services used linguistic structures to signal loss, and sometimes return, of agency in practitioner relationships. This paper has already been published with coauthors in *Communication & Medicine* (Chase, Zinken, Costall, Watts, & Priebe, 2010).

The third paper (chapter 4) was the first local research study I undertook for my PhD. It was a qualitative analysis of the experiences of compliantly 'engaged' outpatients. I feel these findings capture the spirit of the thesis title. The paper has recently been accepted for publication in the *Community Mental Health Journal* (Chase et al., in press).

The fourth paper (chapter 5) is a case study of a local social inclusion day-service. I feel it demonstrates how human agency is compromised in more subtle, yet equally important, ways in contrast to those highlighted in chapter 4. The chapter illustrates the fundamental discord between what people with mental illness consider meaningful human experiences of community psychiatric services and contemporary outcome focussed ways of working. The paper is currently in submission to the *British Journal of Psychiatry* (Chase, Costall, Thomas, Zinken, & Wilson, submitted).

The fifth paper (chapter 6) is an instrumental case study analysis that contrasts the lives of two individuals affected with severe mental illness. Having already discussed in chapters 2, 4 and 5, the failings of contemporary community intervention frameworks, these two narratives exemplify the complexity and richness of human life that contemporary practitioners need to take account of.

The sixth and final paper (chapter 7) provides a general discussion. It summarises the weaknesses in contemporary intervention frameworks and proposes a

pragmatic way forward. In doing so it draws heavily on the early pragmatists' (circa 1900) preferred ways of social intervention. It is suggested that current community psychiatric practice needs to move away from forcing lives into fixed frameworks, and instead should acknowledge and accommodate the dynamic *process* of meaningful experience that comes from living as a human being.

## **2 ‘THE CARROT AND THE STATE’: PERSONAL EXPERIENCES OF SHIFTING IDENTITIES IN THE VOLUNTARY SECTOR OVER TWO DECADES**

For several decades important policy frameworks, and related financial incentives, have meant that local and central Government have had an increasing influence on how community care voluntary sector establishments are run (e.g., National Health Service and Community Care Act 1990; Kendall & Knapp, 1996; Wolch, 1990). Many voluntary sector organisations have had to learn to compromise their founding principles or fall by the way side. As new proposed funding arrangements, theoretically anyhow, offer opportunities for the voluntary sector to reclaim core principles (Audit Commission, 2010; Department of Health, 2011), it is perhaps important to reflect on how the current state of affairs came about. Through personal experiences of working in the voluntary sector over two decades, I will discuss why the values of principled organisations became negotiable and some of the implications this had for the people who accessed their services.

### **2.1 The Introduction of the Carrots**

In the late 1980s, disillusioned with a painting and decorating career in a recession hit UK, I became a community volunteer for a “charitable organisation” in the North of England. For one highly enjoyable year I was one of a number of similar volunteers (working for weekly room, sustenance and £25 per week pocket money) who helped young disabled people live in a small shared bungalow while they studied art at a local tertiary college. The charity was set up by a very determined woman who was inspired by the plight of her two sons, who were challenged in their passion for art by a rare degenerative disease. By establishing the organisation, she enabled a number of similarly young disabled and likeminded people to pursue their love for art, a passion and motivation for which were the only essential requirements to access the service. This was achieved through attending local art classes and living and sharing an environment with able-bodied volunteers who were similarly artistically minded (somewhat artistically challenged I slipped in underneath their radar). When I joined the organisation, some five years after its genesis, it was funded by a combination of

charitable donations (from regular benefactors and charity boxes located throughout the area) and a share of the students' disability benefits. Together, these resources provided the salary for a modestly paid, but very able and committed manager, the running costs of the bungalow, art facilities, mini-bus transport, and the living costs of a team of volunteers who provided care support.

I was saddened when I returned to visit the bungalow in the early 1990s. The environment I found had changed radically. It had been transformed into a small residential dwelling solely for disabled people. The essential criterion, on which the organisation had been built, a desire for students to further their artistic 'selves,' was no longer stringently applied. In its place new criteria dictated merely that residents needed to be young, have a physical impairment and the desire to live 'semi-independently.' Gone was the hive of communal activity, people rushing to make their classes or work on their art, and the seamless ways in which young disabled people and able-bodied volunteers forged friendships. In their place were communal apathy and tacit staff-resident boundaries.

Unbeknown to me at the time was the emergence of a new policy framework that local voluntary sector groups were beginning to work to in the mid to late 1980s. The *independent* sector was slowly making its transition to what I would term a 'darker side,' or what Wolch (1990) has termed the "shadow state" (an extension of the statutory sector). In an acceleration of post war deinstitutionalisation, the then Conservative Government (1979 – 1997) was "strengthening"<sup>1</sup> the voluntary sector (Kendall & Knapp, 1996; Wolch, 1990). With the introduction of the National Health Service and Community Care Act 1990, local authorities were becoming purchasers, rather than providers, of community services that housed and supported disabled people.

Through extensive central Government subsidy and enabling legislation, local health and social services were authorised to dangle financial 'carrots' in front of voluntary sector organisations which could bolster statutory community provision (Kendall, 2003; Kendall & Knapp, 1996). Charities that were struggling to make ends

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<sup>1</sup> It should be noted, however, that other political agendas beyond deinstitutionalisation were likely to be behind the Conservative Government's *strengthening the voluntary sector* programme; not least weakening politically left wing Local Authorities (e.g., Kendall & Knapp, 1996; Wolch, 1990). Extensive funding of Housing Associations throughout the 80s and early 90s, for example, substantially disempowered Council housing monopolies (Kendall & Knapp, 1996).

meet in an ever competitive volunteer market, or who saw opportunities for expansion and *professionalism*, began selling off their *wares* in the form of human and practical resources. But with the carrot came a 'stick'. Organisations who accepted financial subsidy would become accountable to their funders. For the organisation for which I had worked, this meant widening their inclusion policy to incorporate people who had impairment alone (i.e., not excluding those who had no interest in art), and subjecting their dwellings and working practices to increased regulation, bureaucracy, and stifling Health and Safety laws. In place of its core values and purposeful vision, the organisation had lost its autonomy and become another member of the "shadow state" (Wolch, 1990).

## 2.2 Competing for Carrots

After a period of time in higher education and research I returned to practical work in the voluntary sector in the early 2000s, this time in the area of mental health. In the ten years following my first encounter, financial carrots had been fully integrated into the voluntary sector diet. Through the 90s countless voluntary sector organisations embraced the strengthening programme and now thrived in its opportunities for State funding and professionalism. Instead of a *charitable group* I was now working for a "nonprofit-making service provider". The organisation offered supported housing opportunities to people living with severe and enduring mental health difficulties. I was one of six project workers who supported people through a transition period from leaving psychiatric hospital to being set up to live independently of support. Residents lived in small group dwellings for up to a 24 month period of 'rehabilitation' with the help of people like me and the two to four peers they lived with.

The organisation was founded in the late 50s when its pioneer, Elly Jansen, invited people from a local psychiatric hospital to live with her and form a "therapeutic community" in Richmond, London. Elly was concerned that too many people were being released from psychiatric hospital only to relapse and return shortly afterwards because they were not prepared for "ordinary" life. Together with her first residents, Elly established a framework that afforded the core therapeutic principles for the 'halfway houses' that the Richmond Fellowship would go on to provide in the coming decades. For many years after, numerous people would go on to reclaim lives

devastated by mental illness, through the intensive “therapeutic” support of peers and staff, structured work programmes and local community integration initiatives (Jansen, 1980; Rose, 1986).

By the time I joined the voluntary organisation, it had substantially grown. Recipients of its services now ran into the thousands and staff members the hundreds. My *team* was accountable to a senior project worker, a deputy manager and manager, who themselves worked under a cascading management structure that led up to a head office some 200 miles away. The funding for the housing and this professionalism called for more complex funding mechanisms than mere benefactors and charity boxes, the organisation’s early funding sources. The funding now came from the Supporting People Programme, where central Government-directed monies for personal support were complicatedly integrated with local housing benefits (Department of Social Security, 1998; Griffiths, 2000). Now, instead of carrots in the way of grants enticing selected organisations, a ‘contract culture’ had evolved (Kendall & Knapp, 1996; Morris, 2000). Local Government purchasers would outline the services they were commissioning and local nonprofit-making organisations would openly compete for provider status for fixed-term contracts. With the contract culture, organisations faced further compromises to any core principles they had left. Purchasers would emphasise *value for money* and dictate the framework for how this would be assessed. Contractual rules and regulations would place further boundaries on the type of service that would be delivered, and the competitive market forces would place financial constraints on the quality of service they could afford to deliver (Kendall & Knapp, 1996; Morris, 2000; Wolch, 1990).

Working in this type of organisation was very different to my last experience of the voluntary sector. Two of the early notable differences were the *professional* language we used and the *professional* distance we were encouraged to keep at all times. Rhetorical terms like “empowerment” and “boundaries” became essential discourse of our working lives, to the extent that overtly forging friendships with residents (as I did during my last experience of the voluntary sector) was a disciplinary offence.

Undoubtedly the mental health of most residents improved during the time they spent in the projects we oversaw, but whether this was due to anything more than our

offer of shelter, peer support, a watchful eye and listening ear was debatable. Funding restrictions meant that projects were only visited sporadically and any support we gave was more paternalistic than based on the core therapeutic principles on which the organisation was initially founded. Most of the life and coping skills that we preached or facilitated, such as illness management, budgeting, debt management and cooking skills, seemed to be either already learnt in their preillness lives, deliberately disregarded or ungraspable in light of residents' current habitual behaviour or symptoms of illness. While residents appreciated our willingness to offer time and an understanding ear, there was little evidence our "therapeutic" efforts made any impact on enriching their lives. If we were not at the projects, residents would all too easily lapse into apathetic lives of daytime TV and smoking, with an occasional trip to a drop-in day-service.

But there was a more ethically questionable side to what we were doing. The main goal of the project was to help residents achieve what had somehow become, and remains, the gold standard for rehabilitative practice, living independently of support (Department of Health, 2006a, 2011). Our success as an organisation was measured by whether service users *graduated* to autonomy within the period of time they were funded to be under our care. Little attention was paid to the isolation and lack of support that was likely to be experienced after independence was achieved, or indeed, if people would prefer their current living arrangements. In the short period of time we would carry out follow-up visits to people after their graduation, it was no surprise to me that apathetic lifestyles mentioned above continued – only now they were coming home to isolated rather than communal environments.

A year after leaving the supported housing organisation I was fortunate enough to interview someone who had lived in a halfway house run by the Richmond Fellowship in the late 1970s. She described to me how the communal living and structured therapeutic programmes she experienced had turned her life around. She talked about how she "matured", took responsibility for her lifestyle and learnt to accept her illness. Her experiences had little resemblance to ones I witnessed while working for the same organisation (albeit in a later time and geographical area). Somehow, after two decades of voluntary sector strengthening (Kendall & Knapp, 1996; Wolch, 1990) the organisation had lost its way. It had evolved into an *independent living production*

*line* that lost sight of the quality of life people actually experienced both during and after the transition to autonomy. For a select few, the organisation did offer a place to recover from relapse before returning to lives that originally had substance and meaning. For most, however, it was a place of respite before returning to lonely and isolated existences. In embracing strengthening and professionalism, the core therapeutic principles that the voluntary organisation was built on were now merged with the fickle principles of the funding bodies.

### 2.3 Force-Fed Carrots

My most recent encounter with the charitable sector was from between 2009 – 2010. Carrots by now were becoming even more difficult to swallow. This time I was working in the capacity of a researcher undertaking a case study evaluation of a ‘social inclusion’ day-service for people affected by enduring mental illness (see chapter 5). The day-service emerged from a national initiative whereby informal ‘bonding’ type drop-in day-services, where people met up and shared time with friends and peers. This was superseded by ‘bridging’ facilities that were activity focussed and encouraged people to enter more socially inclusive environments (Department of Health, 2006b, 2008; National Social Inclusion Programme, 2007; Putnam, 2000).

My research project proved interesting in two important ways. First, it captured a disparity between what the service providers were contractually commissioned to achieve and what the service users themselves wanted and to some extent were getting from the service. This conflict was most evident in the “resistance to change” voiced prior to the transition from bonding to new bridging service. Many service users insisted they were happier to bond than to bridge. Feelings were so strong that a large number who previously were regular users of the old service opted not to access the new facility.<sup>2</sup>

A more subtle disparity was observed in people who chose to use the bridging service. All the service users seemed to value the provision, especially the commitment and support they received from the staff who run it. However, the initiative was not being used for bridge building to more socially inclusive environments i.e., its

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<sup>2</sup> Although exact figures were not available from the service provider, one participant interviewed estimated that as many as 50% of the old drop-in service users were not accessing the new service.

commissioned purpose; rather, service users continued to use it as a bonding facility. Additional bridging activities added structure to days, but the provision's predominant function was still a place to meet and share time with others (while simultaneously alleviating symptoms of mental illness and the social isolation experienced after the day-service was closed).

The service provider was a regional branch of Mind, a UK national nonprofit organisation that was established in the 1970s. Since its earliest beginnings the organisation had acted as respected lobbyist, advocate and service provider for people affected by mental illness. The second interesting aspect of the research project, for me anyhow, was how an organisation whose core values were originally grounded in giving primacy to the voices of people affected by mental illness, could be unresponsive to the voices and behaviour of the people it now locally served.

The answer may lie in the wider political agendas that had gathered momentum in the ten years preceding my return to the voluntary sector. Following New Labour's election into power in 1997, community care was judged not to be working (Department of Health, 1998). The then new Government's answer was to introduce a series of initiatives that aimed to centralise standards of community care provision (e.g., Department of Health, 1999; National Social Inclusion Programme, 2009a; Social Exclusion Unit, 2004). In mental health, standardised benchmarks for social inclusion for community psychiatric day-services were *mainstreamed* throughout the UK (National Social Inclusion Programme, 2009b; Social Exclusion Unit, 2004). While it could be said that the Government's motives were noble given the extent of social exclusion experienced by people affected with mental illness (Social Exclusion Unit, 2004; cf., Parr, 2008; Spandler, 2007), the knock-on effects of centralising preferred working practices meant that local authorities were less responsive to local social inclusion needs in the day-services they needed to commission (Kendall, 2003).

In this instance, the centrally driven version of social inclusion to which the local service provider was contractually obliged to work meant encouraging people away from safe bonding environments towards, arguably, more hostile socially inclusive and mainstream ones (Department of Health, 2006b; National Social Inclusion Programme, 2009b; Spandler, 2007). Generally, however, the service users were exercising their "choice" (as they were encouraged to in other centrally-driven policy

documents, e.g., Department of Health, 2006a) to bond. This failure to align with contractual policy directives was not, however, viewed as a legitimate choice; it was implicitly counted as a 'failure.' The contracted organisation had no freedom to acknowledge (at least, publicly see chapter 5) that for many people with enduring mental health difficulties, their bonding choice may have been an informed decision that followed years of trying and failing to access mainstream opportunities, or indeed a legitimate questioning of the value, or even the existence of, 'community' or 'mainstream' life (Parr, 2008; Putnam, 2000; Spandler, 2007). In the face of these contextual and ethical factors, the organisation opted to adopt the position of its commissioners in maintaining this narrow social inclusion policy. An organisation, built on core principles of advocacy and participation, ended up forging services that effectively exacerbated rather than alleviated the marginalisation of the local people it was there to support.

#### **2.4 A Change in Diet?**

Over the last 20 years (and before, see Wolch, 1990), the complex contextual factors that have surrounded community care voluntary sector groups have created roller-coaster rides for those involved. Philanthropists who have opted to maintain their own core ideals and principles are rare and have been superseded by organisations with hybrid identities that need to rely on local and central Government 'carrot and stick' approaches to commissioning. For voluntary sector organisations the costs/benefits of the carrots are likely to have been mixed. For some (especially the larger ones, see Morris, 2000), the carrots have meant that through varying degrees of compromise or adaptation to their services they were given opportunities for furtherance and recognition that has enabled more people to experience the perceived benefits of their services. For other organisations, it might not have been until carrots were fully digested that they realised the extent to which their charitable identity had been compromised, and were unable to return things to the way they were. I have often wondered, for instance, how the pioneer of the Art charity where I began public sector work felt following the initial compromises she made in the name of funding back in the early 1990s.

As we enter a new decade, perhaps there is scope for more optimism. In contrast to community voluntary sector services being constrained by locally contractual agreements and centrally driven policies and programme targets, the new Coalition Government (since May 2010) is now emphasising the decentralisation of power to local communities (Department of Health, 2011; The Cabinet Office, 2010). “Personalisation” agendas, whereby service users are funded directly to achieve their own personal goals are likely to lead to alternative funding opportunities and the reconfiguration of services that are more responsive to individual and local needs, rather than being driven by central policy and abstract goals (e.g., National Social Inclusion Programme, 2009b).

With the regulation that has evolved within the community care sector and its contract culture it is difficult to see how we can recapture the ethos that nurtured the informal and organic working relationship I experienced when I first entered the voluntary sector. I am sure many proponents of the (not so) new age of *voluntary professionalism* would argue that this is just as well. However, it is possible we may agree that we now have the opportunity to reverse a policy trend that has increasingly shackled voluntary sector groups for at least two decades. Local Government needs to put carrot and stick methods of commissioning services behind them and judge voluntary sector organisations on their ability to step out of the State’s shadow and offer innovation in response to local needs. In doing so, it might be possible to return an *Independent* sector that is able to provide services capable of affording meaningful choices to people affected with mental illness, as well as creating forums that have more potential to challenge statutory authority and offer opportunities for social reform.

### **3 ‘THESE PSYCHIATRISTS RATE THEMSELVES AS GODS’: DISENGAGEMENT AND ENGAGEMENT DISCOURSES OF PEOPLE LIVING WITH SEVERE MENTAL ILLNESS**

#### **3.1 Abstract**

Positioning analysis, a variant of discourse analysis, was used to explore the narratives of 40 psychiatric patients (11 females and 29 males; mean age = 40 years) who had manifest difficulties with engagement with statutory mental health services. Positioning analysis is a qualitative method that captures how people linguistically *position* the roles and identities of themselves and others in their day to day lives and narratives. The language of disengagement incorporated the passive positioning of self in relation to their lives and treatment through the use of *metaphor*, the *passive voice* and *them and us attribution*, while the discourse of engagement incorporated more active positioning of self, achieved through the use of the personal pronoun *we* and metaphoric references to balanced relationships. The findings corroborate previous thematic analysis that highlighted the importance of identity and agency in the ‘making or breaking’ of therapeutic relationships (Priebe et al., 2005). Implications are discussed in relation to how positioning analysis may help signal and emphasise important life and therapeutic experiences in spoken narratives as well as clinical consultations.

#### **3.2 Introduction**

For many people living with severe mental illness there is a significant and strong association between disengagement from mainstream treatment and services and adverse outcomes (Fenton, Blyler, & Heinssen, 1997; O’Brien, Fahmy, & Singh, 2008). In general it is acknowledged that people with severe mental illness who disengage from treatment and services tend to have an increased risk of social isolation, suicide, homelessness, and a greater number of inpatient days (Mueser, Bond, Drake, & Resnick, 1998). For example, a review of suicide incidences between 1996 and 2001 found that one third of people with severe mental illness who committed suicide had

missed their last outpatient appointment with health professionals (Department of Health, 2001).

Why people disengage from mental health services and what, if anything, makes them want to reengage, are essential issues for both clinical practitioners and commissioners. To date, research efforts in this area have tended to use quantitative methods, exploring research questions related to mental health services attrition and nonattendance and the types of service configuration and patient characteristics that may lead to better therapeutic outcomes (O'Brien et al., 2008). For example, the UK 700 study addressed whether the caseload of professionals had an effect on outcomes such as inpatient days, quality of life and housing stability (Burns, Creed, Fahy, Thompson, Tyrer, & White, 1999), while Priebe, Fakhoury, and Watts (2003) explored how socio-demographic and other patient characteristics affected these outcomes. However, the underlying psychosocial factors that facilitate or inhibit people's engagement with mental health services remain poorly understood.

In order to make better sense of this complex phenomenon, researchers are beginning to turn to qualitative research (Priebe et al., 2005; The Sainsbury Centre for Mental Health, 1998). In contrast to more standardised and structured quantitative procedures, qualitative methods offer a broad range of data analysis approaches that have the potential to delve deeper into research questions that incorporate everyday psychosocial experiences of mental health, including interactions with institutional practices (Slade & Priebe, 2006; Williams, 2002).

Priebe et al. (2005) used grounded thematic analysis to explore the social and personal contexts that led to the disengagement from mental health services by people who had a fragmented history of engagement, and to define what context, if any, surrounded any reengagement. In the grounded thematic approach, themes are encouraged to emerge inductively from the participants' interviews, rather than being deductively led by a priori codes or hypotheses (Braun & Clarke, 2006; Strauss & Corbin, 1998). Through this method, Priebe et al. (2005) identified that the interrelated themes of identity and agency played an integral part in disengagement. The participants, who had manifested difficulties in engaging with mental health services, consistently made efforts to cling on to the lives they knew or remembered and to reject anything that might facilitate the transition to a perceived identity of passivity or

*patienthood*, e.g., the power differentiated therapeutic relationships, the debilitating side effects of medication or the adoption of confining and stigmatising diagnostic labels. Conversely, paramount to the engagement process was the investment of time and commitment into partnership models of care, where therapeutic relationships moved away from a pure medical focus and encouraged people to be active participants in their treatment and lives.

The analysis in Priebe et al. (2005) focused upon the thematic content of the participants' narratives of disengagement. In efforts to further develop our limited understanding of the complexities of the engagement phenomena, the present study analysed these same narratives by utilising an alternative qualitative method, namely discourse analysis.

Discourse Analysis (DA) comes in many guises and transcends the theoretical perspectives of disciplines as diverse as linguistics, psychology, sociology and anthropology, to name but a few (e.g., Chouliaraki & Fairclough, 1999; Edwards & Potter, 1992; Harper, 2006; Willig, 2008). In its broadest sense DA is less interested in narrative detail alone and more, to varying levels of intensity depending on the discipline, interested in how people communicate the identities and roles that they adopt or are positioned into by social contexts. To date DA has been widely applied to important areas of social psychiatry. For example, it has captured how identity and agency is restricted through socially constructed power structures such as diagnostic classifications (e.g., Fee, 2000; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995), how practitioners and patients position themselves in psychiatric interventions and consultations (Leishman, 2004; Mitchell, 2009; Ziolkowska, 2009) or how mental illness is conveyed through the television and media (e.g., Paterson, 2007; Wilson, Nairn, Coverdale, Panapa, & Panapa, 2000).

The present study introduced a further application of DA, namely the extent and ways that the structure of language can signal people's engagement and disengagement experiences with services and practitioners. To do this, a variant of DA, positioning analysis, was used. Positioning Analysis (PA) aims to capture how language, through grammatical markers and other rhetorical (persuasive) devices, *positions* people in social contexts e.g., whether they are active or passive, powerful or powerless, victims or perpetrators (Bamberg, 1997, 2000; Benwell & Stokoe, 2006; Harré & van

Langenhove, 1999). By incorporating PA the current study aimed to contribute to our understanding of the psychosocial factors that facilitate or inhibit people's engagement with mental health services in two ways. First, it investigated the role that the structure of peoples' language serves in communicating psychiatric experiences and narratives of dis/engagement. Specifically it was interested in the ways that language could signal the positioning of self within a therapeutic relationship and how it highlights other important life and psychiatric experiences. Second, as PA was being applied to narratives that were previously extensively analysed with thematic analysis (Priebe et al., 2005) we aimed to evaluate the role that contextualised language analysis, such as PA, can play alongside thematic analysis in health services narrative research.

### **3.3 Method**

#### ***3.3.1 Sampling***

All participants shared the following common diagnostic characteristics:

- a) a diagnosis of functional psychosis according to ICD-10 (World Health Organization, 1992);
- b) the ability to give informed consent;
- c) absence of a significant organic mental disorder;
- d) absence of a primary diagnosis of substance misuse and dependence;
- e) not requiring an interpreter.

Forty participants were strategically sampled based on their history of engagement with generic mental health services. They had all previously disengaged with secondary mental health services support, e.g., had actively missed an outpatient appointment or deliberately ceased taking their medication, and had been referred from a community mental health team to an assertive outreach team (smaller multi-disciplinary mental health teams set up to engage the 'difficult-to-engage') as a result of fragmented engagement with services. All participants were contacted via their key workers from nine assertive outreach teams across the London area.

#### ***3.3.2 Procedure***

Participants were interviewed by a trained researcher who was not involved in their treatment. The unstructured interviews focused on experiences from the time they

first came into contact with mental health services and their relationship with services thereafter. Eleven females and 29 males were interviewed (mean age = 40 years). Thirty-three participants were clinically diagnosed as primarily having schizophrenia or another psychosis related disorder and seven as having psychotic symptoms related to a mood disorder. All interviews were transcribed and originally thematically analysed in a previous study (Priebe et al., 2005) using the qualitative analysis software package QSR\*Nudist 4. In this study, the transcribed interviews and resultant thematic findings were reanalysed using PA and the QSR\*NVIVO 7 software package.

### ***3.3.3 Ethical Considerations***

Local National Health Service (NHS) ethics approval was successfully gained for all areas of London where interviews took place. The interviews were conducted by the first author and took place in participants' homes or in confidential areas in the assertive outreach teams' premises. All interviewees were outpatients and were judged well enough (by their assertive outreach key worker) to participate in the study. Informed consent was only sought at the time of the interview and participants had the opportunity to withdraw from the study at any time (during or post-interview) without having to explain their withdrawal.

### ***3.3.4 Analysis***

An extensive pilot study was undertaken in order to ascertain the discourse analytical approach most likely to capture the linguistic nuances of peoples' experiences of engagement with mental health practitioners and services. Sixteen of the most thematically rich narratives that related to psychiatric hospital experiences were chosen from the interview corpus of Priebe et al. (2005). Following the pilot study, PA was chosen as the main method of approach. Positioning analysis captures how people draw on indexical linguistic devices and expressions such as pronouns, grammatical markers and metaphors, to express their view of the world and how they position themselves and others within it (Bamberg, 1997, 2000; Benwell & Stokoe, 2006; Harré & van Langenhove, 1999).

The pilot study showed that *metaphor* was an important language device used to emotively express positions. For example, it facilitated the communication of passivity within the therapeutic context, e.g., *He made me feel, you know, I was a piece of meat*

*and a number*; as well as within the wider social context of lost aspirations and life goals, e.g., *Its kind of like those people who go to jail and realise the time they've lost*. As a result, the use of metaphor was scrutinised in the present study. Our pilot study also identified two other discursive devices, often used in conjunction with metaphor, which facilitated positioning. These were again targeted in the present analysis. The first one was the use of the *passive voice*. Here, people conveyed their transition from active participant in their day-to-day lives by describing themselves as an *object* in relation to an *action* carried out on them by others, e.g., *I was stamped with a mental illness*. The second device was *pronoun use*, where people negatively and positively positioned themselves through their use of pronouns. For example, people often exemplified positioning within negative therapeutic relationship by lumping all mental health professionals together in the collective and all powerful *they* or *them*, without formal introduction or individualisation e.g., *They get hold of you, [and] if they have to let you go, they have to let you go slowly*.

### 3.3.5 Identifying Discursive Devices

Only active metaphors (Goatly, 1997) were coded and analysed, as opposed to conventional or dead metaphors. Metaphors were considered active when the language was used outside of its dictionary use (Oxford English Dictionary, OED), when an understanding of the utterance required the blending of lexical domains, e.g., *life* and *road* (Bowdle & Gentner, 2005; Zinken, 2007) or when the figurative expression was highlighted with the use of ‘tuning devices’; phrases such as *so to speak*, *in a way* or, *kind of*, *sort of*, *like*, etc., that tend to appear in the proximity of figurative and metaphoric language (Cameron & Deignan, 2003). Discussions between coders were used in the first phase of annotation to resolve unclear cases by incorporating the Metaphor Identification Procedure (Pragglejaz Group, 2007).

Metaphors were identified through reading the original Priebe et al. (2005) transcripts and by undertaking a trawl of queries using QSR\* NVIVO 7 – where metaphoric tuning devices (Cameron & Deignan, 2003) were used as specific search terms. In this context the tuning devices increased the efficiency of metaphor identification, ensuring that metaphors were less likely to be missed in the 550+ pages of transcripts. The other positioning devices of the *passive voice* and *pronoun use* were

identified by targeting narrative that was likely to elicit discourses of engagement and disengagement. Again NVIVO 7 was used for the task. This time a trawl of the thematically analysed data of Priebe et al. (2005) was undertaken. Here previously identified concrete themes such as negative and positive hospital and psychiatrist experiences, and more abstract ones, such as loss of identity and agency, were focused on. Positioning analysis was then targeted at the respective segments of narratives.

### 3.4 Results

Table 3.1  
*Type and prevalence of the ‘turns’<sup>a</sup> incorporating positioning*

Type of positioning	Number of different participants (N = 40)
Use of negative positioning	34
Passive positioning in discourse related to therapeutic experiences:	
Conveying self as passive object	32
<i>Them</i> and <i>us</i> attribution	28
Use of positive positioning	16
Use of term <i>we</i> in discourse related to therapeutic experiences with:	
Assertive outreach (in terms of treatment support)	8
Assertive outreach (in terms of social support)	4
Psychiatrist (in terms of treatment decisions)	4
Use of metaphor	35
Types of metaphor relating to:	
Therapeutic relationships	
Towards disengagement	18
Towards engagement	8
Symptoms of illness	12
Medication/side effects	10
Perceived loss of identity	
Life goals and aspirations are disrupted, e.g., life’s journey is thwarted, obstructed, dislodged	25
Adopting <i>patienthood</i> , e.g., becoming a psychiatric patient, being diagnosed.	13
Stigma	6
Recovery/acceptance	5
Other	4

<sup>a</sup> A *turn* is a time during which a single participant speaks before interruption and with minimal overlap and pause (Levinson, 1983). In this case it meant responses to questions. It is important to note that within one turn there were often multiple examples of discursive and positioning devices.

Only two out of the 40 participants did not use any of the discursive devices of *metaphor*, *passive voice* or *them and us attribution* in their narratives of disengagement. Table 3.1 shows that 35 participants used metaphor and imagery to passively position themselves and to convey to the researcher how their lives had been disrupted by mental illness. As can be seen, this metaphoric use of language was not restricted to particular aspects of their illness, treatment or service relationship, but as a means of conveying the whole experience of their psychiatric lives. The table also reports the extent and ways that 34 different participants used other discursive means to position themselves within the therapeutic relationship. When conveying a sense of poor engagement within the therapeutic relationship, 32 participants adopted a passive positioning of self as object and 28 negatively categorised practitioners as a unified and de-individualised body. More positive discursive positioning was far more difficult to identify. When expressed it would often incorporate the personal pronoun *we* in connection with the therapeutic relationship. Sixteen participants used *we* to talk about their current therapeutic relationships, although only four out of these 16 discussed psychiatrists using this term.

### ***3.4.1 The Discourse of Disengagement***

#### *3.4.1.1 The Use of Metaphor*

One particular category of metaphor used by 25 participants was to passively position themselves in terms of being thwarted in their life goals and aspirations. For example, participants might contrast their lives to a journey; where, despite every effort to remain on a set course, they were inevitably held back, obstructed or dislodged by their illness, treatment or intervening services. Consequently, this impacted on adherence to treatment and engagement in the therapeutic relationship.

I don't know I just feel as if *I've derailed off* my natural course of life. *I've always tried to get back into what I was*, I found that I just can't do it and then I've missed out on so many things because of it. (Int. 36, man aged 22)

Early psychiatric experiences played a crucial role in perceptions of loss of identity. Loss of identity here was metaphorically communicated in terms that helped convey experiences of a transition from independent agent to psychiatric patient ( $N =$

13). For example, participants talked about being passively *tagged, labelled* and even *stamped* with a mental illness. Early hospital experiences were highly memorable for many participants and metaphor was again an important tool used to negatively position themselves and others in relation to their fear of entering these highly stigmatised environments. The imagery chosen by four female participants related to alienation and experiences of other or collapsing worlds. One moment they were in their known world, where they had their identity and where they understood their roles and their place. Then all of a sudden they were *transported* to a world that they knew nothing about – world where they were surrounded by people who were severely mentally ill; a world where they were fundamentally disorientated and scared.

I mean I had some scary thoughts about what a mental hospital was like and that confirmed it, it was quite horrific to see people who are really severely ill, *just on another planet*. (Int. 21, woman aged 37)

Positioning analysis focuses on how language is contextually used rather than on the content alone. As such, the least rich narratives were as likely to tell us something about important experiences as those that were more articulate and thematically rich. This was evident with the following participant who was excluded from the original pilot analysis, as he was judged by the authors to be economic and guarded in his narrative. Through the use of imagery and repetition, he was still able to elicit a powerful discourse message when asked about his first experience of hospital:

*Hell*, that's what I can say. I can't say anything else, *hell, hell, hell, hell!* (Int. 37, man aged 33)

After the initial shock of finding themselves in a psychiatric hospital, people needed to accustom themselves to the restrictive environments that they now found themselves in. *Prison* metaphors and analogies were undoubtedly the most common way to describe hospital admissions, with 35% spontaneously using the term prison to describe previous experiences.

You know that is what I don't like the rules, the silly rules like that door is not allowed to be opened at a certain time ... you're not allowed to do this but you can do that, you know it's like being in a prison. (Int. 11, woman aged 35)

### 3.4.1.2 Use of the Passive Voice

One way used to convey the power imbalance within the therapeutic relationship was the use of the *passive voice* ( $N = 32$ ) to relay a transition of self as active subject to a self as passive object, a grammatical device often used in conjunction with metaphor. The following participant, for example, uses the passive voice to describe his experiences and in doing so foregrounds his lack of agency. He talks about his transformation from an active subject to an object.

We [mother and himself] *were fetched* to the hospital ... *I got taken* into a room ... *I got led* down a corridor, *put into* a ward and was just *left* there. (Int. 20, man aged 28)

Similarly, the following female participant used a combination of metaphor and positioning to express her loss of agency in terms of *self* and *other*. She positions herself as an object to express how she was subservient to the power of mental health services in the way she was sectioned and administered to hospital.

I was *bounced* in and out of [local] hospital until it shut in 1996

I've had CPNs [community psychiatric nurses] in the past, if you tell them the smallest symptom, in my, in my mind, they'd have me *binned*.

I mean the, the staff seem quite happy to *let you rot* in bed...you were very rarely checked to see where you are, what you're doing, how you are, you were just *dumped* there. (Int. 19, woman aged 39)

### 3.4.1.3 'Them' and 'Us' Attribution

The majority of participants ( $N = 28$ ) at some point positioned the medical professionals as a collective and all-powerful *them* and themselves as the passive *us*. For example, the following participant positions all practitioners as a single body of perpetrators; 'they' who use labels to strip other people of their previous identity and position *them* in a passive category with assigned diagnostic attributes.

*they just retreat into labels* because of what *they* see from the outside and this is true of everyone. (Int. 18, man aged 43)

A more obvious metaphor was sometimes used to express passive positions within the therapeutic relationships with psychiatrists. The following example powerfully captures what it felt like to not be listened to compassionately or be encouraged to be an active participant in dialogues. Here the comparison was of superior and authoritarian beings.

They don't listen because these men *rate themselves as gods*. (Int. 31, man aged 55)

Similar imagery was used to express poor therapeutic relationships outside of hospital with community practitioners. Here the discourse methods of metaphor and positioning tended to position practitioners as *parental* rather than God-like.

*So I've got two fathers*, like bullying me you know. It's not much of a life being controlled, you know, being controlled by your father and all the teams. (Int. 2, man aged 28)

Interestingly, the *them* and *us* discourse device was not confined to the positioning of oneself as *passive* in relation to psychiatrists and nurses. It was also used by some participants ( $N = 6$ ) to passively position other patients in relation to themselves, perhaps as a means of retaining some sense of *normality*. This is exemplified in the following narrative, which captures how someone can passively position others but still passively position him or herself.

I understand, when *they* [other patients] are not well, *their* responsibilities are demised [*sic*] and *they* need to be told what to do like children, um, but on the other hand *we* don't want to be *frog marched up and down*. (Int. 21, woman aged 37)

### **3.4.2 The Discourse of Engagement**

Discourses of engagement were sparse. It was estimated that narrative related to negative experiences of practitioners and treatment outweighed positives experiences by a ratio of approximately 4:1. Relative to this, positive positioning of *selves* and practitioners were difficult to identify.

#### **3.4.2.1 Positive Positioning of Therapeutic Relationships**

Participants were less likely to use *them* and *us* discourse when more positive experiences of therapeutic relationships were expressed. This was demonstrated by the

analysis of narratives of participants where they contrasted their experiences of poor and good therapeutic relationships. A particular important discourse device was the usage of the personal pronoun *we*, which was used to convey improved therapeutic relationships with generic practitioners ( $N = 8$ ) and psychiatrists ( $N = 4$ ).

In the following example, a participant who had, over many years, found it very difficult to maintain consistent contact with services talks about a traumatic hospital experience.

And when I was nineteen I got admitted to the local psychiatric unit in Bxx, and I had the most dreadful treatment .... *They drugged me up to my eyeballs on about two major, major anti-psychotics.* (Int. 19, woman aged 39)

Discursively, the woman identifies her loss of agency by positioning all mental health service professionals within the Unit as the people who administered the excessive drugs and utilises metaphor to further emphasise the extent of the perceived medication abuse. This can be contrasted to the description of her present community psychiatric nurse (CPN):

I think he's been my CPN for at least 5 years now. It's absolutely brilliant. I mean *he's, we've* got the right *balance*. (Int. 19, woman aged 39)

Here the same woman's use of positioning is positive and expresses her ability to be active within the therapeutic relationship rather than passive. She implies mutuality in their professional relationship by the introduction of *we've* (following a thoughtful and deliberate change from the use of *he's*) and her reference to *balance*.

Another participant also used *we* to convey how her therapeutic relationship developed. Here she describes how her relationship with her present CPN, who she earlier metaphorically compared to a controlling second mother, progressed over time. In her discourse here she contrasts passive *you* and active *we* pronouns to convey her transition to communicative partner.

The thing is *we* go out for coffees and *we* just, um, *we* just chat about anything and everything really, and that's what's nice about it now, whereas before it was, 'Are *you* well?', um, you know, 'Have *you* been taking your medication?', ... you know the

general, 'I'm from the hospital, you know, *you're* the patient type of thing'. (Int. 8, woman aged 23)

The term 'more like friends' was used by four participants to condense the attributes that went up to make a good therapeutic relationship with community mental health workers. The term seemed to neatly summarise how therapeutic relationships could grow in strength and balance.

*We've become more like friends* now, I find she is very kind, very caring, very helpful, insightful as well. It's nice to have someone to talk with *on the same level now*. (Int. 23, woman aged 48)

Although negative positioning in relation to therapeutic relationships with psychiatrists was found in abundance, positive discourse in this respect was infrequent. The use of the personal pronoun *we* occurred in only four narratives. Where found, the more engaged therapeutic relationships with psychiatrists were again metaphorically talked about in terms of achieving a *balance*, a *level* or a *two-way* process. For example, in the following example positioning through metaphor and pronoun use is used to convey how, over time, the participant made the transition from passive recipient to active participant in his therapeutic communication and treatment.

I had Dr. Z I didn't have much of a chance to tell him how I felt or anything, it was just, 'Take this and take that' ... but with Dr. Y it changed. At first it was very, 'I want *you* to do this that and the other', but now he spends more time asking me what I think about what I am taking, what I think will help, and I will give him suggestions and he either agrees or disagrees with it ... It is more a *two-way* thing, which is more beneficial for me because I feel I am starting to get a say in my treatment. (Int. 35, man aged 39)

### 3.5 Discussion

The focus of the study was to examine the narratives of patients who had previously found it difficult to engage with mental health services, and to ascertain how the form of language, through grammatical and other rhetorical (persuasive) devices, was used to convey dis/engagement experiences. In a former related study (Priebe et al., 2005), thematic analysis of the same data identified that disengagement was essentially the struggle to remain active agents in their lives and treatment, and that

reengagement, where possible, incorporated facilitating the return of agency in this regard. The present study corroborated these findings. Through the power of positioning (Bamberg, 1997, 2000; Benwell & Stokoe, 2006; Davies & Harré, 1990; Shotter, 1989), participants consistently emphasised the impact the interrelated experiences of loss of identity and agency had on their lives and their willingness to engage with services. In particular, the analysis of narratives showed how participants drew on the discursive resources of *metaphor*, the *passive voice* and *them* and *us attribution*, to help make sense of, and communicate with emotional depth, their struggle to maintain or regain their familiar identity and their efforts to resist what they regarded as the transition from independent agent to a *patient*, i.e., an *object* of agency in the grammatical sense.

Metaphors were consistently used to describe the transition from active subject to passive objects in their psychiatric lives. Participants talked about hospital experiences with the most emotion, using an extensive and powerful array of metaphors to describe their psychiatric experiences and the trauma related to their stay. In particular their expression of fear as they entered psychiatric hospitals through their consistent, detailed and thoughtful comparisons of hospital to *other worlds* and *prisons*, further emphasised the extent that they felt they had been stripped of their identity and agency (Goffman, 1961). Throughout the interviews participants consistently positioned themselves in the *passive voice* as objects that were dealt with by mental health services, either metaphorically, e.g., *I was bounced in and out of hospital*, or literally, e.g., *we were fetched to the hospital*. Equally, discourse conveyed how patients were passively *stamped* with a diagnosis or dismissively treated like an *alien* or *a piece of meat* by their psychiatrists.

The use of metaphor to convey the emotive categorisation and positioning of mental health services as the all-powerful *them* and patients as the passive *us* was another important discourse device used to convey further features of loss of identity and agency. Participants compared psychiatrists to *gods*, or community practitioners to controlling *parents*. Participants also used metaphor and imagery to explain the more subtle ways in which they were positioned within the *them* and *us* dyad. They talked in terms of their *disappearance* or *detachment* into silence, as their only means of retaining an element of control within a therapeutic relationship. This might be an

example of what Goffman (1961) termed “removal activities,” whereby patients reestablish a sense of autonomy and identity by distancing themselves from their situation as a patient: “Our sense of being a person can come from being drawn into a wider social unit [where as] our sense of selfhood can arise through the little ways we resist the pull.” (p. 280)

Priebe et al. (2005) concluded that disengagement and engagement with mental health services were opposite sides of the same coin and that a partnership model, where an element of active participation was handed back to the patient, was essential to the engagement process. Over and above an understanding of what facilitates engagement with mental health services, the present study has provided additional insights into the point at which the return of agency was facilitated within the therapeutic relationship. Most specifically, a close examination of the grammar, metaphor and phraseology used by participants has enabled us to pinpoint when people with severe mental illness make the shift from passive references of themselves such as being *fetched, led, left* and *bounced*, and redefine and position themselves as active participants within what they perceive to be balanced and mutual therapeutic relationships through their use of terms such as *we, talking on a level, more like friends* and a *two-way* process.

### ***3.5.1 Limitations of the Study***

With over 550 pages of transcript, targeted discursive devices may have been missed. Further, there may be other possible interpretations of the same data. For example, in some instances the categorical positioning of the diverse mental health service professionals as the collective *they* may have occurred simply because the participant assumed the interviewer knew the type of professional they were referring to, or that they did not recognise the distinction between professionals. In addition, there was no means of gaining a baseline of the participants’ use of metaphor or the passive voice in more neutral contexts. However, the strength of the design was that we focused on participants with manifest difficulties with services engagement, and was able to compare their use of language in relation to their own negative and positive psychiatric experiences. This and the fact that the PA findings were corroborated by earlier thematic analysis (Priebe et al., 2005) means that regardless of the mentioned limitations, the study does demonstrate in-built as well as certain external validity.

### 3.5.2 *Practical Implications of the Study*

The vast majority of narratives were articulate and, apparently, well rehearsed. Participants appeared to have lived and relived the impact of mental illness, and, in doing so, often became coherent and at times expert narrators of their experiences as mental health patients. An important message from this research is that, consciously or unconsciously, participants were driven to use such strategies to convey the importance of losing their ability to be active participants in a known and preferred world and their distress at being thrown into a world of passivity, constraints and alienation. Such positioning devices may serve not only to portray the essence of these experiences to others but also, perhaps, to help conceptualise them to the participants themselves.

As well as *flagging* levels of therapeutic engagement that need to be noted, such language use may also signal other clinical implications. It is important to remember that the discursive devices used were not confined to experiences related to psychiatric therapeutic relationships but used to describe the many other areas of a psychiatric experience that impacted on participants' lives e.g., symptoms, medication effects and experience of stigma (see Table 3.1). As such, the signalling of emotive experiences through positioning devices may afford wider therapeutic possibilities in terms of the *recovery* of agency and identity (e.g., Roberts, 2000; White, 1995). First, they can draw the attention of the clinician to the fact that the narrator is using them. Second, they offer the clinician and narrator the potential to explore the reasoning and meaning behind them. For example, metaphoric talk about being dislodged from a rail, which is fixed, may have different implications to that of dislodgement from a path, which is not necessarily fixed. Lastly, they afford the opportunity to reframe narrative positions in order to redefine situations and develop personal agency in their lives (e.g., White, 1995).

A methodological strength of the study was that important confounds were limited by the fact that two distinct qualitative methods were applied and contrasted using identical data and, in part, analysed by the same researchers. As such, we believe this puts us in a strong position to critically evaluate the role that discourse analysis in the form of positioning analysis can play alongside thematic analysis in health services narrative research.

First, our findings showed that positioning devices added emotional depth to the conveyance of a person's sense of engagement or disengagement with psychiatric services. In doing so, PA demonstrated it can strengthen research based on narratives of relived experiences, in that it has the potential to signal emotionally charged episodes that can be explored in the interview context or, retrospectively, in the qualitative analysis. A further strength of PA was that it was less time consuming than thematic analysis. In the original Priebe et al. (2005) study an additional six months funding was needed (and granted by the Department of Health) to finish the project, due in large part to the unforeseen length of time needed for rigorous grounded thematic analysis. The analytical process here was undoubtedly facilitated by the qualitative database software used, which enabled the researchers to focus their efforts on language use in specific therapeutic and social contexts. A further benefit of the PA method over thematic analysis was that the narratives did not need to be thematically rich in order to elicit important information about the psychiatric experience of the narrator.

Perhaps the largest question that hangs over the use of PA is what role, beyond a synergetic one, it can play in health services projects where evidence of underlying motives and processes are needed. If, for example, the object of the research (or clinical) exercise is to highlight, through their use of language, people's positioning within a therapeutic context, then PA is undoubtedly capable of fulfilling the task. If, on the other hand, we want to fully critically explore the underlying processes that lead to the positions that people are assigned to, or adopt, then knowledge and interpretation of thematic content is also likely to be needed.

### **3.6 Conclusion**

In addition to previous applications of discourse analysis (e.g., Leishman, 2004; Parker et al., 1995; Paterson, 2007; Wilson et al., 2000; Ziolkowska, 2009) our findings introduce new insights into how language positions people in the psychiatric context. By incorporating linguistic structure, rather than thematic content alone, discourse analysis, in the form of positioning analysis, has the potential to highlight the emotional emphasis that people place on important life and therapeutic experiences. As such, the most limited communication within a clinical or research narrative context can signal

important shifts in the therapeutic process which are either positive or indicative of therapeutic breakdown.

## 4 'IN SIGHT, OUT OF MIND': THE EXPERIENCES OF THE COMPLIANTLY ENGAGED COMMUNITY PSYCHIATRIC OUTPATIENT

### 4.1 Abstract

Research on engagement within community-based psychiatric services in the UK has mainly focussed on factors related to those *'at risk'* of nonattendance or noncompliance, with the tacit assumption that those in regular attendance are largely content and hence not a priority. The present study systematically explored the experiences and views of 25 people with severe and enduring mental illness who had regularly attended outpatient settings for more than five years. Regular attendance at consultations was not synonymous with satisfaction – in fact it masked varying levels of unmet needs and *'de-humanisation'*. In order to establish and maintain non-coercive community services that prioritise *'recovery'* above illness and *'risk'* containment, it is essential that the experiences of people in established and apparently *'less troublesome'* therapeutic relationships are also taken into account and integrated into policy and practice.

### 4.2 Introduction

Community psychiatric practice aims to play an important role in the prevention and management of psychiatric relapse and supporting people in their efforts to once again achieve and maintain meaningful and purposeful lives (Burns, 2004; Department of Health, 2002, 2005b; The Royal College of Psychiatrists, 2009). Research on people's engagement with community practitioners has tended to focus on factors related to attrition and nonattendance, or the experiences of those who have had *troubled* relationships with services. Previous studies have established the underlying correlates associated with people ceasing to attend community psychiatric appointments (Garety & Rigg, 2001; Killapsy, Banerjee, King, & Lloyd, 2000; Mitchell & Selmes, 2007; O'Brien et al., 2008; Priebe et al., 2003; Spencer, Birchwood, & McGovern, 2001); the risk factors involved in the communication interface between primary and secondary mental health care (Killapsy, Banerjee, King, & Lloyd, 1999); the psychosocial processes that take place in therapeutic relationships during initial

consultation (Compton, 2005); and the reengagement of those who had previously opted to detach themselves from practitioners and services (see chapter 3; O'Brien et al., 2008; Priebe et al., 2005; Ridgeway, 2001; Tait, Birchwood, & Trower, 2003).

No systematic empirical research has been carried out on the type and quality of engagement that occurs for people in long-term established relationships with community practitioners and who have good records of attendance. In our view this is a neglected and important sample group to study. First, there are likely to be qualitative differences in established therapeutic relationships compared with therapeutic relationships in their formative stages (where existing research has tended to focus). For example, we now know that barriers to early therapeutic engagement are likely to include the negotiation of an acceptance period where people need to acknowledge that: a) they have a psychiatric illness and that it will not necessarily go away; b) as a result they may need ongoing psychiatric or other support; and c) their established *identities* or living practices may need to be altered (see chapter 3; Deegan, 1996; O'Brien et al., 2008; Priebe et al., 2005; Ridgeway, 2001; Spencer et al., 2001; Tait et al., 2003). These initial hurdles are likely to have been already negotiated by people with more established psychiatric histories. Second, as the current research emphasis suggests, the views of people who are engaged with, or at least in consistent contact with community practitioners, are likely to be de-prioritised or ignored in favour of people who are more *at risk* or able to assertively negotiate and articulate their journey through the psychiatric system (e.g., O'Brien et al., 2008; Priebe et al., 2005; Ridgeway, 2001). However, it is all too easy to take the silence of *low risk* regular attendees as a mark of satisfaction with the service they are receiving, or confine any of their feedback to nonempirical internal service audits that are rarely scrutinised by wider audiences. Third, by not incorporating the views of people who have maintained contact with psychiatric services over time, important insights into how effective therapeutic relationships work and can be developed and sustained over time are lost.

The present study worked from the premise that there is in fact much we can learn from established therapeutic experiences in our efforts to enhance the quality of psychiatric services for all. Using qualitative research methods we have examined the factors and processes that encourage or inhibit positive relationships in community

settings for people with good histories of attendance and established contact with their community psychiatric service (five years or more).

### 4.3 Method

#### 4.3.1 *Community Psychiatric Outpatient Services in England, UK*

The configurations of statutory community mental health services vary considerably across the UK (Department of Health, 2005b, 2007; National Workforce Programme, 2009). They will, however, share some common features, not least that people living with milder mental health illness will be treated and supported by a first level primary health care service (e.g., coordinated by a General Practitioner Service) and those affected with more complex and enduring difficulties will access a secondary level community service. This latter provision, the focus of this study, tends to come in the form of Community Mental Health Teams (CMHTs).

CMHTs are multidisciplinary, consisting of psychiatrists, social workers, community psychiatric nurses, psychologists, occupational therapist and multi-skilled outreach support workers (The Royal College of Psychiatrists, 2009). The central role of a CMHT is to provide assessment and care coordination for people with more complex mental health needs. Their role is to help people avoid psychiatric relapse, working with *Crisis Intervention* and *Home Treatment* teams when necessary, and, where possible, support and advise people on wider aspects of their *recovery*; referring, where possible, people on to specialist services in regard to housing, employment and *social inclusion*. While the range of CMHT professionals will, when necessary, visit and work with people in their own homes, most regular ongoing outpatient reviews and consultations take place in CMHT bases at fixed time periods e.g., once every three month. Traditionally the contact person for outpatient reviews and consultations was a psychiatrist. Nowadays, this is more likely to vary across England and chosen forms of service configuration (Department of Health, 2007; National Workforce Programme, 2009).

### ***4.3.2 Sampling***

Participants were recruited through community mental health day-services and drop-in centres in an area of England, UK. It was anticipated that these outlets would house participants likely to fulfil the following inclusion criteria:

- a) have primarily a severe and enduring mental illness and not a learning disability,
- b) a long-term relationships with statutory secondary mental health services (> five years),
- c) a current and regular attendance record for outpatient consultations, and
- d) the ability to give informed consent.

Verbal presentations and written materials were used to publicise the study in the day-services. The first 30 people who volunteered were interviewed. From these 30, five were later excluded from analysis when it became apparent they did not fulfil the inclusion criteria (two people had only experience of private psychiatric services, two people were relatively new to secondary mental health services (< five years), and one person primarily had a learning disability and not a mental illness). The remaining 25 participants consisted of 13 females and 12 males and had a mean age 47.2 years. Participants reported a mean of 18.9 years contact with secondary mental health services and an average total of five psychiatric hospital admissions. For all participants in the study their fixed outpatient reviews tended to be every three months and were carried out by psychiatrists. All participants confirmed they were regular attendees at outpatient clinics, with no participant admitting to knowingly missing an outpatient appointment (without rescheduling) unless affected by their mental health. See Table 4.1 for summary of diagnoses and further demographic characteristics.

Table 4.1  
*Participants' diagnoses and key demographic characteristics (N = 25)*

Psychiatric condition	N	Gender		Marital status		Type of housing		
		Male	Female	Divorced or single	Married	Rented	Privately owned	Supported
Schizophrenia or psychosis related disorder	7	4	3	7	0	4	0	3
Bipolar disorder	9	5	4	9	0	8	1	0
Uni-polar depression	5	1	4	4	1	4	1	0
Personality disorder	2	1	1	2	0	1	0	1
Dual diagnosis: depression and substance misuse	2	1	1	2	0	1	1	0
<b>TOTAL</b>	<b>25</b>	<b>12</b>	<b>13</b>	<b>24</b>	<b>1</b>	<b>18</b>	<b>3</b>	<b>4</b>

### 4.3.3 Procedure

All interviews were carried out individually or jointly by the first two authors. Both had clinical experience of working in the area of mental illness but were not involved in treatment of any of the participants. The first author interviewed the first 18 participants. For training purposes the first and the second author interviewed the next two participants together. The second author then interviewed the remaining five participants independently. Participants were interviewed at a time and place of their convenience. Fifteen participants were interviewed on departmental premises; seven were interviewed in their own homes and three in community sector bases where they were recruited from.

Participants were informed that the intention of the interviewer was to influence participants as little as possible and to encourage them to speak freely about their psychiatric experiences. The researchers were particularly interested in narrative related to outpatient experiences and probed interesting, evasive or closed answers related to this area. Interviews were conducted until saturation was reached i.e., no new themes or concepts emerged (Corbin & Strauss, 2008). The length of interviews ranged between 35 min and 110 min. All interviews were digitally recorded and fully transcribed for analysis.

#### ***4.3.4 Analysis***

The data were analysed using inductive thematic analysis (Braun & Clarke, 2006; Corbin & Strauss, 2008). The first author analysed all 25 interviews and the second author analysed the last nine. In the early stages of their analyses, open line-by-line verbatim coding was undertaken. In subsequent interviews, lower and eventually higher level (more abstract) themes were constructed (Braun & Clarke, 2006; Corbin & Strauss, 2008). Constant comparison techniques (contrasting concepts and themes within and across interviews) were used throughout to develop and dimensionalise emerging themes. Memos (Corbin & Strauss, 2008) were used by both researchers to develop and evidence properties and dimensions of the concepts and themes that were established. In addition, selective coding (Braun & Clarke, 2006; Corbin & Strauss, 2008) was utilised in the later stages of analyses to establish how superordinate concepts embraced subsidiary ones. A qualitative analysis package, QSR\* NVIVO 8, was used to manage and evidence the data analysis.

In addition, four of the other coauthors analysed nine randomly selected interviews. These researchers were trained in qualitative analysis techniques but had no clinical experience. They analysed the interviews separately and met regularly with the first author to share and develop the themes and concepts that emerged from the data. Once strong consensual agreement was achieved between all researchers, the resultant framework was used to revisit all interviews to quantify themes and subthemes.

#### ***4.3.5 Ethics***

The study was ethical approved by the UK National Health Services (NHS) and the first author's departmental ethics committees before any interviews were

undertaken. Informed consent was only sought at the time of the interview and participants were told they had the opportunity to withdraw from the study at any time (during or post-interview) without having to explain their withdrawal.

#### 4.4 Results

Table 4.2

*Type and frequency of reported barriers to better therapeutic relationships in outpatient consultations (N = 25)*

<b>Predominant barriers</b>	<b>Number of participants (N = 25)</b>
<i>Perceived problems with outpatient service</i>	
Nonlistening	17
A 'conveyor-belt' or 'template' approach	17
Lack of effort to understand experiences	20
<i>Structural constraints</i>	
The need for more time in consultations	14
The need for continuity of practitioners	8
The need for easier access to psychotherapy opportunities	8
<i>Most important practitioner qualities</i>	
Encouraging involvement in treatment decisions	13
Acknowledging the person outside of the illness	12
A good 'chair-side manner'	9
Good knowledge of mental illness and treatment	9
To be nonjudgemental	6
To be caring	4

##### 4.4.1 Retaining a Human Connection

The overarching superordinate concept that embraced the following subsidiary themes was 'wishing to retain a human connection.' This was identified by all the researchers analysing the data. Ultimately participants wanted their views and experiences to be listened to, understood, and valued by practitioners who

acknowledged their status as fellow human beings. The following analyses outline the composite structural and professional constraints to ‘retaining a human connection.’

#### ***4.4.2 A Predominantly Nonlistening Service***

Seventeen participants (68%) made reference to the fact that not being listened to was the fundamental basis of their negative experiences of community therapeutic relationships. They felt that being listened to validated their existence in therapeutic communications, and, conversely, not having a voice served to dehumanise and negate existences. In short, the majority of participants wanted to be acknowledged, taken seriously, and ultimately respected.

It’s treating somebody like a human being ... you need to be listened to; you need to feel that somebody actually cares. (Int. 24, woman aged 50)

It doesn’t matter what you say in there – it all just flies over their head and it makes no difference. (Int. 19, woman aged 46)

In this context being listened to was considered to incorporate two important dimensions. First, there needed to be the opportunity to express important experiences and views. Second, people wanted to see their practitioner making efforts to *hear* and understand what they were being told:

I mean actually bothering to find out what it is, what you’re trying to get across to them; rather than just a list of questions, a list of answers and here’s what you need to do - actually [being] on a level with them. (Int. 20, man aged 37)

I’ve felt when I’ve gone in there ... I’ve been stuck with what to say ... and the questions were the same that were asked previous about medication [sighs] and nothing seemed to change. (Int. 18, man aged 39)

I’ve spent some time talking to people and they quite plainly have been listening, but they haven’t actually heard, really heard what I’ve said. (Int. 9, man aged 57)

Feeling listened to and understood seemed to evoke what one participant termed a sense of *togetherness* with their psychiatrist. For others it validated their self-worth and self-esteem.

Well, it makes you feel more hopeful. Sort of boosts your self-esteem and you sort of think, well, I'm worth something. (Int. 3, woman aged 49)

Instead of sort of like telling you what you should be saying, and what you should be thinking, and what you should be doing ... you just feel you know, like you've been heard you know, as a person, you know, not just a case. (Int. 5, woman aged 60)

#### ***4.4.3 Factors Defining a Nonlistening Service***

Seventeen participants (68%) made reference to a *conveyor-belt* or *tick-box* type service where practitioners were perceived to prefer, or at least feel the necessity, to adhere to agendas of fixed questions related to medication, risks, and illness categories. In response, these participants felt unable to contribute beyond the answers to questions practitioners wanted or preferred to hear.

Given the centrality placed on having a voice in their therapeutic encounters, unsurprisingly participants also identified the factors which they considered to influence whether or not professionals were likely to listen to them. A combination of *structural constraints* and an inability to interact with a *human and knowledgeable professional* were identified as being at the heart of a nonlistening service.

##### *4.4.3.1 Structural Constraints*

###### *4.4.3.1.1 A lack of time for listening.*

The most important structural constraint was that of time. Fourteen participants (56%) made reference to the fact that the limited length of outpatient appointments meant they were unable to uninhibitedly communicate their experiences.

[B]efore I got to answer any questions, he'd be saying, 'right, that's it then', you know, 'this is over, well we'll see you in three months time', not really listen to what you've got to say, it's only what he had to say. (Int. 23, woman aged 38)

If they [psychiatrists] just spend just one session really getting to know the patient that they, they're supposed to be dealing with, there would be a far greater understanding, there'd be a far better recovery rate in the end, and you know, things could be totally different. (Int. 9, man aged 57)

Conversely, when people were given the time to express themselves more fully then it was noticed and appreciated:

Dr X, who was lovely, Dr [first name] X ... she would listen ... You know, some you go in, and you know darn well you've got some 10 or 15 minutes, and that will be it ... Yeah, if it was going to take half or three quarters of an hour then it did, with [first name] X. (Int. 21, woman aged 51)

#### 4.4.3.1.2 *Lack of continuity of support.*

A further factor that contributed to a nonlistening *tick-box* service was discontinuity of practitioners. Eight participants (32%) talked about how their practitioner consistently changed over short periods of time. This exacerbated the problem of *time for listening* and other barriers to building mutually trusting relationships. For example, it led to a lack of opportunities to make decisions with respect to diagnosis and treatment based on a broader understanding of the whole person.

I see the psychiatrist, but I am not happy because I see almost a different one every time. I feel I am given pills as opposed to solutions. (Int. 24, woman aged 50)

Meeting different practitioners at different points meant that people had to tell their story over and over again and go through the process of negotiating agreements that may not be followed up by the next practitioner. Not only would these types of incidences lead to *patchy* treatment without a systematic intention, future therapeutic relationships were negatively influenced because outpatients felt *let down* and *disappointed*.

They're always cancelling appointments and changing doctors and things like that, which is quite unsettling, really unsettling. (Int. 13, man aged 51)

I had three psychiatrists since I came out [ten months before]. (Int. 17, man aged 52)

#### 4.4.3.1.3 *Limited access to nonmedicalised interventions.*

Twelve participants (48%) wanted their practitioner to be able to see the individual outside of their illness category, and either offer related emotional and practical support or refer them on to someone who could:

Can they help me in the emotional, through the emotional crisis that mental illness has caused? ... It's a question of just having a shoulder to lean on, saying look, these are my problems, have you got any ideas regarding solutions? (Int. 2, man aged 52)

For eight participants (32%) this emotional and practical support was most likely to have been requested in the form of psychological interventions. These opportunities for what several participants termed 'talking therapies' were valued, not least because they seemed to offer emotional support that was difficult to give in time-restricted community outpatient appointments. The problem reported, however, was that these opportunities were scarce and when available there was a long waiting list:

I sort of had to wait a year, just under a year to actually get any of those talk therapies and by the time they came up I was sort of semi-well again. (Int. 9, man aged 57)

#### *4.4.3.2 Interacting With a Human and Knowledgeable Professional*

##### *4.4.3.2.1 Important practitioner attributes and skills.*

Participants recognised that being listened to and understood was not simply limited by time and other structural constraints alone, but it also required important qualities and skills on the part of the practitioner. They looked for key signals from the people working with them, including: evidence that they cared for them, that they were nonjudgemental and could empathise with their experiences in objective ways. They also wanted them to be knowledgeable and well-informed about mental illness and treatment, but still able and willing to acknowledge the contribution the person with the illness could make to treatment decisions.

Rather than judging them for falling by the wayside, you care for why they have fallen by the wayside and you do your best to help them on a personal level. (Int. 6, man aged 45)

A good understanding of ... where that person's coming from, what they mean by what they're saying, reading between the lines. (Int. 4, man aged 57)

For reasons already identified the practitioner's behaviour was often experienced as lacking human compassion, cold and impersonal:

I just felt like ... I belong on a park bench ... I'm labelled as an alcoholic and that's it and that's all I am. (Int. 3, woman aged 49)

Seeing the person behind the practitioner was another aspect that rendered the contact a human experience and assured the person that it was not merely the professionals' job but that they had a genuine interest to help:

I believe Dr X ... treated you like you were actually, well as I said on a level, you were equal to him. He didn't treat you like I'm the doctor you're below me. (Int. 1, man aged 28)

[H]e was lovely, it wasn't the fact he was a psychiatrist, it was that he was a nice bloke; he said, 'ok, what can we do?' ... I don't need to know that he has been in school for hundreds of years, I need to know that person and how I feel. (Int. 12, woman aged 47)

#### 4.4.3.2.2 'A chair-side manner'.

Making efforts to listen to, take on board, and integrate the participants' experiences and views were crucial factors in showing this important human side. However, nine participants (36%) also made specific reference to the important role *manner* had on the quality of the relationship:

I felt like I knew him, he talked to me like, I didn't feel like he was sitting behind a file, I felt like he had a clean sheet of paper. And he looked into my eyes and he spoke to me like a person, not a label or a prospective label even, and made me feel, gave me respect. (Int. 24, woman aged 50)

The following participant contrasts two practitioners; one she describes as robotic, and the other as engaging and proactive.

The problem with Dr Robot X was, it was one drug after the next after the next ... and that was his way of doing it. But Dr. Y was such a different type of psychiatrist, he actually, where Dr. X would sit in a chair talking to you in a monotone, Dr. Y was kind of there and he was leaning forward, 'so, right, you're feeling this ...' and actually was engaging with you. You felt he was going to be proactive with your care, purely because of his manner, his speech, all of that. (Int. 25, woman aged 31)

Another aspect of *manner* that contributed to outpatients feeling genuinely cared for by another human being was to experience simple acts that were not formally part of conventional professional roles. Simply being remembered as a person outside the appointments gave this participant the confirmation that the psychiatrist also saw her as a person and cared for her:

And just from saying Mrs. X he knew who I was. I felt like, he hadn't just forgotten me as soon as I walked out the door, he actually did genuinely care. (Int. 8, woman aged 28)

Similarly, the following participant talks about meeting her present practitioner:

What the difference was; he met me ... downstairs, exactly at the time he was supposed to meet me, shook my hand, introduced himself, took me upstairs; 'have a seat'. (Int. 3, woman aged 49)

#### ***4.4.4 Compliant Engagement***

Despite participants at recruitment being outwardly perceived to be engaged with services, the majority (20 out of 25) were judged by the researchers to be merely compliantly attending their outpatient appointments, either at the time of their interview or for significant periods of their psychiatric lives prior to interview:

I've got to have contact with him, but really I don't want anything to do with him. (Int. 16, man aged 43)

Over a number of years people consistently turned up to outpatient appointments with practitioners who were judged to make little effort to listen or integrate what they were saying into treatment decisions. The following participant spent 15 years compliantly turning up to see the same psychiatrist. Things only changed after the practitioner in question moved on to another service.

He wasn't caring, he wasn't understanding, he sort of put it all down on a piece of paper [her voiced dissatisfaction with his service], on my file, it was sort of pointless really. And in the end I found out he was leaving and I thought 'hooray, hooray!' [laughs]. (Int. 15, woman aged 50)

These two participants summarized why they and others would turn up to outpatient appointments despite no perceived benefit.

I think it is this belief that they [psychiatrists] are in authority and they must know what they are doing sort of thing ... maybe [people] are scared of the consequences, maybe they think they are going to get thrown out of the system or something if they challenge it too much. Maybe there is just a tendency to go a long with what's said sort of thing. (Int. 20, man aged 37)

[T]hey are looking down at your file and they are looking up at you and you don't feel listened to. And how can you shout and scream because that just makes you look hysterical. How do you say, 'look, listen to me, I know me!' How can you say that? Without some sort of comeback or notes on your file, how do you do it? It's the sort of impotence of it, so in the end you do what they ask and hope for the best. (Int. 8, woman aged 28)

Given the lack of satisfaction with their outpatient-psychiatrist relationship, why were so few unwilling or able to change their practitioner? These participants offered their views:

[I]t is very difficult, if you are a patient, you're terrified to say to your psychiatrist; 'I am sorry but I don't think you are good enough'. You know what I mean, it is a hell of a thing, you need a hell of a lot of support. (Int. 5, woman aged 60)

So, of course, few of the people ... have enough confidence to turn around and say, 'I want to change my psychiatrist'. Because you haven't got confidence in yourself in the first place, you tend to feel battered into doing whatever's going. (Int. 6, man aged 45)

## 4.5 Discussion

### 4.5.1 *The Need for a Service That Values and Supports Human Connection*

Under the broad heading of *wishing to retain a human connection*, people described how being listened to, understood and allowed to be active participants in treatment decisions were fundamental to positive relationships with community-based practitioners. They emphasised important structural factors which facilitated the quality

of these relationships, most notably time to discuss experiences, practitioner continuity, and opportunities for referral to psychotherapeutic services. Over and above these factors however, it was the personal qualities and manner of the practitioner which formed the positive basis for people to feel valued, respected, and genuinely cared for. *Re-humanising* in this way was achieved *through active listening* and positive gestures made by the practitioner that were judged to be outside the ‘norm.’ Acts such as finding additional time in appointments, personally greeting people outside of their office and remembering people’s names outside of consultations, had a profound impact on how much the participants felt professionals cared for and about them. In the absence of evidence of a collaborative relationship with an empathetic clinician, a *conveyor-belt* or *tick-box* service was reported. Practitioners were judged to prioritise illness, risk and medication issues above attempts to develop a more personal understanding of those in front of them. Consequently many people felt they were treated as one homogenous group rather than as valued individuals, and only a few felt able to assert their voice and human identity.

The core category of participants *wishing to retain a human connection* is strongly supported by the *recovery model* literature (Davidson, 2003; Deegan, 1996; Farkas, 2007; Ridgeway, 2001) and research undertaken in other therapeutic contexts, most notably nursing (Dziopa & Ahern, 2009; Shattell, McAllister, Hogan, & Thomas, 2006; Shattell, Starr, & Thomas, 2007). In these examples, creating opportunities for *active listening* and other ways of establishing collaborative treatment programmes is seen as fundamental in *humanising* the therapeutic relationship (Davidson, 2003; Davidson & Strauss, 1992; Deegan, 1996; Dziopa & Ahern, 2009; Farkas, 2007; Laing, 1990; Shattell et al., 2006, 2007; Ridgeway, 2001) and improving recovery outcomes (Adams & Drake, 2006; Farkas, 2007; von Korff, Gruman, Schaefer, Curry, & Wagner, 1997).

#### ***4.5.2 The Need for Nonhomogeneous Services***

In spite of the observed *template* service that tended to treat people as a homogeneous group, there was extensive diversity in the types of participants and the service they required. A large proportion were resigned to what they perceived to be poor services, some protested but failed to influence the quality of the service they

received, while a few of the more assertive and articulate managed to impact positively on the service they were given. There were also qualitative differences in what people wanted from the service. Some were focused on medication advice and support, others wanted more emotional support or ‘a shoulder to lean on,’ still others wanted ‘talking therapies’ (at times that coincided with their needs); some wanted fixed-time outpatient reviews, while others said they would prefer the opportunity to manage their own reviews (without fear of withdrawal of services or other retribution). There are also likely to be other factors relating to the type and quality of relationship that people experiencing severe mental health problems may want to build with practitioners. For example, all but one participant was single and living independently of others. Whether or not similar *more caring* levels of therapeutic relationships would be preferred for people who have access to greater social support is an interesting and important question. However, while there may be value in ascertaining personal qualities and demographic correlates of preferred therapeutic relationships, perhaps the most important challenge (and question) for any community psychiatric service is how they can be flexible and responsive enough to offer a quality service to everyone, irrespective of their needs.

#### ***4.5.3 Importance of Time***

It is likely that the notion of the *nonlistening practitioner* has evolved mainly as a result of limited time for consultations. It is a constraint also likely to be more acute in typical outpatient settings compared to other therapeutic environments (Dziopa & Ahern, 2009; Priebe et al., 2005). In this sense it would be a mistake to treat time and practitioners’ therapeutic skills and qualities as separate entities, since the former is likely to intensify the latter. Not only does a short time-frame restrict the scope of experiences and views that can be addressed or shared in consultation, it is likely to limit the opportunities to exhibit much valued positive attributes and gestures outside of the norm, as well as exacerbate tendencies towards prejudices and prioritising illness and social categories (Burgess, Fu, & van Ryn, 2004).

Nonetheless, it is encouraging that positive experiences of outpatient therapeutic relationships were reported. Some practitioners found time for participants to express themselves and skilfully and caringly made efforts to understand, respect and value their

views and experiences – in spite of systemic constraints which seem to discourage both good intentions and good practice.

#### ***4.5.4 In Sight, Out of Mind***

An important finding from this research is that, even when people are consistently attending their community psychiatric appointments, it does not mean they are satisfied with the service. Despite sometimes intense displeasure with their psychiatrist, participants described how they compliantly endured them for a number of years. For many, fortunes only changed when their practitioner changed: “I found out he was leaving and I thought ‘hooray, hooray’ [laughs]”. Such experiences warn us that an *in sight, out of mind* attitude should be guarded against. The quality of therapeutic relationships for people who may be lost or struggling to be heard in community psychiatric services should be as important as focusing on the quality of relationships experienced by those who are struggling to make or stay in contact with services – which is where the present emphasis of research in this area lies – or the narratives of those who have assertively negotiated a stronger position in their therapeutic relationships (e.g., Compton, 2005; Deegan & Drake, 2006; Garety & Rigg, 2001; Killapsy et al., 1999, 2000; Mitchell & Selmes, 2007; O’Brien et al., 2008; Ridgeway, 2001; Spencer et al., 2001).

The fact that people may be perceived by day-to-day practitioners as engaged when in reality they are merely compliant also gives additional weight to calls for further clarification of the concepts of dis/engagement (O’Brien et al., 2008). Engagement is more than just consistently turning up to appointments. People need to be given the potential to be active participants in treatment actions and goals and the time and opportunity to assert their *human identity* and individual experiences. Given its centrality in this and studies of other therapeutic contexts (Dziopa & Ahern, 2009; Priebe et al., 2005) the *listening practitioner* is an essential element in *engaged* psychiatric experiences and one that warrants further research scrutiny.

#### ***4.5.5 Incorporating Recovery Principles Into UK Community Services***

In highlighting the need for outpatients to be recognised and acknowledged as collaborative therapeutic partners with *human identities* outside of diagnostic labels, our findings strongly support the principles of the *recovery movement* (Adams & Drake,

2006; Deegan, 1996; Deegan & Drake, 2006; Torrey, Rapp, van Tosh, McNabb, & Ralph, 2005; Warner, 2010). Nevertheless, our results also show that contemporary methods of community practice in the UK, in this study area at least, are still prioritising illness and *risk* maintenance, over proactively encouraging and supporting people in their efforts to become active participants in their treatment programmes and wider lives. As Lester and Gask (2006) have also observed:

With the exception of many of those working in rehabilitation services, the recovery model – despite its growing evidence base and patient support – has yet to make a significant impact on the working practices of the majority of mental health professionals in primary or secondary healthcare. Chronic care is the dominant framework. (p. 401)

The diffusion of ‘power’ in therapeutic relationships and other core *recovery principles* are slowly infiltrating community mental health policies and service configurations in the UK (Compton, 2010; Lester & Gask, 2006; National Workforce Programme, 2009; Scottish Recovery Network, 2009; Shepherd, Boardman, & Burns, 2010). Our findings offer additional weight to calls for this process to be accelerated. In contrast to the narratives of those who have negotiated and *survived* disenfranchising psychiatric systems (e.g., Farkas, 2007; Ridgway, 2001), our results are grounded in the experiences of people who are apparently still *trapped* inside contemporary working practices. The fact that these participants’ narratives confirm similar views found in the *survivor* literature can only strengthen the call for the better integration of recovery principles into community services in the UK.

#### ***4.5.6 Methodological Limitations***

Eliciting the narratives and perspectives of people using psychiatric services was the primary focus of the adopted methodology. Although participants’ accounts were taken to be accurate and truthful, the fact that no practitioner’s views were considered in the analysis should be borne in mind when drawing conclusions from these results. Practitioners may not have recognised how they were described or else felt they had good reason for the behaviour reported. Their perspectives would also have added further insights into how structural constraints interplay with preferred methods of practice.

The sample consisted of participants who accessed the outpatient services of two Community Mental Health Teams (CMHTs) situated in a mental health trust in England, UK. Up until the time of revising this paper (November 2010), the CMHT's for all the participants who were still contactable ( $N = 16$ ) had opted for a traditional community outpatient configuration, where consultations with a psychiatrist occurred approximately every three months. We are aware, however, that this more orthodox approach has been replaced in some mental health trusts (for alternative approaches, see e.g., Department of Health, 2005b, 2007; National Workforce Programme, 2009). However, despite the extensive variation in service configurations that may now exist over the UK, our findings have general implications. First, regular attendance with community outpatient services should not be taken to mean guaranteed satisfaction in the therapeutic relationship, and, second, the views of people with established relationships with practitioners indicate core values that community psychiatric intervention should respect.

#### ***4.5.7 Implications of the Study***

The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. (Deegan, 1996, p. 92)

As the debate on the preferred methods of practice within the field of psychiatry in the UK continues to develop (Benbow, 2008; Department of Health, 2011; Lelliott, 2008; National Workforce Programme, 2009; Vize, Humphries, Brandling, & Mistral, 2008), it is important to stay in touch with the core qualities that outpatients desire from a community psychiatric service. Regardless of the service configuration in place, its success should be measured by its potential to afford the opportunity for people to be listened to, respected and ultimately acknowledged as fellow human beings. This simple, yet profound request, continually surfaces in the narratives of people who are affected by severe and enduring mental illness (see also Davidson, 2003; Deegan, 1996; Ridgeway, 2001). As such, psychiatric practitioners should be sensitive to the simple compassionate acts that can ultimately validate lives and have lasting effects on the value people place on therapeutic relationships and on their efforts to be active *human* agents once again. In this vein community psychiatry in the UK needs to progress from frameworks that statically monitor and contain illness and *risk*, and accelerate current

efforts to integrate core *recovery movement* principles seamlessly into working practices (Farkas, Gagne, Anthony, & Chamberlin, 2005; Scottish Recovery Network, 2009; Shepherd et al., 2010). In order to exist outside of their illness category, to grow, and to lead validated and meaningful lives (Deegan, 1996), outpatients need to be afforded real and consequential life and treatment choices and be pivotally involved in the implementation of those choices. For this to happen, service practitioners need to be equipped with an understanding of the importance of *human agency*, as well as a service infrastructure and the resources to facilitate it (Farkas et al., 2005; Scottish Recovery Network, 2009; Shepherd et al., 2010). Furthermore, our findings suggest that practitioners should be aware that regular community outpatient attendance does not in and of itself guarantee *engagement* with a service – in fact it may often mask underlying feelings of coercion, dissatisfaction, and even resentment. As such, the views and experiences of outpatients in established and apparently *passive* therapeutic relationships should be prioritised alongside those who have had more *complex* or *assertive* interactions with services.

## **5 ‘BONDING OR BRIDGING?’ A CASE STUDY OF A SOCIAL INCLUSION DAY-SERVICE**

### **5.1 Abstract**

Drop-in ‘bonding’ day-services for people affected with severe and enduring mental illness have recently been superseded by provisions intended to encourage people to make ‘bridges’ to more ‘socially inclusive’ environments. The aim of the present study was to examine how service users and providers have managed and experienced the transition from bonding to bridging facilities. A case study design incorporated formal and informal interviews with service users and staff, participant observations of day activities, and attendance data. The day-service did not afford bridges to socially inclusive environments, but instead continued to provide important social contact and support, structure to days, and relief from social isolation and illness symptoms i.e., bonding. Service users’ engagement in a service designed to promote wider social inclusion may themselves be seeking and finding quite different but important social support.

### **5.2 Introduction**

In spite of the confusion that surrounds the term (Morgan, Burns, Fitzpatrick, Pinfold, & Priebe, 2007; Sayce, 2001); ‘social inclusion’ continues to be an important rehabilitative goal for people affected with severe and enduring mental illness. Over the last five years informal ‘drop-in’ day-services, where people have met up and shared time with friends and peers, have been superseded by initiatives intended to promote wider integration. In this new type of service, ‘bonding’ forums that lead to homogeneous and exclusive groups (Putnam, 2000) are discouraged in favour of formalised activities that help people build ‘bridges’ towards inclusive ‘mainstream communities’ (Department of Health, 2006b, 2008; National Social Inclusion Programme, 2009a). Evidence for the efficacy of this service model is outcome-focused and centres on whether participation-targets for local commissioners have been met or whether the individual has experienced improvements in social inclusion (Department of Health, 2006b; National Social Inclusion Programme, 2009a, 2009b). There is,

however, a dearth of research on how not only people living with severe mental illness but also service providers have experienced and responded to the transition to services focused primarily on social inclusion through bridging rather than on bonding. The present study used single case study analysis (Stake, 1995) to examine some of these responses and consider their implications for policy and practice.

## **5.3 Method**

### ***5.3.1 The Case Under Review***

The Social Inclusion Project (SIP) was established in late 2008 when it replaced a traditional drop-in day-service for people with severe and enduring mental illness. The SIP consisted of a Café and Recovery Service. The Café was run by service user volunteers and staff members, and, as it was set up in a local community centre, was also open to the general public. The Recovery Service incorporated a range of initiatives aimed at promoting individual wellbeing and ‘recovery’ and the progression towards more ‘socially inclusive’ environments (see Table 5.1). These initiatives were mainly housed in a neighbouring building. With the exception of peer-led activities, services were only accessible with referral support from a General Practitioner (GP) or secondary mental health service professional. At the time of the study 130 people were registered to access the SIP.

The SIP was led by a General manager who oversaw this and other local projects targeted at people living with severe and enduring mental illness. A Service manager, two Support workers, and three Social-work students were responsible for running the Café and group workshops. The staff also coordinated external facilitators, and supported service users in their general health and safety.

Table 5.1  
*Overview of SIP initiatives*

<b>Service type</b>	<b>Description</b>
<i>Café<sup>a</sup></i>	Drop-in facility that was open two days (for 6 – 6½ hours) a week and run by staff and service users.
<i>Recovery Service</i>	
Recovery workshops	Workshops took place once a week and were run by staff or an invited facilitator. Sessions focused on aspects of ‘recovery’ from mental illness and community engagement. Training included ‘independent’ living skills, illness-coping strategies, and confidence building.
Peer support groups	Women or mixed groups facilitated by staff once a week. People were encouraged to share experiences of living with mental illness and difficulties or successes with social inclusion.
Relaxation groups	Once a week a trained facilitator taught relaxation and meditation techniques.
Ceramics group	A ten-week course (one session per week) ran on a rolling programme with another community centre. Facilitated by a trained individual.
Art group	In partnership with local Further Education colleges, courses were run periodically throughout the year for one day a week. Sessions focused on the artistic representation of ‘change’ and ‘recovery.’
Peer-led activities in ‘mainstream’ settings <sup>a</sup>	Meetings were arranged on an ad hoc basis by service users in community places e.g., Public House. Staff did not attend but provided support in motivating and guiding service users in the planning stages.
Recovery STAR review	A holistic quality of life measure (Mental Health Providers Forum, 2010) covering areas such as managing mental health, living skills, social networks, relationships, identity and aspirations. The intended frequency of the STAR review was every three months per individual.

<sup>a</sup>No referral by a relevant mental health professional or GP for individuals suffering with severe and enduring mental illness required.

### **5.3.2 Procedures**

A mixed-methods single case study design (Flyvbjerg, 2006; Gomm, Hammersley, & Foster, 2000; Stake, 1995; Tashakkori & Teddlie, 1998) was used to evaluate what the Café and Recovery Service aimed to achieve and how service users and providers experienced the new service in respect to the old service. The study incorporated the following methods.

#### *5.3.2.1 Participant Observations*

Over a four week period the first (MC) and third author (CT) participated in and observed Café activities. CT took part in Recovery Service workshops, where he observed and contributed to groups under the guidance of a facilitator. All observation and participation notes were made after leaving the respective activities.

#### *5.3.2.2 Informal Interviews*

Café-based discussions with service users about their experiences of the SIP were carried out throughout the four week participation observation period.

#### *5.3.2.3 Formal One-to-One Interviews*

An opportunity for a formal interview was given to all service users accessing the SIP at the time of the research. This led to eight service users (mean age = 51.1 years) being interviewed. All four full-time staff members (mean employment time = 12.5 months) were interviewed, along with two service users of a neighbouring mental health facility who were eligible to access the SIP but had opted not to (mean age = 45 years; Table 5.2). The service users and staff members were interviewed on the SIP premises, while the two nonactive service users were interviewed on University premises.

Interviews were carried out individually or jointly by MC and CT. The researchers were particularly interested in experiences and views of participants in relation to the new SIP and the old drop-in service, and probed for further detail as appropriate when participants raised interesting issues or were reticent in sharing their views or experiences. The length of interviews ranged between 27 and 84 minutes. All interviews were digitally recorded and transcribed for analysis.

#### *5.3.2.4 Quantitative Review of Service-Attendance Data*

A monthly average of recent attendance for each of the SIP services was ascertained from the four months leading up to the 31st March 2010 (excluding a four week period surrounding Christmas and New Year holidays). Monthly service-attendance data (between April 2009 and April 2010) was used to ascertain the average number of Recovery STAR reviews administered per person in a year.

Table 5.2.  
*Participant details*

<b>Participant</b>	<b>Age</b>	<b>Gender</b>	<b>Diagnosis</b>	<b>Services accessed</b>
<i>Service users</i>				
1	59	Female	Anxiety disorder	Café, Recovery workshops, Peer support groups, Relaxation groups
2	46	Male	Schizophrenia	Café, Peer support groups
3	47	Male	Schizophrenia & substance abuse	Café, Recovery workshops, Peer support groups, Relaxation groups, Peer-led activities
4	62	Male	Schizophrenia	Café
5	32	Male	Schizophrenia	Café
6	56	Female	Bipolar disorder	Café, Relaxation groups
7	66	Male	Obsessive compulsive disorder	Café
8	41	Female	Uni-polar depression	Café
<i>Nonactive service users*</i>				
9	40	Male	Schizoid affective disorder	None
10	50	Female	Bipolar disorder	None
<b>Participant</b>	<b>Gender</b>	<b>Title</b>	<b>Time of service affiliation (in months at the date of interview)</b>	
<i>Service staff member</i>				
11	Female	Support worker	12	
12	Female	Support worker	10	
13	Female	Service manager	12	
14	Female	General manager	16	

\*Study participants who opted not to use SIP.

### ***5.3.3 Analysis of Qualitative Data***

For qualitative analyses of the 14 formal interviews, as well as the participant observation and informal interview notes, the first and third authors used inductive thematic analysis (Braun & Clarke, 2006). Both researchers analysed all qualitative data separately and met regularly to share and discuss themes and concepts that emerged. Thematic data frameworks (Ritchie, Spencer, & O'Connor, 2003) were constructed to evidence, manage, and share the data analyses.

### ***5.3.4 Ethical Considerations***

University ethical approval was gained before interviews or observations took place. All participants were informed that the study was an informal service evaluation of the SIP. Informed consent was sought for all formal interviews. Participants were reassured that they could withdraw from the study at any time (during or post-interview) without having to explain their withdrawal.

## **5.4 Results**

### ***5.4.1 The Aims and Ideals of Service Providers***

All the professionals interviewed considered 'social inclusion' into more 'mainstream' environments to be an essential end-goal to 'recovery' and that the Social Inclusion Project (SIP) could make an important contribution to this process. The unanimous view was that service users needed to learn new skills, or relearn old ones, and (re)claim social inclusion opportunities that they had lost to illness and circumstances.

To give service users skills, back-to-work skills and social inclusion again, getting them back into the community, getting them used to working again, getting them in with people so they can make new friends. (Participant 11, Support worker)

Staff members did acknowledge, however, that the transition to more inclusive environments was not necessarily easy for the people using the services. In the consultation process prior to and during the transition from old to new service, "resistance to change" (Participant 14, General manager) amongst service users was

repeatedly witnessed, so much so that an unspecified number of people who previously were regular users of the old ‘drop-in’ opted not to access the new facility. Staff members were also aware that current and new service users would sometimes struggle to leave familiar, ‘safer’ environments to enter more mainstream ones. However, the staff believed that with appropriate training and the gradual withdrawal of support, service users would be able to receive the full benefits of a socially inclusive environment.

Because people are often scared, ‘we don’t want to be part of mainstream services, we don’t want to be out doing mainstream services, we want it as it is, it doesn’t feel safe to us, we want a safe place to come’. So that would be about very small steps of saying, you know like, ‘what if we arrange a small group, where you can all go down to a [city] Café, and let that start off and we back off?’. (Participant 14, General manager)

#### ***5.4.2 What the Social Inclusion Project Achieved***

Through the SIP, a valued day-service resource was established. All service users we observed or interviewed appreciated the services they were accessing and the care and support offered by all members of staff. However, questions arose as to the type of services that were established and their relevance to the actual needs of the people using them. Furthermore, there were a considerable number of people who could have accessed the service but chose not to.

##### *5.4.2.1 Low Uptake of Recovery Services*

One hundred and thirty people were registered with the SIP. Of these, an average of 51 people (29 males, 22 females) accessed the services each month – leaving up to 79 (61%) who did not regularly attend. Table 5.3 gives a breakdown of the workshops and services utilised by the 51 regular attendees.

Table 5.3.  
*Uptake of services*

Type of service	Average number of attendees per session
<i>Café</i>	21
<i>Recovery Service</i>	
Ceramics group	9
Art group	6
Recovery workshops	5
Relaxation groups	4
Peer support groups	
Mixed	3
Women	3
Others	3

The Café service was by far the most popular service, followed by the Ceramics and Art groups. The workshops and activities intended to provide more formal support for people's recovery and social inclusion were the least well attended (Recovery workshops, Relaxation groups, Women and Mixed Peer support groups). With an average of only three to five people participating, these sessions would sometimes either be cancelled due to no one taking part or else be run with as few as one or two people.

Our participant observations showed that the Recovery Service sessions were not only the least well attended, but they also tended to attract the same small number of people. We also observed that the peer support groups often had no clear objectives, had limited or no theoretical foundation, and were lacking in *professional* facilitation. Consequently, it was unclear what the sessions were offering over and above informal interactions in the Café.

Formal interviews with regular attendees of the Recovery Service activities revealed little to no evidence that people were willing or able to apply the knowledge or skills *learnt* in the group sessions in their home environments to other aspects of their lives. One service user compared the learning experience to his University education where he would pick up information from lectures that was sometimes interesting but was rarely useful in life outside of the education institution (for similar observations, see Davidson, Stayner, Lambert, Smith, & Sledge, 2001).

[D]o I use what I learn there? I sometimes take away pieces of paper with information on them. I might not use them that much at home because as soon as I get home I go to pieces and struggle to breathe at home, because I am paranoid about the neighbours downstairs and people outside. (Participant 3, male)

They do confidence building but I don't know how to change really. (Participant 1, female)

Peer-led community activities, where people using the service were encouraged to plan and meet up in more mainstream community environments outside of service-hours, rarely happened. When they did occur it appeared to be more as a result of loyalty to staff impetus and encouragement, than spontaneous ideas and desires to meet up in more mainstream environments. However, our formal interviews revealed that planned and impromptu meetings in mainstream environments were nevertheless arranged independently of these more formalised service initiatives. When necessary or desired, sets of friends would meet up during the week in places such as pubs and Cafés or even go to music festivals and take holidays together.

#### *5.4.2.2 People not Accessing Services*

Seventy-nine of the 130 registered service users (61%) were not actually accessing the new service. While people accessing the Café and Recovery Service appeared to favour 'bonding' (localised contact with people who share similar experiences) over 'bridging' (willingness to make contact with wider people and communities), there was evidence that some of those not accessing the service may, in fact, have preferred a more effective bridging facility. For example, two participants who had opted not to access the new service expressed the view that the scope of activities and workshops provided were not sufficiently stimulating or adaptable enough to cater for what they felt they needed.

I certainly would be interested in a service that was more intellectually stimulating than what presumably the [SIP] are. You don't want to be painting pictures or doing things as simple as that. I would certainly want more stimulating company from the members they had at the [old drop-in service]. (Participant 10, Nonactive service user, female)

It would help if there were more tailored individual things, as I said, to where people's interests lie. I don't feel services at the moment do that. I feel, as I said to you earlier, they create a service and people adapt to it. That is what I feel is kind of happening at the moment. (Participant 9, Nonactive service user, male)

### ***5.4.3 What People got out of the Social Inclusion Project***

#### *5.4.3.1 Social Contact, Activity and Structure*

All of the people interviewed who had experienced the previous old drop-in style service thought the new day-service was an improvement. The premises were better lit and more aesthetically pleasing than the previous service (the premises of the old service were regularly compared to a 'dungeon' by participants). The majority of interviewed participants appreciated that there were more opportunities to attend different activities. However, our one-to-one interviews and participatory observations suggested that the new service mainly served as an opportunity to meet with friends and others in a safe and comfortable environment. This allowed those attending to get away from their isolated home environments and to spend time with peers, friends or staff who they felt comfortable with, and who could empathise with important aspects of their lives such as living with severe mental illness and related stigma.

I've met new people which is nice because I've got more people that I know now and I can talk to and just chat about general stuff, doesn't have to be depressive stuff just stuff in general. (Participant 8, female)

We are all asking for evenings [opening times for the Café] ... you see a lot of people live on their own and they get very lonely, and it's horrible. (Participant 6, female)

In addition to social contact, the Café and recovery activities provided routine to day-to-day existence. Importantly the various levels of activities such as socialising, volunteering in the Café or attending workshops, added elements of purpose, responsibility and self-worth to lives – as one participant put it, she did not "... feel like a 'signing-on sponger' " – and also distracted people from symptoms of mental illness such as hearing voices and paranoia.

It does help me with coping with my mental illness, and it is somewhere to escape from my flat as well. I do go there to escape from my flat and its during a working day

because I get voices in my head telling me I am on the dole, get a job etc, so it is like going to work. (Participant 3, male)

I think one of the good things about [the new Service] compared to [the old Service] is getting people active, it is getting me active and other people active. We are not just sitting around and drinking tea. (Participant 1, female)

#### *5.4.3.2 Informal Peer Support*

While participants did not seem to gain any noticeable benefits from the formal peer support groups beyond further bonding opportunities, Café interactions were observed to offer a rich source of informal peer support. As well as meeting and spending time with others, people would share important knowledge and experience of aspects of living with mental illness. For example, in an informal Café interview, a service user (John) was saying that an important reason for coming to the SIP was to get away from his flat and being left alone with his voices and paranoia.

It was at this point that a second service user (Jim) entered the discussion and asked: ‘Do your voices always persecute you?’ John responded that this was not always the case and that his interaction with his voices would often be about day-to-day mundane things. To this Jim said: ‘Oh, do you know what? I think I get voices too’. It turned out that Jim had been experiencing voices for a number of years, despite his unknowing denials to his psychiatrists for a number of years. (Café notes, MC)

#### *5.4.3.3 Staff Support*

While staff perceived their main role to be (re)developing skills that would facilitate integration into more mainstream environments, service users most appreciated that the staff were simply ‘being there.’ All participants got on well with staff and those we interviewed emphasized the commitment, understanding and support that staff demonstrated when someone was struggling with their mental health or needed some advice.

You can talk things through a bit, if you got something on your mind, instead of waiting till it gets really bad and getting depressed and going to the doctor, you got somebody here to give you advice on how to deal with it or how to make things a bit better. (Participant 8, female)

I think that is a great thing in the Café when there are support workers, where if you got any problems or you're worried you can talk to them in the Café and also talk to them privately. (Participant 7, male)

With staff and time often being a limited resource, one-to-one interventions tended to be prioritised for people experiencing exceptional mental health difficulties or personal crises. This fact was consistently discussed by staff and people using the service.

We won't do a lot of one-to-one key working but if necessary we will do one-to-one key working. Like if someone is upset or got a crisis at the time we can give them a few weeks of key working. (Participant 12, Support worker)

They [staff] ask people if they'd like a chat if they see the need. (Participant 7, male)

The only other opportunity for one-to-one consultations with staff outside of illness and personal crises situations was the routine Recovery STAR review (see Table 5.1). The intended frequency of the reviews was every three months per individual. However, service performance data for April 2009 to April 2010 showed that in the first six months of this period only two people in total were reviewed per month, and in the last six months, less than one per month were reviewed. In addition, none of the participants formally or informally interviewed were fully aware of what the Recovery STAR review entailed and what it was administered for.

#### *5.4.3.4 Unmet Social Inclusion Needs and Aspirations*

Our analysis of the formal interviews highlighted that the main interventions, namely group discussions and workshops, and crisis-driven one-to-one consultations, failed to fully identify with and respond to important barriers to social recovery. It was clear that a large number of needs relating to social inclusion remained unmet. Outside of the SIP, people were still experiencing loneliness and isolation. Most people stressed the importance of the service in terms of social contact. Others talked about their wish to contribute more meaningfully to society and identified barriers to this happening such as their age, their shyness around others, or their over-dependence on income support and disability benefits. Some talked about hobbies and interests that they felt unable to pursue, and most talked about the barriers to them forming and sustaining personal or

working relationships and the difficulties they faced with respect to managing ‘disclosure’ (the business of if, when or how you tell others you have a severe mental illness).

With women there is always that problem that you would have to hide it [that he has a mental illness] until they got to know you, that is always a problem. That is the main stigma I have with meeting women. (Participant 2, male)

[I]f people become aware of association of mental illness then, if previously they entertained the idea of associating with you as a friend or as a workmate or as a colleague or whatever, that goes out the window once they know about any prior connection with mental illness. (Participant 4, male)

## **5.5 Discussion**

The Social Inclusion Project (SIP) was appreciated by every service user involved in the study. Contrary to the aims of commissioners and service providers, however, the provision was not being used for building ‘bridges’ to ‘mainstream’ environments (Department of Health, 2006b; National Social Inclusion Programme, 2009a). Instead, the initiative was predominantly seen and used by the service users as a ‘bonding’ facility that afforded social contact, support and structure to their lives and apparently helped alleviate symptoms of mental illness and feelings of isolation.

However, there were strong indications that some people using services did want more ‘social inclusion’ in their lives. They talked openly about their loneliness and isolation in their housing environments, and, very importantly, their desire for more personal and intimate relationships. These types of social inclusion appeared vital to service users achieving more meaningful social existences, but were barely touched on in the multiple workshops that were provided or the one-to-one, crisis-driven staff interactions. So although service users benefited in important ways from the bonding opportunities it provided, the SIP only made a marginal impact on improving the social existences of its service users (Parr, 2008).

### ***5.5.1 Bonding or Bridging? A Complex Story***

Importantly, well over half of the people who were registered to access the new initiatives opted not to use them. Our findings suggest that these abstainers either felt

the new services were either not bridging enough, or else they were not bonding enough. The social inclusion needs of people were far from homogeneous. Further research is needed to ascertain the full extent to which these needs vary and what the core principles might be in providing a type of service in keeping with these needs. In addition, more information is needed about the places (if any) people are willing or likely to frequent in the absence of a social inclusion day-service.

The relationship between bonding and bridging is complex. Although bridging was the overriding objective of the current SIP, this was only likely to happen when people had already bonded on some level and felt able to forge contacts and relationships in wider circles (Bolin et al., 2004; Putnam, 2000). The SIP provided ample opportunities for bonding (intentionally in the form of the Café and unintentionally in the form of existing workshops) and in doing so created a sound foundation for people to bridge into wider communities if that is what they wanted to do. However, although there was some evidence of people meeting up and spending time with peers in mainstream places, there was no evidence that people did in fact strive for any wider inclusion. For some, bonding opportunities may be a stepping stone to wider societal inclusion but for an important number of others they are not. For these people, ‘safe’ places to go to and spend time with others who share similar experiences appear to have far greater importance than integrating into work or nonmental health environments (Parr, 2008).

Service providers were not unaware of the complexities of the bonding- bridging relationship. As such they recognised that they had a certain role in retaining bonding elements in new initiatives, despite commissioning pressures to encourage bridging (Department of Health, 2006b). In the early consultation process, managers became aware of the “resistance to change” voiced by service users and as a result negotiated with commissioners ways of incorporating services that had strong bonding elements e.g., Café drop-in and Ceramic groups. These types of initiatives provided opportunities to meet friends and peers, and, on paper at least, possessed some bridging credentials i.e., they were housed in ‘general public’ community premises and had voluntary work or ‘activity’ opportunities. Similar “resistance” (Taylor, 2008) to the age of new bridging facilities, by both service users and providers, has been reported elsewhere (Department of Health, n.d.; National Social Inclusion Programme, 2009a;

Rankin, 2005; Taylor, 2008). It is important to know if these initiatives also incorporated comparable negotiations concerning a place for bonding in new service configurations. Rather than covertly *dealing* with bonding preferences, they need to be openly researched and discussed.

### ***5.5.2 Implementing Social Inclusion: Practical and Ethical Considerations***

The dissonance between the intended provision of services and their actual use by those accessing them is likely to derive from the ways in which social inclusion has been defined and locally operationalised for rehabilitative day-services (Department of Health, 2006b; National Social Inclusion Programme, 2009a, 2009b). While the version of social inclusion translated into practice by service providers within the current day-service makes intuitive sense (supporting people to integrate into wider communities), it was not grounded in the meaningful views and experiences of users of the provision. In this respect our findings bear a strong resemblance to those reported elsewhere (Davidson et al., 2001). Following the author's failure of their recidivism intervention workshops, they 'resorted' to asking the participants themselves why their initiatives were not working. Hospital readmissions, they found, had little to do with illness relapse and more to do with people seeking respite from their deprived and isolated living environments. The authors concluded (Davidson et al., 2001): "[F]or any method to be useful in identifying factors in recovery it first needs to be grounded in an understanding of the experience and role of the person with the disorder." (p. 177).

Our findings highlight important ethical considerations for service providers and commissioners. Day-services have been commissioned to "... help people move on from 'safe places' and make bridges to the mainstream community" (Rankin, 2005, p. 17) yet this is not necessarily what all people with severe and enduring mental illness themselves want. People in the present case analysis were exercising their *choice* (Department of Health, 2005a, 2006a) for bonding opportunities over participation in wider community activities, but under the existing policy directives they thereby count as 'failures'. Moreover, for many people with enduring mental health difficulties, the bonding choice may in fact be an informed decision that follows years of trying and failing to access mainstream opportunities or indeed a legitimate questioning of the

value placed on (or even existence of) community or mainstream life (Putnam, 2000; Spandler, 2007). As Spandler (2007) has put it:

Although the mantra of ‘individual choice’ and ‘person centeredness’ often accompanies social inclusion initiatives, in effect the inclusion imperative inadvertently imposes certain choices as more desirable than others. In other words some choices are privileged and encouraged while others are problematised or pathologised. (p. 7)

### ***5.5.3 Study Limitation***

The study was introduced to all participants (staff and service users) as an ‘informal service evaluation’. It is likely that the service providers interviewed may have emphasised the *party line* in terms of what service they were commissioned to deliver, and, as importantly, service users were keen to present the service provider in a favourable light. However, while these *agendas* were evident in the data, we believe our main findings, that service users preferred bonding opportunities over bridging ones, and that bridging initiatives were predominantly used as further bonding opportunities, still holds. Moreover, given the reported ‘resistance’ of service users and staff to embrace bridging initiatives elsewhere (Department of Health, n.d.; National Social Inclusion Programme, 2009a; Rankin, 2005; Taylor, 2008) the adopted party line demonstrated here may have actually led to an under reporting of the importance of bonding by both service users and providers in the study.

### ***5.5.4 Implications of the Study***

With all the confusion and political distortion (Morgan et al., 2007; Parr, 2008; Spandler, 2007) that surround the terms social exclusion and inclusion, the question remains whether they still serve a useful function – at least in how they have been translated into rehabilitative policy and practice. No service user in the study spontaneously used the term social inclusion in their discourse and service users’ social aspirations failed to fit into the narrow outcome frameworks that service commissioners and providers were working to. Our findings suggest that for a social inclusion service to make a positive and constructive impact on people’s lives, the individual and group recovery goals should be based upon the personal meaning that service users themselves place on social inclusion. To achieve this, more reflective, pragmatic and flexible

approaches to rehabilitative interventions need to be considered and further researched (Greenwood & Levin, 2007; Iveson, 2002; Schön, 1983).

Under the previous Labour Government (until May 2010), local Social Inclusion services were constrained by centrally driven policy governing what social inclusion entailed (Department of Health, 2006b, 2008). In contrast, the new Coalition Government emphasises the decentralisation of power to local communities (Department of Health, 2011), ‘personalised’ budgets and person-centred outcome measurement (Audit Commission, 2010; Department of Health, 2010). Proponents of this approach claim that services, previously driven by top-down policy and programme targets, will be replaced by ones that are more responsive to individual and local needs (Audit Commission, 2010; Department of Health, 2010, 2011; National Social Inclusion Programme, 2009a, 2009b; Social Exclusion Unit, 2004; Spandler, 2007). Whether this leads to improvement in the ways that the concept of social inclusion is translated into practice remains to be seen. For example, will people who make the choice to bond rather than bridge be supported or further alienated? Whatever the future has in store, we suggest it is time to delve beneath the current social inclusion framework criteria (Department of Health, 2006b, 2008; National Social Inclusion Programme, 2009b). Regardless of the wider political and structural factors that contextualise lives affected with severe and enduring mental illness, social rehabilitative day-services should be concerned primarily with understanding the support that service users themselves are seeking, even when they are attending provision officially devoted to bridging more than bonding.

## **6 THE 'SCRATCHING THE SURFACE' PROBLEM: LIVING WITH MENTAL ILLNESS AND COMMUNITY PSYCHIATRIC PRACTICE IN THE UK**

### **6.1 Introduction**

In chapters 4 and 5, I have already identified different forms of community psychiatric provision available to people affected with severe and enduring mental illness. I have demonstrated that for many of these people contemporary practice often has little positive impact on their lives beyond illness management, and that it may in fact limit more broadly human identity and agency.

As outlined in chapter 4, formal community outpatient environments, through a complex combination of limited resources, contextual 'power' issues and deficits in the skills of practitioners may 'dehumanise' the therapeutic experience and personal identities. The more informal day-service described, on the other hand, to some extent appeared to make the lives of people affected with mental illness more bearable by affording structure to days and 'bonding' opportunities, but failed to achieve 'bridges' to more 'social inclusive' environments (see chapter 5). Moreover, and perhaps more importantly, the service fell short of making any systematic efforts to find out what social inclusion meant to its individual service users. A tacit primary aim of the day-service in question was to fulfil the contractual agreement of its commissioners rather than prioritise furtherance of the individual 'recovery' of its users (see also chapter 2).

In this chapter, through two illustrative examples, I aim to further highlight the disparity between the lived realities of people affected with enduring mental illness and contemporary psychiatric support available. Using the experiences of two individual participants from the social inclusion day-service case study, I describe the social and psychiatric background that brought them into contact with community psychiatric services, identify what I believe to be currently important issues in their lives, and further demonstrate how service provision only serves to scratch the surface with respect to responding effectively to their lived experiences. I conclude the chapter with a discussion about the negative impact that contemporary fixed intervention frameworks have on efforts to understand the rich lived experiences of people with enduring mental illness and their lack of ability to fundamentally improve people's lives.

## **6.2 Method**

### ***6.2.1 Design***

For the purpose of this chapter I used an instrumental case study design (Stake, 1995). With instrumental case studies, cases are selected on the basis of the important issues they highlight. This approach differs from the intrinsic case study design described in the preceding chapter which, although it provided an exemplar of current community day-service provision, was restricted by the fact that there was no local alternative service to analyse (see Stake, 1995, for further discussion). The two cases, henceforth referred to by their pseudonyms, John and Chris, were therefore selected for case study analysis on the basis that side-by-side they were interesting examples of how contemporary community psychiatric services only scratch the surfaces of psychiatric lives.

### ***6.2.2 Participants***

#### ***6.2.2.1 John***

John was 47 years old and diagnosed with paranoid schizophrenia. He was also a recovering alcoholic. John first came into contact with psychiatric services through hospitalisation in 1986 and, at the time of the study, was accessing community mental health support in the form of a Community Mental Health Team (seeing a consultant psychiatrist every three months and a Community Psychiatric Nurse [CPN] once a month) and a range of day-services (most notably the Social Inclusion Project [SIP] highlighted in chapter 5 and substance abuse drop-ins). Apart from regular attendance at day-services (which he primarily used to alleviate the torment from his voices and the isolation he experienced when at home alone in his flat) John had limited social outlets. He had no intimate partner or any form of employment in his life (although he said he would like both) and he was wary about mixing socially with others outside of his peers and friends (who all also lived with severe mental illness). After his onset of schizophrenia John quickly accepted his new psychiatric 'identity' and adjusted to the social exclusion that accompanied it. Apart from giving up alcohol one year prior to being interviewed John's lifestyle and social patterns did not change much in the 20+ years he had lived with his schizophrenia. In the course of the study he was interviewed

twice, both times on the premises of the SIP. The first interview lasted approximately 30 minutes, the second 55 minutes.

#### *6.2.2.2 Chris*

Chris was 41 years old and was diagnosed as living with stress-induced schizoid affective disorder. He first came into contact with psychiatric services when he was hospitalised in 1992. When I interviewed Chris he was accessing community psychiatric support through a Community Mental Health Team (like John, seeing a consultant psychiatrist every three months but unlike John he did not have a CPN). Chris played tennis for an hour each week in a day-service that encouraged sporting activity and attended a reading group once every two weeks for two hours. Unlike John, Chris lived with his parents (who he got on well with) rather than live independently. Similar to John, Chris did not have a partner, or employment, in his life (although unlike John he was ambivalent about having either), and similar to John, Chris did not have many social outlets outside of the limited day activities he attended. Although Chris would occasionally do social things with his family, again, like John, Chris preferred the contact of a few friends he had (who all lived with enduring mental illness) and was very guarded about mixing in more 'socially inclusive' environments if he was on his own. However, one important distinction between Chris and John was that after initial onset of his mental illness, Chris had a far more turbulent journey in getting to the 'here and now'. For a number of years Chris made stringent efforts to resist his label of mental illness and try to cling on to his preillness identity. So while Chris currently shares a number of social lifestyle 'choices' with John, Chris was metaphorically beaten into submission by lifestyle choices he made on the way to where he is now. In the course of the study Chris was interviewed three times, each time on University premises. Interviews lasted between 45 and 65 minutes.

#### **6.2.3 Procedure**

The interviews were carried out individually or jointly with one of two research assistants. I was particularly interested in experiences and views of each participant in relation to what had happened in their lives up until the point of the interview and their current and previous experiences of community psychiatric services. A semistructured interview schedule was used, allowing me to sensitively probe for further detail when

participants raised interesting issues or were reticent in sharing their views or experiences (Rubin & Rubin, 1995). The length of interviews ranged between 35 and 70 minutes. All interviews were digitally recorded and transcribed for analysis. For analysis of the interviews I incorporated inductive thematic analysis procedures (see chapter 4).

## **6.3 Results & Discussion**

Beginning with John, what follows is a synopsis of the description of two lives affected by severe mental illness and the limited role that community psychiatric services play in supporting their ‘recovery.’

### **6.3.1 John**

#### *6.3.1.1 Background*

John age 47 lives with paranoid schizophrenia and is a recovering alcoholic. Born in Leeds where he lived until the age of 19, John described an unhappy childhood and feels his mother was particularly neglectful and “cruel” to him. His unhappiness at home extended to school where he felt he was singled out for being different:

Even at primary school classmates were saying that I was mad and at secondary school I was bullied a lot, not physically, but I got the ‘Mickey’ taken out of me a lot, and you know I used to find some of the children at both schools very hurtful.

John left school at 18 with O’ levels and one A’ level, a reasonable achievement although he felt he could have done better. Anxiety issues he said, including a strong fear of failure, severely hampered his exam performance. His results, however, were good enough for him to leave home and study for a Higher National Diploma in Physics at Sussex University.

John thoroughly enjoyed his time at University and his initial success at the course enabled him to transfer after the first year to a Bachelor of Science degree. Yet, while friendships with both men and women were better than at school, John began to realise that he was unable to develop intimate relationships with women and continued to feel an intense shyness around them: “I went out with a few girls on dates but wouldn’t touch them.” Apart from losing his virginity to a ‘prostitute’ during his degree

days, at the time I spoke to him he had never since had a sexual relationship. This lack of intimacy in his life went on to play an important part in John's mental (ill) health. John continued to enjoy University life but was dogged by anxieties of failure that got the better of him, especially during exam times. He finished his degree but only just passed it.

After his degree, John felt no compulsion to return to Leeds and decided to stay in Sussex. His anxieties continued and at 21 he was still very shy (particularly around women) and, despite wanting employment, was too apprehensive to achieve it. His first ever job offer came in the form of a temporary cashier's job at a local supermarket, one he talked himself out of attending on the first day.

I saw it as a woman's job. I'd only ever seen one male cashier there, everyone else was a woman. I was only 21, I was very shy and I just chickened out of turning up on the first day. That made me depressed; I thought what a shame my first chance of employment and I'd blown it.

For a further eighteen months after graduation John was again unemployed, a time during which he lapsed into depression and a moderate drinking habit. His spirits were lifted when he took up his first ever employment post with an Agency. For a few weeks at least he received a wage packet: "I was well chuffed about that." However, because of scarcity of work at that time, and the fact that Agencies were unable to contact him because he could not afford to have a phone installed in his bedsit, employment opportunities dried up.

With the return to unemployment and its resultant depression and anxiety, drink and now cannabis became an integral part of his day. While he had two brief psychotic episodes a year either side of finishing his degree (incidences he put down to stress and early cannabis use) this time his psychotic symptoms were intensifying to the point he was hearing voices constantly. In March 1986 he was admitted into a local psychiatric facility for the first time.

#### *6.3.1.2 Present Day-to-Day Life*

[I] in a way a lot has changed in the last 23 years and in a way not a lot has changed. I still haven't got a job, I am still not married, I still haven't got any kids but I am still alive, I am quite happy, I have my problems but I am quite happy.

Once addiction and schizophrenia took their hold, life took on a familiar routine of semistability and relapse, where he would be hospitalised every couple of years. Although John never went back to fulltime employment again, he did take on part ‘sheltered’ work at a facility within the local psychiatric hospital. For nearly 11 years (before the facility closed) he received therapeutic earnings for undertaking industrial wiring and packaging. John’s shyness and insecurity around woman continued, and although he went on to have several brief, drug-encouraged, sexual encounters with women in the early 1990s, these never evolved into intimate relationships.

At the time of interviewing, John felt the biggest change in the last 23 years had been giving up alcohol and drugs for over a year: “I think the last year has been the best year since before I went to hospital in ’86.” However, while he was managing his addiction to alcohol and drugs, he still experienced acute symptoms of schizophrenia (mainly paranoia and persecutory voices), especially when at home alone in his flat. The two important elements of his life that he has not been able to resolve constantly torment him through his voices; not having a job and not having a girlfriend.

When I try to work I hear voices saying don’t work you are on the dole. And when I find myself thinking about woman that I like I hear voices saying ‘you got no chance, you are on the dole’ ... It is basically that voice that I have been hearing for 24 years saying, ‘... you are on the dole, you might as well be dead or whatever.’

John was living independently in a city centre flat but did not like it. When he was alone he felt isolated and paranoid about his neighbours. To help manage his illness, John knew that he needed to be around others as much as possible:

Even if I am with one other person, if I can see a person I don’t keep hearing people and wondering if they are people outside or voices in my head.

Consequently, John tried to attend as many day-services and support groups as he could including Alcoholics Anonymous and Narcotics Anonymous. The main structure to his week came from attending a local social inclusion initiative (a service offering a drop-in Café and workshop activities, see chapter 5). While the main purpose of the service was to provide ‘bridges’ for wider social inclusion, John’s motives for using the service were more basic:

I do go there [SIP] to escape from my flat and its during a working day because I get voices in my head telling me I am on the dole, get a job etc ... So I treat it as a job; it is somewhere to go five days a week that makes you feel less guilty about not working.

As well as giving structure to his day, the service helped him form some important friendships and more generally he enjoyed the informal peer support in the cafe. In addition, he found the staff friendly, approachable and supportive if he was struggling with or wanted to talk about his mental illness.

In summary, John's continual access to day-services has meant that John is living an active life. His activity, however, is focussed on 'survival' rather than recovery, his main aim being to limit the distress of his psychotic symptoms. On the whole, for all his regular attendance at services, John remains relatively unnoticed and services have shown little interest in finding out more about the stresses and strains of his life and thwarted life ambitions. Since due to his 'shyness,' John is unlikely to make demands on services to proactively help him achieve his existential aspirations, it is difficult to see how things might change. Now let us turn to Chris. As you will see, unlike John, Chris in his past has achieved important social identity markers, such as working and enjoying intimate relationships in his life, but like John, albeit for different reasons, Chris still feels frustrated by his inability to reach his ambitions, a fact to which the services he accesses appear blissfully unaware.

### **6.3.2 Chris**

#### *6.3.2.1 Background*

Up until the age of 23, Chris was living a typically young adult life. He described a happy childhood both at home and at school, bar the odd run-in with teachers. He left school at the age of 16, with five CSEs (Certificate of Secondary Education), trained as a plasterer and then had seven years of stable employment with an established building contractor. During that same time, he had a long term relationship with a partner with whom he shared a house and a mortgage. When not working, Chris enjoyed socialising with friends, watching his local football team, watching live bands and listening to music.

Two important life-changing events occurred in and around 1992. Chris's longterm employer made him redundant and, following a series of problems, his

relationship of seven years with his partner broke down. Combined, these events led to a period of depression. Unable to pay the mortgage, Chris gave up the house and chose to move back to live with his parents. He became self-employed and went through a stressful period of earning money month to month as a subcontractor for different building companies. Before long, symptoms of psychotic mental illness started to emerge and, in addition to his feelings of depression, Chris began to feel persecuted by work colleagues who, he felt, were conspiring against him. Chris's family, realising that he was not well, eventually convinced him to discuss his symptoms with his GP (someone Chris said he was avoiding for fear of what he would be told). Chris estimates that it took about a year for him to summon up the courage:

I can remember going in and saying, 'I think everyone's trying to kill me,' I can remember going in and saying that to her, and then she said, 'I think you'd better talk to someone at [the local psychiatric hospital].' By then I just thought, 'yeah I will.'

Chris described very ambiguous feelings about going to the hospital. On the one hand, he wanted to find out what was happening to him, for an 'expert' to tell him what was going wrong and to give him some form of treatment that would make him right again. On the other hand, despite being paranoid and scared, he was acutely aware of the stigma surrounding mental health institutions:

I had all the thoughts of stigma and everything that people have when they've not sort of had any contact with mental illness or anything, you know, and they think I just don't want to, I don't want to have that, I can't, I just want to be alright, I don't want to have anything to do with this you know.

To Chris's surprise he was discharged quickly.

[H]e [the psychiatrist] just seemed to take me at face value ... he was a bit sort of sceptical at first but I was never given any follow up appointments or any medication given to me or anything or any sort of nothing really. So I left, went back to work and then it wasn't long before I started getting symptoms again.

Within a couple of months Chris was readmitted to hospital, again via his GP. Although his recollection of his second admission was hazy, he was aware that his symptoms were taken more seriously this time and he was put on what he referred to as

“proper medication.” Chris was diagnosed with a ‘depressive disorder’ and discharged to his parents’ house a second time. This time, however, he was given follow-up community support, outpatient appointments with a psychiatrist and oral antipsychotic and antidepressant drugs to control the symptoms. While he did not like taking the medication, he saw it worked and it became part of his daily routine.

When I met and first interviewed Chris he was involved in advocating for better local psychiatric services. The transition from someone who initially had not wanted to be associated with mental illness in any form, to being a mental health advocate, had taken some five years of gradual and painful acceptance of his condition.

Approximately two years after his initial diagnosis, Chris gave up trying to return to the building trade. He started part-time work as a caretaker for a local community centre through a sheltered employment scheme. While he enjoyed the experience, he still struggled to accept the ‘tag’ of being mentally ill and being associated with other people with mental illness. After three years, Chris decided to leave his caretaking job. He had recently met a new partner who influenced him into thinking about doing a degree:

Yeah, but do you know why I left to do it, I left to do it because I wanted to be normal. I wanted to be a normal person I didn’t feel that I could be, where I was [the caretaking job]. They were nice enough people [his work colleagues] but I felt different. It was always a ‘me and them’ type feeling where I felt they knew about my mental illness and treated me differently, and ... it may have been related to my paranoia but I felt different.

Chris did a year long access to University course and, towards the end of it, moved with his new partner to her home town and started a degree in Media with Cultural Studies at a nearby University. He enjoyed the course and was successful, achieving a 2:1 degree at the end of it. However, more important than his academic success, he felt it was during this period of his life, when he was living and mixing in more integrated environments, that he became more accepting of his illness.

Yeah you know why? Because I was mixing with people who, who came from all walks of life and I, and were from different background to me and were more ... just nicer than

the Sun and Daily Mail readers I was used to mixing with on building sites and in pubs. And it changed the way I thought to a large extent.

In his immediate celebrations following his degree, Chris had a relapse (likely he thinks to have been brought on by exam stress) and was admitted to hospital. Although Chris's girlfriend was aware he had some mental health difficulties, he had been reluctant to tell her everything about his illness. After his hospitalisation, she decided to end the relationship and Chris returned to live with his parents.

Following the structure, stimulation and enjoyment of his degree and his relationship with his girlfriend, Chris entered a period of almost two years during which he felt depressed, isolated and alone. He did, however, become more accepting of community day-services and signed up for a men's group which ran for about 18 months and through which he gained good social support and a very close friend. He went on to try other day-services but became disillusioned when they failed to deliver what he wanted or what they promised. An important service he tried was one that offered back to work training:

[W]ell it was meant to get people working again but it never ever did it ... They started of trying to push people into doing computing training but people weren't that interested ... it ended up to be more of a drop-in where people use to go in, do a bit of cooking and stuff like that. It didn't really do what it said and it got closed in the end. They withdrew the funding.

#### *6.3.2.1 Present Day-to-Day Life*

Today Chris is 41 and lives with a revised diagnosis of stress-induced schizoid affective disorder. Despite opportunities to live independently, Chris has opted to live with his family:

[I]t is not what is cracked up to be all this independent living and everything. Friends and a lot of people I know through services are living in bedsits, bloody lonely, totally depressed with their lives and they don't want to be living alone. That is why I choose to live with parents at the moment. I know I am 43 and I sound like a sad git but the bottom line is I think to myself, I get on with them, it is someone to talk to, its company, it is better than being depressed in a place on your own crawling up the wall and I am happy with that.

Acceptance of his illness means that managing it takes priority in Chris's day-to-day life. While he does not rule out returning to some form of work, he doubts he will ever be able to work fulltime, especially in a stressful environment. Chris's social life centres on meeting a handful of friends, most of who are living with mental illness or disability. Friendships are an important part of his life and he reflects on how they have been affected by his mental illness.

I lost friends through the whole thing ... I used to go out drinking a lot before I was ill and then on medication I thought, 'I can't really do that' ... and in the end I had to not see these people. So they fell by the wayside. Other people weren't interested when they heard what was wrong with you; they thought he was a lunatic sort of thing. They probably weren't friends anyway ... and my partner disappeared. I just had my parents; that was it.

Chris went on to talk about how he has become very guarded about who he mixes with and talks to, often feeling an outsider when trying to mix in more socially inclusive environments. A particular concern for him is how best to manage disclosure (the business of when or how you tell others you have a severe mental illness), something which fundamentally impacts on his ability to forge relationships with people outside his immediate social circle. At events such as funerals or weddings, he dreads questions such as: 'And what do you do for a living?', often replying with a lie that he works in mental health. Even a trip to a barber becomes something he would prefer to avoid: "And you think oh no! (laughter). I can't tell anyone I have a mental illness in front of people sitting waiting to have their hair cut." Fear of disclosure also influences another important aspect of his life:

Chris: [L]ike when you talk about like building up relationships in terms of love life, or something like that, how do you go about that? Because if you don't tell them and then they find out that you are taking tablets or something and they ask you what it is for, then you have to lie about that, if you are not straight with them from the beginning. If you are straight with them from the beginning there is a chance they are going to tell you to piss off kind of thing or just walk in the other direction.

Mike: Do you think that actually stops people from actually trying?

Chris: Yeah, that's actually what it is has done to me over the years. And now I just think: oh sod it I can't be bothered. That is what I think. It's not worth the hassle is what I think now ... I have just accepted my lot if you know what I mean. Is that a lack of ambition on my part? I don't know.

Throughout his psychiatric life, therefore, Chris appears to have been much more proactive than John in trying to reclaim aspects of his social identity that were lost to illness. This is arguably because he had stronger preillness identity markers to aim for. As a consequence of his efforts, however, Chris has been metaphorically bashed about by the stigma of his illness, to the extent that his recovery has become confined to moving only in the circles of his close family and friends. Having outlined the background of John and Chris's lives, I will now turn to a critical analysis of the community psychiatric services that are there to support them in their recovery.

### ***6.3.3 The Role of Community Mental Health Support***

Both Chris and John access formal and less formal community psychiatric support in the form of Community Mental Health Teams (CMHTs) and community day-services. As part of the Enhanced Care Programme (Department of Health, 2007), each of them sees an assigned psychiatrist for a 20 – 30 minutes outpatient consultation every three months. A rehabilitative 'care plan,' devised at the time of their most recent hospital discharge (one year ago in the case of John, four years for Chris), is reviewed and their respective community psychiatric consultant attempts to ascertain: how they feel their mental health and life in general is going, whether they are perceived to be a risk to self or others, and, on the basis of this assessment, what, if anything, needs to be changed in their current support provision (Burns, 2004; Department of Health, 2007).

Chapter 4 of this dissertation has already considered the limitations of current outpatient forums as a means of capturing and fostering human experience and agency. Due in no small part to lack of time and other resources, the traditional outpatient appointment is more about monitoring chronic illness than it is about helping people reclaim their lives and recovering (Lester & Gask, 2006; cf., Deegan, 1996; Ridgeway, 2001).

For Chris, the outpatient appointment is currently his only means of community psychiatric support, the additional support of a carer coordinator having previously been

considered no longer necessary. While he tends to get on with the psychiatrists he sees (and he has experienced a number over the years), he is sceptical about how their priorities compare to his own and finds that they tend to focus on illness management rather than on the things that matter most to him:

They [the consultants] don't seem to be interested in a great deal really. You seem to go in and they see you're not climbing the walls and they tick a load of boxes and say 'oh yeah, right, see you in 3 months.' It seems a bit like that to me.

He went on,

No, no, no one has ever said anything to me about these all important other things that come with mental illness, you know the if and how you tell someone you have mental illness. No one has ever said anything. And I think it is important but I don't know how you do deal with it other than lying [and] doing what I have been doing really. No one has ever said anything about that, never mentioned it.

Similarly, John also expressed dissatisfaction with the psychiatric support he received and in particular the fact that frequent changes in his psychiatrist found him having to repeatedly retell his story. In addition to his psychiatrist, once a month John sees a care coordinator, a community psychiatric nurse. This is because of the severity and complexity of his condition and the fact that he is living alone. Like Chris, John finds that his CMHT relationship centres primarily on his illness, addiction and medication.

If I see my psychiatrists or CPN then it is only for about half an hour. I don't use [the name of CMHT] that much and I don't phone [the name of CMHT] that much ... but it does help to review my medication and to see how I am going and how long I have been off the booze and things.

The only other interaction that John and Chris have with psychiatric professionals is through community day-services. Chris accesses day-services primarily in pursuit of his two main hobbies, tennis and reading. He enjoys the groups but feels that the professional support is not directly related to wider aspects of his mental health and wellbeing and he is unsure about how much psychiatric support he would receive from day-services if he really needed it.

In my experience you can go to a day-service and if you don't appear severely impaired you can be completely ignored, you can fade into the background and you wonder what you are doing there. Very few people would engage with me.

John, on the other hand, described the day-services as a crucial source of support for him. Beyond his addiction meetings, he accesses the Social Inclusion Project on a daily basis, enjoys the informal peer support in the Café as well as the more formalised peer support groups and workshops that are run by staff or external facilitators (see chapter 5). Yet while these activities help John structure his day and enable him to spend more time away from the isolation of his flat, the only potential for one-to-one consultations with staff, aside from times of illness or personal crisis, is a Recovery STAR review – a holistic quality of life measure covering areas such as managing mental health, living skills, social networks, relationships, identity, and aspirations (Mental Health Providers Forum, 2007). The reviews, however, are rarely administered (see chapter 5) and John himself has never taken part in one even though he struggles on a daily basis with his paranoia and difficulties with living independently.

#### ***6.3.4 The Disparity Between Lived Experience and Professional Intervention***

For all the contact that John and Chris have with psychiatric services, they fail to make any substantial impact on those aspects of their lives which are most important to them. John, in particular, spends as many as six days a week attending community psychiatric day-services but they have done little to respond to the two key aspirations in his life which have remained the same for the past 24 years and predate his first psychotic episode; to have the confidence to develop and sustain an intimate relationship and to have at least a part-time job (or other means of contributing to society) that will increase his self-esteem and worth, and may alleviate his guilt and the torment from his voices. The only people he has shared these personal goals with are his best friends and the people who interviewed him for this project. He did hint, however, that it was hard to find the time and opportunity to talk about these things with psychiatric professionals:

I find it difficult to talk to the staff when there are other people about because it is a personal thing. I find it easier to open up in this room with only two other people like yourself.

On the surface at least, Chris is in less need of practitioner support and in fact acceptance of his illness and its management has become an integral part of his life. The hardest thing for Chris to accept over the years, however, has been the ‘tag’ of mental illness and the stigma that it entails. In fact Chris appears to have done what some theorists refer to as ‘internalised the stigma’ (Goffman, 1963; Leff & Warner, 2006). While his contact with psychiatrists helps manage his illness and medication, no one has ever helped him deal with this internalised stigma. Consequently, he has arguably retreated into a world that is safe and untrusting of others outside his immediate circle of family and close friends. And yet, despite being resigned to his condition and the social barriers it imposes, Chris claims that he would welcome opportunities to challenge him:

My attitude may be wrong and hopefully someone can show me, but the way I see it there are no choices, no real choices for people like me, just the same old services and ideas that they throw at you.

#### **6.4 General Discussion**

The inability of community psychiatric services to gain a fuller understanding of the lives of people like John and Chris is due in large part to the target and outcome culture that has emerged within contemporary rehabilitative practice (Brody, 2007; Department of Health, 2006b, 2008; National Social Inclusion Programme, 2009b). Essential aspects of what Chris refers to as the tick-box list that he feels psychiatrists work to, govern their interaction with people with mental illness e.g., whether someone is compliant in treatment, are a risk to self or others, are living independently, are economically self sufficient (on or off benefits), are free from debt, are involved in employment or community based day-service facilities and so on.

The ‘contract culture’ within the voluntary sector, as outlined in chapter 2, has meant that support too is largely driven by performance-related targets and outcomes. In the case study evaluation of the SIP outlined in chapter 5, it was telling for me that all the monthly performance targets for commissioners e.g., attendance figures broken down by demographics and workshop type, were up to date and accessible, whereas the more personalised Recovery STAR reviews (where people were given more of an individualised and holistic measure of achievement) were never fully implemented.

Likewise, in the same service, little or no attention was paid to the quality of the groups that people were attending and how conducive they were to the personal goals that people wanted to achieve.

In addition, the exclusive focus on outcomes, without considering how well they are achieved or the feasibility of sustaining them, means that they risk becoming meaningless. John for example has ‘achieved’ his independent living status for a number of years but at a price; his day-to-day life involves a constant search for others to alleviate the torment that accompanies his independence. Similarly, when I last spoke to Chris, he had been told that because he was managing his illness, life and treatment so successfully, his outpatient reviews need only happen every six months instead of every three. While he does indeed manage his illness well, Chris would be the first to admit that it too has come at the existential price of social isolation.

Ellwood (1998) has described outcome management approvingly as turning patient experience into a technology. He has argued it to be part of a twofold process. On one level, established standards and guidelines are used as frameworks to assess and monitor someone’s functioning at particular time intervals (e.g., Brody, 2007; National Social Inclusion Programme, 2009b). At a further level, outcomes are able to inform decision makers and funding bodies of the efficacy of a service or treatment (Burns, 2007; Ellwood, 1998; chapter 2). This dual functioning of management (as a means of assessing and monitoring the progress of individuals and service provision) heightens its appeal as an evaluation method within rehabilitative practice for both central and local Government.

CLG [Communities and Local Government] was therefore keen to encourage AAs [Administrating Authorities] and service providers to start to capture outcomes information ... to encourage the sector to focus more on outcomes and less on processes and inputs. (Outcomes Framework for Supporting People, 2007, p. 3)

A fundamental problem with outcome frameworks and protocols is that they are often driven by the need for political goal-scoring and rhetorically-led social theory, rather than by empirical investigation (see e.g., discussion of the Independence and Social Inclusion Outcomes, chapter 2 and 5 respectively). As Blumer (1954) puts it:

[w]hen applied to the empirical world social theory is primarily an interpretation which orders the world into its mould, not a studious cultivation of empirical facts to see if the theory fits. (p. 1)

As a result theoretical outcomes such as independence and social inclusion (Department of Health, 2006a, 2007) are treated as definitive and unchallengeable concepts, when in reality they can be no more than ill-informed or vague ones (Morgan et al., 2007; Spandler, 2007; Vernon & Qureshi, 2003).

As outlined in chapter 2, the problem is exacerbated when outcome frameworks coevolve with service provision, and, consequently, service provision becomes led by political rhetoric. For example, the widely accepted 'Independence' outcome that drives much of rehabilitative practice (Department of Health, 2006a; National Social Inclusion Programme, 2009a) relates to a model of independence that can be defined as self-sufficiency, where the preferred end-product is people who are less reliant on others and who consequently draw less heavily on support resources (see e.g., Vernon & Qureshi, 2003; cf., Lewis & Glennerster, 1996). If we also take into account (as I have discussed in chapter 2) that local statutory services are likely to integrate this narrow definition of independence into their commissioning frameworks, and that potential service providers who compete for provider status are chosen on their ability to fulfil their criteria, then we can also see the fundamental role that the independence outcome framework plays. It is omnipresent in the personal lives of people living with severe and enduring mental illness and acts to monopolise the support services that people are able to access (see also Milligan, 2000; Parr, 2008; Spandler, 2007; Wolch, 1990). Yet, as Chris, John and many others have testified, lives are often unlikely to be enriched by living independently of others. The end result is a model of independence that can lead to liminal, lonely and isolated lives in 'mainstream communities' (Dear & Wolch, 1987; Mandiberg, 2010; Milligan, 2000; Parr, 2008).

Finally, let us return to Chris to further underline the shallowness of current intervention frameworks and the challenges that community psychiatric practitioners face. For all the restrictions that mental illness and stigma have placed on him over the years, Chris remains dubious about what else, at this stage in his life, he feels he wants or can achieve:

But the thing is that I am not sure if I want my life back the way it was because everything is different now. It has changed so much I am not sure I would want it to be back the way it was and I am not sure if it ever could – do you know what I mean? I feel I have learnt so much from being mentally ill in terms of relationships with others, how you look at life and how you prioritise things. I don't think you could just go back to where you were all those years ago and pick it up again. I don't think it will work like that. Because I have changed so much through experiences, both my mental health experiences and just day to day life since it has been different. I don't know if you can just put yourself back to where you were – in fact I don't think you can.

Chris articulately conveys how he now has a different identity to preillness; one that is not all his own making. His 'new' identity is a culmination of acceptance of his mental illness and the stigma that goes with it and demonstrates a break from his initial ambitions to break free from a 'psychiatric life'; to work and freely mix with others outside the immediate circles of his family and mental illness. He is now trapped. He is aware that he has changed (for the good as well as the bad), and that there is no going back to his preillness days. But he is unconvinced, too, that he has anywhere to go. His experiences of stigma have been internalised to the point that 'disclosure' management governs how he lives his day-to-day life (see Gallo, 2004; Goffman, 1963; Leff & Warner, 2006). At the same time he feels abandoned by psychiatric services that are theoretically there to support him:

My attitude may be wrong and hopefully someone can show me, but the way I see it there are no choices, no real choices for people like me, just the same old services and ideas that they throw at you.

Herein lies the extent of the challenges that community psychiatric practitioners have to face. They need the skills and motivation to be able to challenge apathy and internalised stigma and to be equipped with methods of intervention that help people in the process of achieving, maintaining and identifying new existential goals. More broadly they need to be able to work within a model of community psychiatric practice that offers real choices and which is not constrained by rigid outcome measures and protocols but is rather primarily concerned with fully understanding the lives of people affected by mental illness. While I believe that most practitioners have the skills and motivation to do this, I question whether they have an appropriate framework to work

within. In the last chapter, I suggest an alternative approach to working which might allow them to engage more effectively with these concerns.

## **7 'DIGGING BENEATH THE SURFACE': ADOPTING A PRAGMATIST PERSPECTIVE WITHIN COMMUNITY REHABILITATIVE PRACTICE**

### **7.1 Abstract**

Increasingly, the focus of community rehabilitative practice for people with mental health problems is on a set of predefined explicit as well as tacit outcomes which are related to abstract constructs such as independence, choice, social inclusion and risk. As a result, there is a widening disparity between professional objectives and the reality of people's lives, evidenced by unsuccessful interventions, alienating therapeutic relationships and marginalised existences. In this chapter I argue that early Pragmatists such as George Herbert Mead and John Dewey offer us a viable alternative to current community rehabilitative interventions with people living with severe and enduring mental illness. In particular, pragmatism works from the basis that all meaningful activity and experience involves an active agent and is embedded within a dynamic context. In contrast to present day practice, these eminent academics, and early social reformers, suggested that community practitioners should, as much as possible, achieve and maintain a level of intimacy with the people they were supporting, should be devoid of preconceptions, dogma or fixed rules of conduct, and should emphasise that there are no fixed outcomes just experiential processes and provisional solutions (e.g., Mead, 1907). It is these broad pragmatist principles that I suggest should underpin contemporary community psychiatric interventions.

### **7.2 Introduction**

In the preceding chapters I have highlighted how contemporary community psychiatric outpatient and day-services are overly dependent on intervention on fixed intervention frameworks and consequently fail to fully acknowledge or capture the human experience of people living with severe and enduring mental health illness. In chapter 6, I highlighted how, for people affected with mental illness, such intervention technologies only scratch the surface of their lives. Furthermore, the explicit and tacit outcomes that are embedded in these intervention frameworks not only risk distancing practitioners from the important realities of people's lives but can also impose contrived

and undertheorised targets such as ‘independent living’ and ‘social inclusion’ (e.g., Morgan et al., 2007; Vernon & Qureshi, 2000; see also chapter 2 and 5).

The purpose of this chapter is to further highlight the conceptual weaknesses that underpin our intervention frameworks and to propose an alternative approach. I suggest that we can learn much from the work and philosophies of the early Pragmatists, George Herbert Mead and John Dewey and in particular their emphasis on people as socially contextualised agents engaged in a *process* of ongoing meaningful activity, rather than as distinct individuals experiencing or striving to attain predetermined outcomes. In addition to being eminent philosophers and theorists, both Mead and Dewey were social reformers who endeavoured to apply their theory to important social problems of their time and culture, such as the lived problems of the impoverished immigrant communities of Chicago in the early 20th century (Joas, 1985; Menand, 2001; Shalin, 1988). However, in sharp contrast to today’s practice, that encourages distance through predefined services and outcome measures, both Mead and Dewey emphasised that methods of social inquiry and intervention should be more organic and primarily concerned with keeping in sight the complexities of human existence (Dewey, 1966a; Joas, 1985; Mead, 1907; Menand, 2001; Shalin, 1988).

These forerunners in the pragmatist movement therefore emphasised the centrality of the active human agent and the importance of judging any means of enquiry (whether it be philosophy, scientific analysis or social intervention) by its potential to help people meet and solve the challenges of day-to-day living (e.g., Dewey, 1966b; James, 1904; Mead, 1907, 1934; Peirce, 1905). In doing so, they acknowledged human experience was a ‘messy’ affair and that in our efforts to make sense of it all, methods of inquiry and intervention needed to be varied and have the ability to adapt to the contexts they are applied to (Brendel, 2006; James, 1904; Mead, 1913). I will argue here that there is evident scope to integrate these pragmatic principles into contemporary community psychiatric practice.

### 7.3 The Early Pragmatists

Owing to the fact that experience is a process, no point of view can be the last one.  
(James, 1904, p. 221)

The early pragmatists believed that life was an ongoing engagement between self and world, and that meaningful experience, e.g., our intelligence, consciousness and motivations, were manifest in the activity of doing and working towards our practical ends (e.g., Dewey, 1896; James, 1904; Mead, 1934; Peirce, 1905). Like other nondualist theorists (see e.g., Heidegger, 1962; Merleau-Ponty, 1845/1996) they emphasised that in the natural order of doing things, meaningful experience is not explicitly presented to or passed onto the individual, rather the individual transforms their environment in the *process* of meaningful activity. In this sense *meaning* is part of a dynamic interplay between agent and world (Dewey & Bentley, 1947; Mead, 1934).

Both Mead (1934, 1956/1964) and Dewey (1896) stressed that organised forms of empirical human study tended, on the whole, to treat participants as ‘passive agents,’ where they were given artificial stimuli and directed to respond. This form of inquiry they argued only told us what happens in the unnatural order of doing things and had very limited practical worth. In ‘real life,’ they said, people were far from passive:

Here we have the [individual] as acting and determining its environment. It is not simply a set of passive senses played upon by the stimuli that come from without. The [individual] goes out and determines what it is going to respond to and organises that world. (Mead, 1956/1964, p. 139)

Methods of human inquiry, they believed, had to be approached with the same degree of empirical rigour as traditional methods, but, at the same time needed to be flexible and adaptive to the context they were being applied in. There were no ‘absolute truths,’ only provisional solutions (e.g., Brendel, 2006; Dewey, 1896; James, 1904; Mead, 1913; Menand, 2001) and methods of practice needed to reflect this if they were able to get to (and stay in contact with) the heart of the problems of human existence.

Both Dewey and Mead made stringent efforts to apply their theory to practical problems of living. In his discussions, for example, on the need for educational reform, Dewey was highly critical of traditional methods of teaching. These placed the child in

a metaphoric 'straitjacket.' Children's natural tendency to engage with and transform their own environment was stifled by contrived and restrictive authoritarian teaching approaches that demanded order, limited movement and discouraged interaction with others and world (Dewey, 1938,1966a).

The child is thrown into a passive, receptive, or absorbing attitude. The conditions are such that he is not permitted to follow the law of his nature; the result is friction and waste. (Dewey, 1966a, p. 54)

Similarly for Mead and his writing on progressive social work (which we will discuss in more detail later), the human agents who were experiencing the problems of living needed to be at the centre of any intervention and professional means of enquiry and practice (Mead, 1907).

Although to my knowledge, Dewey and Mead did not write explicitly on the problems of living with psychiatric illness, it is not difficult to see why they might be critical of contemporary community rehabilitative practice. For the pragmatists, meaningful experience was a dynamic process (Dewey, 1896; Garforth, 1966; Mead, 1934). In contrast, current methods of psychiatric practice tend to ignore the process of experience by situating lives into fixed frameworks. Lives are thus dissected into quantifiable goals and outcomes which assume far greater importance than consideration for how they are achieved or, as important, for what happens after they are reached (Mixon, 1980; Roberts & Wolfson, 2004). Hence the concerns of pragmatists clearly resonate with the discussions in preceding chapters, and demonstrate the fact that the processes leading up to and maintaining 'successful' outcomes such as 'independent living' and 'social inclusion' are likely to be more important to understand than whether or not the outcomes are in effect achieved.

From a pragmatist perspective, existing psychiatric frameworks deny the active agent by limiting 'choices' and imposing frameworks for action on to people's lives with rigid timeframes and milestones. Although there may be value in having outcomes for certain aspects of peoples' lives e.g., issues of housing, employment and economic self sufficiency, these are unlikely to come to the forefront of people's lives in a prescribed way or necessarily surface as meaningful objectives at times that neatly coincide with the outcome target monitoring – as the pragmatists have stressed,

meaningful experience is not fixed but is a process. As I have highlighted in the previous chapter, the harsh realities of people living with severe and enduring mental illness may mean that their preferred life outcomes e.g., living more meaningful existences, differ substantially from those envisaged by practitioners and may thus be far more difficult to support. With central Government policies encouraging us to focus on outcomes instead of processes, we risk not only ignoring the complexities of the lives of people living with severe mental illness but also perpetuating systems that set those people up to 'fail.' Having introduced pragmatist theory and how it runs counter to current community psychiatric practice, we can now turn to how a pragmatist perspective could be applied to modern practice.

#### **7.4 Applying Pragmatism to Community Psychiatric Practice**

In the varied topography of professional practice, there is a high, hard, ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution .... Shall the practitioner stay on the high, hard ground ... where he is constrained to deal with problems of relatively little social importance? Or shall he descend to the swamp where he can engage the most important and challenging problems if he is willing to forsake technical rigour? (Schön, 1983, p. 41)

As noted earlier, as well as being eminent academics, the early pragmatists (most notably Dewey and Mead) were social reformers, touched by the harsh realities of living in their own time and context: that of Chicago in and around the turn of the 20<sup>th</sup> century (Joas, 1985; Menand, 2001; Shalin, 1988). Both Dewey and Mead worked closely with Jane Addams<sup>3</sup> and were highly engaged with the workings and philosophies of Hull House, considered to be the first settlement house within the US. Hull House (like other settlement houses to come) was set up to house, support, educate and train underprivileged adults and children of the time.

An important part of its philosophy was that the social work practitioners and researchers (known as residents) were required to live within the settlement house with the people and circumstances they were supporting or scrutinising (Addams, 1910; Joas, 1985; Mead, 1907; Menand, 2001). In doing so a 'level of intimacy' was instilled,

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<sup>3</sup> Jane Addams was a pioneering social worker and Nobel Peace Prize winner (see Gehlert, 2006).

where practitioners became aware of the real life experiences that people were facing, and alliances formed were grounded in close ‘human relationships’ rather than *them and us* dichotomies:

The settlement worker distinguishes himself from either the missionary or the scientific observer by his assumption that he is first of all at home in the community where he lives, and that his attempts at amelioration of the conditions that surround him and his scientific study of these conditions flow from this immediate human relationship. (Mead, 1907, p. 108)

It might be highly unrealistic to expect present day practitioners to move in and live with those who they are there to support (although in some cases there would undoubtedly be pedagogical value in this!). But there is an essential need for practitioners to become more grounded in their understanding of the day-to-day realities of people living with enduring mental illness and for therapeutic relationships to be more attuned to these realities. Rather than incorporating rigid predetermined intervention frameworks that encourage detachment, methods of practice at all therapeutic levels should encourage the exploration of lived human realities, something which the early pragmatists were wise to 100 years ago:

It is the privilege of the social settlement to be a part of its own immediate community, to approach its conditions with no preconceptions, to be the exponents of no dogma or fixed rules of conduct, but to find out what the problems of this community are and as a part of it to help toward their solution. (Mead, 1907, p. 110)

#### ***7.4.1 Understanding the ‘Process’ of Recovery***

a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993, p. 12)

As outlined in chapter 4, community psychiatry in the UK needs to progress from frameworks that statically monitor and contain illness and risk towards adopting core recovery movement principles more seamlessly into working practices. In order to

exist outside of their illness category, to grow, and to lead validated and meaningful lives people living with severe and enduring mental illness need to be afforded real and consequential life and treatment choices and be pivotally involved in the implementation of those choices (Deegan, 1996). For this to happen, service practitioners need to be equipped with an understanding of the importance of *human agency* and the *process* of recovery, as well as a service infrastructure and the resources to facilitate it (Farkas et al., 2005; Scottish Recovery Network, 2009; Shepherd et al., 2010). However, while incorporating these key recovery movement principles is likely to improve therapeutic relationships and ultimately enhance people's lives, we still need a better understanding of how the process of recovery can best be identified and managed.

In order to grasp fully the process of human and psychiatric experience, practitioners need to leave what Schön (1983) terms the security and comfort of the (outcome focussed) high ground and enter the “swampy” low ground. They need to be encouraged (and trained) to move away from deductive and closed interventions that distance practitioners from the people they are there to support, towards inductive-deductive methods that are more likely to diffuse “them and us” therapeutic relationships (see chapter 4). Methods of inquiry and intervention need to be selected based on their suitability for addressing the problem at hand and aim inductively to capture experience of mental illness for a given individual and context (in other words from the bottom up as opposed to the outcome down). Once an understanding of the problem is ascertained, multiple therapeutic and practical interventions can be used to achieve, revisit and reformulate what the pragmatists would define as provisional solutions (Brendel, 2006; James, 1904). To do these things, there are a number of established and validated pragmatist methods of practice that can be utilised (see e.g., Reflective Practice, Schön, 1991; Action Research, Greenwood & Levin, 2007; Grounded Theory, Corbin & Strauss, 2008; and Solution-focused approaches, O'Connell, 1998).

### ***7.4.2 Flexible and Reactive Services***

The only thing to be dreaded in the Settlement is that it loses its flexibility, its power of quick adaptation, its readiness to change its methods as its environment may demand. (Addams, 1910, p. 126)

Community psychiatric services also need to be pragmatically responsive and adaptive to transient need. As the New ways of working framework (Department of Health, 2007) has identified, people may not want support at pre-given intervals e.g., outpatient appointments every 2 – 3 months. And not all the immediate stresses that impact on people with enduring mental illness will need ongoing support and monitoring; they may just be problems of the moment such as dealing with a financial problem, working through bureaucracy or responding to neighbourhood victimisation. These types of problems of living (that may undoubtedly influence longer term relapse) are unlikely to be fully captured and dealt with in a fixed framework and protocol that is administered once a person has negotiated a lengthy and complicated referral process. As the pragmatists suggest, human experience just happens; not in a fixed way and not at a fixed time. ‘Floating’ support services that can be freely accessed and which are flexible and responsive to expressed need rather than prescribed outcomes would be a welcome addition to the lives of many people living with severe mental illness, a premise shared by the early social workers. In addition to access to more reactive practical support, people living with mental illness also need more direct access to trained psychotherapy support. While it is encouraging that recent initiatives have improved this provision (Department of Health, 2011), such support could go further towards addressing problems that may not be obviously related to the mental illness itself but nonetheless impact significantly on the core self e.g., living with internalised stigma, issues of disclosure and anxieties related to forming relationships (see chapter 6; Davidson et al., 2001).

### ***7.4.3 Solutions and Choices Based on Substance and not Rhetoric***

[w]hen applied to the empirical world social theory is primarily an interpretation which orders the world into its mould, not a studious cultivation of empirical facts to see if the theory fits. (Blumer, 1954, p. 1)

As outlined in chapter 2 and elsewhere in this thesis, community psychiatric practitioners do not work in a political vacuum. Political and related rhetorical structures have an important part to play in how practitioners work and the service and choices they can offer the people they serve. Although history has told us that it may be unwise to build theory on the basis of political promises, I am cautiously optimistic that the new macro political climate has greater potential to encourage and accommodate more pragmatic (and Recovery Movement) principles in to psychiatric practice than the previous one.

An integral part of the new Coalition Government's 'vision' for social care is their decentralisation policy and 'personalisation' agenda (Department of Health, 2011). Self-directed support, where individual support plans are paid for out of personally assigned budgets (managed by service user themselves or their designated 'other'), are intended to diffuse the block funding of rehabilitative services and the *contract culture* (see e.g., Department of Health, 2010; chapter 2). This has important implications for provision and is likely to instil more naturally (as opposed to rhetorically) 'person centeredness' and 'choice' into practice. As more people with mental illness assume the status of paying customers, there will be less reliance on traditional 'off-the-peg' services that are funded for several years at a time. In addition, there should be more motivation for service providers to tailor their provision to the identified needs of the individual (Audit Commission, 2010; Department of Health, 2010).

Here and elsewhere in this dissertation I have argued that current outcome frameworks that are intertwined within rehabilitative practice models only serve to distance practitioners from the real problems faced by many people living with severe and enduring mental illness. However, I would not advocate that rehabilitative psychiatric practice is entirely stripped of outcome frameworks – goals undoubtedly guard against apathy on both sides of the sides of the therapeutic relationship. There does however need to be a conceptual shift in how outcome frameworks are developed and utilised; we need to start focussing on what is important to measure rather making what we can measure important (Roberts & Wolfson, 2004). Therapeutic outcomes and goals need to be as grounded, as far as possible, in the real experiences of people living with severe mental illness. In this respect it is encouraging that the Personalisation agenda is promoting performance outcomes which are assessed in terms of whether

individual goals and objectives are achieved rather than on whether top-down policies and programmes have met their own targets (see Audit Commission, 2010; Department of Health, 2010; Spandler, 2007).

A further important direction advocated by the new Coalition Government is towards decentralising of power to local communities (Department of Health, 2011; The Cabinet Office, 2011). I am hopeful that this shift will bring opportunities for local (and national) community service providers to step out of the shadow of the State and once again offer more choice, innovation and reform (see chapter 2). One very important area for innovation and reform that is needed to improve the lives of many people living with enduring mental illness is ‘social inclusion.’

Community was important to the early pragmatist and pragmatic solutions, whether they were social practice or education, were judged on their ability to keep in touch with the realities of living with others and their potential to change things communally for the better (Dewey, 1966a; Mead, 1907). For many people living with severe and enduring mental illness there is little sense of community, with thousands living liminal and isolated lives somewhere between ‘asylums’ and ‘mainstream’ life (Dear & Taylor, 1982; Mandiberg, 2010; Parr, 2008; Pinfold, 2000). In spite of central Government drivers and antistigma initiatives (National Social Inclusion Programme, 2007; [www.time-to-change.org.uk](http://www.time-to-change.org.uk)), the NIMBY (not in my back yard, Dear & Taylor, 1982) attitude is, arguably, as prevalent today as it was when the phrase was coined nearly 30 years ago (cf., Department of Health, 2009). And while we are waiting for the wider society to be more accepting, people affected by mental illness are currently not only deterred from bonding but also viewed as ‘failures’ for not trying to integrate (Mandiberg, 2010; Spandler, 2007; chapter 5).

In a paradox of contemporary mental health programming, people often receive services together and in so doing build friendships, interdependencies, and mutual support. At the point of discharge, these interdependencies are ignored and these people are told to be independent and fully assimilated in the broad community, rather than spending too much time with other mental health consumers. (Mandiberg, 2010, p. 174)

Instead of blindly following abstract and de-situated government ventures such as the ‘Supporting People’ and the ‘National Social Inclusion’ Programmes, what is needed are creative and localised initiatives, based on pragmatic principles, to make

inroads into stigmatised and marginalised lives. With less centralised control, there may be scope for innovative solutions to social inclusion that encourage both ‘bonding’ and ‘bridging’ social capital (see Leff & Warner, 2006; Mandiberg, 2010; Parr, 2008; Pinfold, 2000; Putnam, 2000). Mandiberg (2010), for example, has argued that community and ‘interdependent living’ for people affected with severe mental illness can be modelled on migrant ethnic communities. Ethnic community enclaves offer peer support, employment and other forms of enterprise, while, at the same time, providing a base for bridging into wider communities – and they are not viewed as failures for doing so (Leff & Warner, 2006; Mandiberg, 2010). Likewise Parr (2008) also gives examples of how arts, social networks and Environmental enhancement initiatives can offer peer support, reaffirm social identities and build bridges to more inclusive environments.

More flexible policy and legislation might help sow the seeds for innovative methods of reclaiming human agency and social identity while at the same time supporting people in the *process* of maintaining their recovery outcomes (see Leff & Warner, 2006, for extensive summary of innovative approaches and macro obstacles to social inclusion for people with severe and enduring mental illness). With the emphasis on innovation and localised solutions, both practitioners and consumers of mental health services can collaboratively ascertain the levels and types of social inclusion that consumers want to build on and the barriers that exist for consumers achieving meaningful social existences.

## 7.5 Conclusion

Over a hundred years ago pragmatists were arguing that for social work and rehabilitation initiatives to be effective, those seeking solutions had to foster a degree of intimacy with the problems of living that were being observed. Contrary to this ethos, the last century has seen models of social intervention which accentuate distance and detachment between those experiencing the problem and those disposed to alleviate it or offer solutions. While it is unlikely that things will fully return to the early pragmatist ways, there is much we can learn from the pragmatist principles. Contemporary community psychiatric practice should be structured primarily around practitioners gaining a sound understanding of the complexities involved in living with psychiatric illness. From these foundations practitioners should aim to use multiple therapeutic and

practical interventions to devise provisional solutions, revisiting them, and reformulating them, in accordance with the living problems identified. In short practitioners need to move away from forcing lives into fixed frameworks, and instead should acknowledge and accommodate the dynamic *process* of meaningful experience that comes from living as a human being.

**REFERENCES**

- Adams, J., & Drake, R. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal, 42*(1), 87–105.
- Addams, J. (1910). *Twenty Years at Hull House*. New York: MacMillan Co. Retrieved August 31, 2010, from <http://media.pfeiffer.edu/lridener/dss/Addams/2hh6.html>
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal, 16*(4), 11–23.
- Audit Commission (2010). *Financial management of personal budgets: Challenges and opportunities for councils*. Retrieved August 31, 2010, from <http://www.audit-commission.gov.uk/nationalstudies/localgov/personalbudgets/Pages/default.aspx>
- Bamberg, M. (1997). Positioning through structure and performance. *Journal of Narrative and Life History, 7*(1–4), 335–342.
- Bamberg, M. (2000). Critical personalism, language development. *Theory & Psychology, 10*(6), 749–767.
- Benbow, S. M. (2008). New ways of working: Power, responsibility and pounds. *Psychiatric Bulletin, 32*(5), 195–196.
- Benwell, B., & Stokoe, E. (2006). *Discourse and identity*. Edinburgh: Edinburgh University Press.
- Blumer, H. (1954). What is wrong with social theory? *American Sociological Review, 19*(1), 3–10.
- Bolin, B., Hackett, E. J., Harlan, S. L., Kirby, A., Larsen, L., Nelson, A., Rex, T. R., & Wolf, S. (2004). Bonding and bridging: Understanding the relationship between social capital and civic action. *Journal of Planning Education and Research, 24*, 64–77.
- Bowdle, B., & Gentner, D. (2005). The career of metaphor. *Psychological Review, 112*(1), 193–216.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.
- Brendel, D. (2006). *Healing psychiatry: Bridging the science/humanism divide*. Cambridge, MA: MIT Press.

- Brody, S. (2007). Supporting People framework sets new challenges for providers and councils. Retrieved April 23, 2011, from <http://www.communitycare.co.uk/Articles/2007/06/05/104698/Supporting-People-framework-sets-new-challenges-for-providers-and.htm>
- Burgess, D., Fu, S., & van Ryn, M. (2004). Why do providers contribute to disparities and what can be done about it? *Journal of General Internal Medicine, 19*(11), 1154–1159.
- Burns, T. (2004). *Community mental health teams: A guide to current practices*. New York: Oxford University Press.
- Burns, T. (2007). Evolution of outcome measures in schizophrenia. *British Journal of Psychiatry, 191*(50), 1–6.
- Burns, T., Creed, F., Fahy, T., Thompson, S., Tyrer, P., & White, I. (1999). Intensive versus standard case management for severe psychotic illness: A randomised trial. UK 700 Group. *Lancet, 353*(9171), 2185–2189.
- Cameron, L., & Deignan, A. (2003). Combining large and small corpora to investigate tuning devices around metaphor in spoken discourse. *Metaphor and Symbol, 18*(3), 149–160.
- Chase, M., Malden, A., Lansbury, L., Hansen, J., Ambrose, A., Thomas, C., Costall, A., Wilson, C., & Zinken, J. (in press). 'In sight, out of mind': The experiences of the compliantly engaged community psychiatric outpatient. *Community Mental Health Journal*.
- Chase, M., Zinken, J., Costall, A., Watts, J., & Priebe, S. (2010). 'These psychiatrists rate themselves as gods': Disengagement and engagement discourses of people living with severe mental illness. *Communication & Medicine, 7*(1), 43–53.
- Chouliaraki, L., & Fairclough, N. (1999). *Discourse in late modernity: Rethinking critical discourse analysis*. Edinburgh: Edinburgh University Press.
- Compton, M. T. (2005). Barriers to initial outpatient treatment engagement following first hospitalization for a first episode of non affective psychosis: A descriptive case series. *Journal of Psychiatric Practice, 11*(1), 62–69.
- Compton, M. T. (2010). Mental illness in 2010: Putting the recovery model into practice. Retrieved April 23, 2011, from <http://www.medscape.com/viewarticle/730233>

- Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: Sage Publications Inc.
- Davidson, L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: New York University Press.
- Davidson, L., Stayner, D. A., Lambert, S., Smith, P., & Sledge, W. H. (2001). Phenomenological and participatory research on schizophrenia: Recovering the person in theory and practice. In D. L. Tolman & M. Brydon-Miller (Eds.), *From subjects to subjectivities: A handbook of interpretive and participatory methods* (pp. 163-179). New York: New York University Press.
- Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65(2), 131–145.
- Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, 20(1), 43–63.
- Dear, M. J., & Taylor, S. M. (1982). *Not on our street*. London: Pion Ltd.
- Dear, M. J., & Wolch, J. R. (1987). *Landscapes of despair: From deinstitutionalisation to homelessness*. Princeton: Princeton University Press.
- Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 91–97.
- Deegan, P., & Drake, R. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services*, 57(11), 1636–1639.
- Department of Health (1998). *A first class service: Quality in the new NHS*. London: Department of Health.
- Department of Health (1999). *A national service framework for mental health*. Retrieved March 10, 2010, from [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4077209.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf)
- Department of Health (2001). *Safety first: Five-year report of the national confidential inquiry into suicide and homicide by people with mental illness*. Retrieved March 10, 2010, from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4006679](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006679)

- Department of Health (2002). *Community mental health teams: Mental health policy implementation guide*. Retrieved April 23, 2011, from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4085759](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4085759)
- Department of Health (2005a). *Independence, well-being and choice: Our vision for the future of social care for adults in England*. Retrieved April 23, 2011, from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4106477](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4106477)
- Department of Health (2005b). *New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts – Final report ‘but not the end of the story’*. Retrieved April 23, 2011, from <http://www.dh.gov.uk/assetRoot/04/12/23/43/04122343.pdf>
- Department of Health (2006a). *Choice matters: Increasing choice improves patients’ experiences*. Retrieved April 23, 2011, from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4135541](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4135541)
- Department of Health (2006b). *From segregation to inclusion: Commissioning guidance on day services for people with mental health problems*. Retrieved August 31, 2010, from [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4131068.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4131068.pdf).
- Department of Health (2007). *New ways of working for everyone: A best practice implementation guide*. Retrieved April 23, 2011, from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079102](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079102)
- Department of Health (2008). *From segregation to inclusion: Where are we now?* Retrieved August 31, 2010, from <http://www.library.nhs.uk/MENTALHEALTH/ViewResource.aspx?resID=2780>  
17.
- Department of Health (2009). *Attitudes to mental illness: Research Report*. Retrieved April 23, 2011, from

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_100651.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100651.pdf)

Department of Health (2010). *A vision for adult social care: Capable communities and active citizens*. Retrieved August 31, 2010, from [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_121971.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971.pdf)

Department of Health (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. Retrieved April 23, 2011, from [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_124058.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf)

Department of Health (n.d.). Commissioning for social inclusion outcomes: Workshop report. Retrieved April 23, 2011, from <http://www.socialinclusion.org.uk/publications/Commworkshoprep.pdf>

Department of Social Security (1998). *Supporting people: A policy and funding framework for support services*. London: Department of Social Services.

Dewey, J. (1896). The reflex arc concept in psychology. *Psychological Review*, 3(4), 357–370.

Dewey, J. (1917). The need for a recovery of philosophy. In J. Dewey (Ed.), *Creative intelligence: Essays in the pragmatic attitude* (pp. 3-69). New York: H. Holt and Company

Dewey, J. (1938). *Experience and education*. New York: Collier Books.

Dewey, J. (1966a). My pedagogic creed. In F. W. Garforth (Ed.), *John Dewey: Selected Educational Writings*. London: Heinemann.

Dewey, J. (1966b). The school and society. In F. W. Garforth (Ed.), *John Dewey: Selected Educational Writings*. London: Heinemann.

Dewey, J., & Bentley, A. (1947). "Definition". *The Journal of Philosophy*, 44(11), 282–306.

Dreyfus, H. L. (1991). *Being-in-the-world: A commentary on Heidegger's Being and Time, Division I*. Cambridge, MA: MIT Press.

Dziopa, F., & Ahern, K. J. (2009). What makes a quality therapeutic relationship in psychiatric/mental health nursing: A review of the research literature. *The*

- Internet Journal of Advanced Nursing Practice*, 10(1). Retrieved April 23, 2011, from [http://www.ispub.com/journal/the\\_internet\\_journal\\_of\\_advanced\\_nursing\\_practice/volume\\_10\\_number\\_1\\_8/article/what\\_makes\\_a\\_quality\\_therapeutic\\_relationship\\_in\\_psychiatric\\_mental\\_health\\_nursing\\_a\\_review\\_of\\_the\\_research\\_literature.html](http://www.ispub.com/journal/the_internet_journal_of_advanced_nursing_practice/volume_10_number_1_8/article/what_makes_a_quality_therapeutic_relationship_in_psychiatric_mental_health_nursing_a_review_of_the_research_literature.html)
- Edwards, D., & Potter, J. (1992). *Discursive psychology*. London: Sage Publications.
- Ellwood, P. M. (1998). Shattuck lecture—Outcomes management: A technology of patient experience. *The New England Journal of Medicine*, 318, 1549–1556.
- Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. *World Psychiatry*, 6(2), 68–74.
- Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidenced based programmes: Identifying the critical dimensions. *Community Mental Health Journal*, 41(2), 141–158.
- Fee, D. (2000). *Pathology and the post modern: Mental illness as discourse and experience*. Thousand Oaks, CA: Sage Publications.
- Fenton, W., Blyler, R., & Heinssen, R. (1997). Determinants of medication compliance in schizophrenia: Empirical and clinical findings. *Schizophrenia Bulletin*, 23(4), 637–651.
- Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, 12(2), 219–245.
- Gallo, K. M. (2004). First person account: Self-stigmatisation. *Schizophrenic Bulletin*, 20, 407–410.
- Garety, P. A., & Rigg, A. (2001). Early psychosis in the inner city: A survey to inform service planning. *Social Psychiatry and Psychiatric Epidemiology*, 36(11), 537–544.
- Garforth, F. (1966). *John Dewey: Selected Educational Writings*. London: Heinemann.
- Gehlert, S. (2006). The Conceptual Underpinnings of social work in health care. In S. Gehlert & T. A. Browne (Eds.), *Handbook of Health Social Work* (pp. 3–22). New Jersey: Wiley.
- Goatly, A. (1997). *The language of metaphors*. London: Routledge.

- Goffman, E. (1961). *Asylum: Essays on the social situation of mental patients and other inmates*. New York: Penguin.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.
- Gomm, R., Hammersley, M., & Foster, P. (2000). *Case study method*. London: Sage Publications Ltd.
- Greenwood, D., & Levin, M. (2007). *Introduction to action research: Social research for social change* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Griffiths, S. (2000). *Supporting people all the way: An overview of the Supporting People programme*. York: York Publishing Services Ltd.
- Harper, D. (2006). Discourse analysis. In M. Slade & S. Priebe (Eds.), *Choosing methods in mental health research: Mental health research from theory to practice* (pp. 47–67). London: Routledge.
- Harré, R., & van Langenhove, L. (1999). *Positioning theory*. Oxford: Blackwell.
- Heidegger, M. (1962). *Being and time*. New York: Harper & Row.
- Iveson, C. (2002). Solution-focused brief therapy. *Advances in Psychiatric Treatment*, 8(2), 149-156.
- James, W. (1904). The pragmatic method. *The Journal of Philosophy, Psychology and Scientific Method*, 1(25), 673–687.
- Jansen, E. (1980). Therapeutic community models: IV The Richmond Fellowship (UK). In E. Jansen (Ed.), *The therapeutic community* (pp. 112–120). London: Croom Helm Ltd.
- Joas, H. (1985) *G. H. Mead: A contemporary re-examination of his thought*. Cambridge: Polity Press.
- Kendall, J. (2003). *The voluntary sector: Comparative perspectives in the UK*. London: Routledge.
- Kendall, J., & Knapp, M. R. J. (1996). *The voluntary sector in the UK*. Manchester: Manchester University Press.
- Killapsy, H., Banerjee, S., King, M., & Lloyd, M. (1999). Non-attendance at psychiatric outpatient clinics: Communication and implications for primary care. *The British Journal of General Practice*, 49(448), 880–883.

- Killapsy, H., Banerjee, S., King, M., & Lloyd, M. (2000). Prospective controlled study of psychiatric out-patient non-attendance - Characteristics and outcomes. *British Journal of Psychiatry*, *176*(2), 160–165.
- Laing, R. D. (1990). *The divided self: An existential study in sanity and madness*. Middlesex, England: Penguin Books.
- Leff, J., & Warner, R. (2006). *Social inclusion of people with mental illness*. Cambridge: Cambridge University Press.
- Leishman, J. L. (2004). Talking the talk: A discourse analysis of mental health nurses talking about their practice. *International Journal of Psychiatric Nursing Research*, *10*(1), 1136–1145.
- Lelliott, P. (2008). Time for honest debate and critical friends. Commentary on ... New ways of working. *Psychiatric Bulletin* *32*(2), 47–48.
- Lester, H., & Gask, L. (2006). Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery? *British Journal of Psychiatry*, *188*(5), 401–402.
- Levinson, S. (1983). *Pragmatics*. Cambridge: Cambridge University Press.
- Lewis, J., & Glennerster, H. (1996). *Implementing the new community care*. Buckingham: Open University Press.
- Mandiberg, J. (2010). Another way: Enclave communities for people with mental illness. *American Journal of Orthopsychiatry*, *80*(2), 170–176.
- Mead, G. H. (1907). The Social Settlement: Its basis and function. *University of Chicago Record*, *12*, 108–110. Retrieved April 23, 2011, from [http://www.brocku.ca/MeadProject/Mead/pubs/Mead\\_1907g.html](http://www.brocku.ca/MeadProject/Mead/pubs/Mead_1907g.html)
- Mead, G. H. (1913). The social self. *The Journal of Philosophy, Psychology and Scientific Methods*, *10*(14), 374–380.
- Mead, G. H. (1934). Mind, self and society: From the standpoint of a social behaviourist (C. W. Morris, Ed.). Chicago: University of Chicago Press. Retrieved April 23, 2011, from <http://www.dominiopublico.gov.br/download/texto/bu000001.pdf>
- Mead, G. H. (1964). *On social psychology: Selected papers* (A. L. Strauss, Ed.). Chicago: University of Chicago Press. (Original work published 1956)
- Menand, L. (2001). *The metaphysical club: A story of ideas in America*. London: Flamingo.

- Mental Health Providers Forum (2007). Recovery Star Approach. Retrieved April 23, 2011, from <http://www.mhpf.org.uk/recoveryStarApproach.asp>
- Mental Health Providers Forum (2010). Mental health Recovery Star: User guide. Retrieved April 23, 2011, from <http://www.mhpf.org.uk/recoveryStarResources.asp>
- Merleau-Ponty, M. (1996). *Phenomenology of perception* (C. Smith, Trans.). London: Routledge. (Original work published 1945)
- Milligan, C. (2000). 'Breaking out of the Asylum': The impact of the informal sector in a restructured mental health environment. *Health and Place*, 6(3), 189–200.
- Mitchell, A. J., & Selmes, T. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advances in Psychiatric Treatment*, 13(6), 423–434.
- Mitchell, P. F. (2009). A discourse analysis on how service providers in non-medical primary health and social care services understand their roles in mental health care. *Social Science & Medicine*, 68(7), 1213–1220.
- Mixon, D. (1980). The place of habit in the control of action. *Journal for the Theory of Social Behaviour*, 10(3), 169–186.
- Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V., & Priebe, S. (2007). Social exclusion and mental health: Conceptual and methodological review. *The British Journal of Psychiatry*, 191(6), 477–483.
- Morris, D. (2000). Charities in the contract culture: Survival of the largest? *Legal Studies*, 20(3), 409–427.
- Mueser, K., Bond, G., Drake, R., & Resnick, S. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin*, 24(1), 37–74.
- National Social Inclusion Programme (2007). *Outcome indicators framework for mental health day services*. Retrieved August 31, 2010, from <http://www.socialinclusion.org.uk/publications/DSdoccover1.pdf>
- National Social Inclusion Programme (2009a). *Bridge building database*. Retrieved April 23, 2011, from <http://www.socialinclusion.org.uk/resources/index.php?subid=78>

- National Social Inclusion Programme (2009b). *Outcomes framework for mental health services*. Retrieved August 31, 2010, from [http://www.socialinclusion.org.uk/publications/Broadened\\_Social\\_Inclusion\\_Outcomes\\_Framework.pdf](http://www.socialinclusion.org.uk/publications/Broadened_Social_Inclusion_Outcomes_Framework.pdf) .
- National Workforce Programme (2009). 'MOVING ON' from new ways of working to a creative, capable workforce. Retrieved April 23, 2011, from <http://www.newwaysofworking.org.uk/>
- O'Brien, A., Fahmy, R., & Singh, S. P. (2008). Disengagement from mental health services. A literature review. *Social Psychiatry and Psychiatric Epidemiology*, 44(7), 558–568.
- O'Connell, B. (1998). *Solution-focused therapy*. London: Sage Publications.
- Outcomes Framework for Supporting People (2007). Framework and Guidance for Completing SP Outcomes for Long Term Services. Retrieved April 23, 2011, from [http://www.gateshead.gov.uk/DocumentLibrary/Care/supporting%20people/outcomes\\_Itguidance.pdf](http://www.gateshead.gov.uk/DocumentLibrary/Care/supporting%20people/outcomes_Itguidance.pdf)
- Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage Publications.
- Parr, H. (2008). *Mental health and social space: Towards inclusionary geographies*. Oxford: Blackwell Publishing.
- Paterson, B. (2007). A discourse analysis of the construction of mental illness in two UK newspapers from 1985-2000. *Issues in Mental Health Nursing*, 28(10), 1087–1103.
- Peirce, C. S. (1905). What pragmatism is. *The Monist*, 15(2), 161–181. Retrieved April 23, 2011, from <http://www.cspeirce.com/menu/library/bycsp/whatis/whatpragis.htm>
- Pinfold, V. (2000). 'Building up safe havens...all around the world': Users' experiences of living in the community with mental health problems. *Health & Place*, 6(3), 201–212.
- Pragglejaz Group (2007). A practical and flexible method for identifying metaphorically-used words in discourse. *Metaphor and Symbol*, 22(1), 1–39.

- Priebe, S., Fakhoury, W., & Watts, J. (2003). Assertive outreach teams in London: Patient characteristics and outcomes. Pan-London assertive outreach study, part 3. *British Journal of Psychiatry*, *183*(2), 148–154.
- Priebe, S., Watts, J., Chase, M., & Matanov, A. (2005). Processes of disengagement and engagement in assertive outreach patients: Qualitative study. *British Journal of Psychiatry*, *187*(5), 438–443.
- Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon & Schuster.
- Rankin, J. (2005). *Mental health and social inclusion: Mental health in the mainstream* (Working paper Two). London: Institute for Public Policy Research. Retrieved April 23, 2011, from [www.mentalhealthshop.org/document.rm?id=847](http://www.mentalhealthshop.org/document.rm?id=847)
- Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, *24*(4), 335–343.
- Ritchie, J., Spencer, L., & O'Connor, W. (2003). Carrying out qualitative analysis. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice* (pp. 217-262). London: Sage Publications Ltd.
- Roberts, G. (2000). Narrative and severe mental illness: What place do stories have in an evidence-based world? *Advances in Psychiatric Treatment*, *6*(6), 432–441.
- Roberts, G., & Wolfson, P. (2004). Rediscovery of discovery: Open to all. *Advances in Psychiatric Treatment*, *10*(1), 37–48.
- Rose, J. (1986). *Half-way home: The story of Elly Jansen and the Richmond Fellowship (Faith in action)*. Exeter, UK: Wheaton & Co. Ltd.
- Rosenhan, D. L. (1973). On being sane in insane places. *Science*, *179*(4070), 250–258.
- Rosenhan, D. L. (2009, July 27). The pseudo-patient study. (Narr by David L. Rosenhan). [Radio series episode] In *Mind changers*. [Radio Broadcast]. London: Radio 4, BBC.
- Rubin, H., & Rubin, I. (1995). *Qualitative interviewing: The art of hearing data*. London: Sage Publications Ltd.
- Sayce, L. (2001). Social inclusion and mental health. *The Psychiatrist*, *25*, 121–123.
- Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

- Schön, D. A. (1991). *The Reflective Turn: Case Studies In and On Educational Practice*. New York: Teachers College Press.
- Scottish Recovery Network (2009). Scottish recovery indicator. Retrieved April 23, 2011, from <http://www.scottishrecoveryindicator.net/>
- Shalin, D. N. (1988). G. H. Mead, Socialism, and the progressive agenda. *The American Journal of Sociology*, 93(4), 913–951.
- Shattell, M. M., McAllister, S., Hogan, B., & Thomas, S. P. (2006). “She took the time to make sure she understood”: Mental health patients’ experiences of being understood. *Archives of Psychiatric Nursing*, 20(5), 234–241.
- Shattell, M. M., Starr, S. S., & Thomas, S. P. (2007). 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing*, 16(4), 274–284.
- Shepherd, G., Boardman, J., & Burns, M. (2010). *Implementing recovery: A methodology for organisational change*. London: The Sainsbury Centre for Mental Health.
- Shotter, J. (1989). Social accountability and the social construction of ‘you’. In J. Shotter & K. Gergen (Eds.), *Texts of identity* (pp. 133–151). London: Sage Publications.
- Slade, M., & Priebe, S. (2006). *Choosing methods in mental health research: Mental health research from theory to practice*. London: Routledge.
- Social Exclusion Unit (2004). *Mental health and social exclusion: Social exclusion unit report*. London: Office of the Deputy Prime Minister. Retrieved August 31, 2010, from <http://www.socialinclusion.org.uk/publications/SEU.pdf>
- Spandler, H. (2007). From social exclusion to inclusion? A critique of the inclusion imperative in mental health. *Medical Sociology Online*, 2(2), 3–16.
- Spencer, E., Birchwood, M., & McGovern, D. (2001). Management of first-episode psychosis. *Advances in Psychiatric Treatment*, 7(2), 133–140.
- Stake, R. (1995). *The art of case research*. Thousand Oaks, CA: Sage Publications.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications.

- Tait, L., Birchwood, M., & Trower, P. (2003). Predicting engagement with services for psychosis: Insight, symptoms and recovery style. *The British Journal of Psychiatry, 182*(2), 123–128.
- Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publications.
- Taylor, B. (2008). How do we get from here to there? *A life in the day, 12*(1), 12-16.
- Taylor, C. (1993). Engaged agency and background in Heidegger. In C. Guignon (Ed.), *The Cambridge Companion to Heidegger* (pp. 317–336). Cambridge: Cambridge University Press.
- The Cabinet Office (2010). *Building the big society*. Retrieved September 7, 2010, from <http://www.cabinetoffice.gov.uk/media/407789/building-big-society.pdf>
- The Cabinet Office (2011). The big society. Retrieved April 23, 2011, from <http://www.cabinetoffice.gov.uk/big-society>
- The Royal College of Psychiatrists (2009). Community mental health teams. Retrieved April 23, 2011, from <http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/communityteams.aspx>
- The Sainsbury Centre for Mental Health (1998). *Keys to engagement*. London: The Sainsbury Centre for Mental Health.
- Thurstone, L. L. (1923). The stimulus-response fallacy in psychology. *Psychological Review, 30*(5), 354–369.
- Torrey, W., Rapp, C., van Tosh, L., McNabb, C., & Ralph, R. (2005). Recovery principles and evidence-based practice: Essential ingredients of service improvement. *Community Mental Health Journal, 41*(1), 91–100.
- Vernon, A., & Qureshi, H. (2000). Community care and independence: Self-sufficiency or empowerment. *Critical Social Policy, 20*(2), 255–276.
- Vize, C., Humphries, S., Brandling, J., & Mistral, W. (2008). New ways of working: Time to get off the fence. *Psychiatric Bulletin, 32*(2), 44–45.
- von Korff, M., Gruman, J., Schaefer, J., Curry, S. J., & Wagner, E. H. (1997). Collaborative management of chronic illness. *Annals of Internal Medicine, 127*(12), 1097–1102.
- Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist, 34*, 3–5.

- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide: Dulwich Centre Publications.
- Williams, B. (2002). The role of qualitative methods in evidenced-based mental health care. In S. Priebe & M. Slade (Eds.), *Evidence in mental health care* (pp. 109–125). Hove: Brunner-Routledge.
- Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Buckingham: Open University Press.
- Wilson, C., Nairn, R., Coverdale, J., Panapa, F., & Panapa, A. (2000). How mental illness is portrayed in children's television: A prospective study. *The British Journal of Psychiatry*, *176*(5), 440–443.
- Wolch, J. (1990). *The shadow state: Government and voluntary sector in transition*. New York: Foundation Centre.
- World Health Organization (1992). *International classification of diseases*. 10th Revision. Geneva: WHO.
- Zinken, J. (2007). Discourse metaphors: The link between figurative language and habitual analogies. *Cognitive Linguistics*, *18*(3), 445–466.
- Ziolkowska, J. (2009). Positions in doctors' questions during psychiatric interviews. *Qualitative Health Research*, *19*(11), 1621–1631.