Hugh Middleton and Melanie Jordan

Mental Health Uncertainty and Inevitability

Rejuvenating the Relationship between Social Science and Psychiatry

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Hugh Middleton • Melanie Jordan
Editors

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Editors
Hugh Middleton
School of Sociology and Social Policy
University of Nottingham
Nottingham, United Kingdom

Melanie Jordan
School of Sociology and Social Policy
University of Nottingham
Nottingham, United Kingdom

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Foreword

I was asked to provide a foreword for this book before having a view of the chapters themselves, so was unsure how I'd feel about the work—especially as the title included the terms 'mental health', 'uncertainty', and 'inevitability'. However, having studied the authors' contributions, I can state at the beginning of this foreword that I commend this book to the field of mental health and illness and encourage scholars, clinicians, service users, and carers to read and consider its contents. It represents a timely, apt, and worthy contribution to both psychiatry and social science. I support its arguments and hope its implications will have a frontline impact.

The biomedical model with its discourse of 'illness', 'pathology', 'chemical imbalance', and 'treatment' has the appearance of certainty about it. This apparent certainty can be a refuge to service users who want to be seen as 'having an illness like any other physical one' such that they are 'sick not weak'. This understanding is often seen as a weapon in the fight against social stigma. Receiving a 'diagnosis' can offer an explanatory framework which makes sense of the service user's experience, so to question the 'diagnosis' can be interpreted as a dismissal of the genuineness and validity of the service user's experience. People who criticise the dominant world view can easily be dismissed as 'anti-psychiatry', who are fuelling a 'pill shaming' agenda that is harmful to service users themselves. Therefore, in this context, a book on mental health and the social sciences might be met with suspicion from people who use mental health services.

As I read the case studies presented in this book, however (reading them as a mental health service user myself), I was challenged in regard to my own formulation of my experiences and of how mental health services could be of use to me. There are alternative conceptualisations and narrations of 'mental health difficulties' grounded in the social sciences. No one would deny that it is important to study and understand the social context of an individual's experience. This book challenges the apparent certainty of the medical model and offers psychosocial perspectives without minimising the service user experience. I would argue that such perspectives allow for a more rounded understanding of my experiences and of the services which I choose to use.

In the opening chapter of this work, Middleton helpfully sets the scene, arguing that there is growing uncertainty about how 'mental health difficulties' may be conceptualised; in fact, he suggests that 'tribal' institutional and epistemological allegiances may actually be hindering the study of the social consequences of a mental health difficulty. Critical voices within psychiatry itself on the identification of biomarkers and the efficacy of psychopharmacological interventions raise serious questions about the biomedical model that we need to face up to. Furthermore, if conducive relationships between professionals and their clients lead to therapeutic gains, then the study of social structures and human relationships becomes all important and the social sciences really come to the fore.

Given my background, I was particularly interested in the three case studies of community-based mental health services. Middleton's new insights into how different community-based services function and how different staff felt about their activities and roles is really eye opening. I was particularly fascinated by his account of a user-led study on service user perspectives on community services and recovery. Similarly, Roe's novel application of sociological theory to the work of an assertive outreach team highlights how users of the service were viewed by professionals, which allows us to reflect upon the social construction of clients' identities. Narayanasamy then describes the decision-making process in the context of a Single Point of Access meeting in a community mental health team. These studies really ‘open the lid’ on these conventional kinds of community-based mental health services and on staff roles and their activities. In so doing, they redefined to me what services could offer me in terms of beneficial interventions that would be conducive to my recovery.

Aside from these traditional community-based mental health service settings, two of the case studies reported here represent ‘seldom heard’ groups: Jordan’s work focusing on staff experiences of mental health-care provision in a penal context and Hui’s study of staff experiences of working within a high secure hospital. Moreover, two further settings are studied in this book: Clarke presents work on two therapeutic communities for individuals with a diagnosis of personality disorder and explores how everyday social encounters play a role in facilitating change. Finally, Scales’ work focuses on care homes for older persons with dementia and traces the contextual and relational processes through which different ‘dementia experiences’ emerge, regardless of clinical diagnosis. Thus, a range of different service settings are described and analysed here using a range of sociological theories.

These studies have a number of commonalities that are worth reflecting on: first and foremost is the relational aspect of mental health service provision—both in terms of the relationships of team members within the different team settings and their impacts and the relationships between clinicians and the service users on their caseloads. I have argued elsewhere that it is these relationships that are important to service users themselves; they are looking to build relationships of mutual respect and trust with their clinicians. A second and related feature is the organisational and bureaucratic context in which the different teams function, which can constrain the relational work and even infringe on a service user’s identity. Third, it is these complex webs of relationships, then, that have the potential to helpfully or unhelpfully define a service user’s identity in terms of the social context in which their care occurs; we can move beyond the more narrow focus of the biomedical model to more fruitful social identities.

This book will obviously be of benefit to anyone interested in social theory as it presents novel applications of existing sociological theories; it will also help clinicians to step back and consider the social context in which they are working and the impacts that it can have on their practice. But it is my hope that this book will also be of benefit to mental health service users (and their carers) as they consider their social identity and what they want to get out of the services that they choose to use.

Andrew C. Grundy
School of Health Sciences
University of Nottingham
Nottingham, UK

Contents

1 **Returning to the Fray: Revisiting What Social Science Can Offer Psychiatry … and Vice Versa** 1
Hugh Middleton

2 **A Symbolic Interactionist Approach to Mental Health Assertive Outreach** 21
James Roe

3 **The Role of Everyday Interaction Rituals Within Therapeutic Communities** 47
Jenelle Clarke

4 **The Dementia Experience: Sociological Observations on the Construction of Cognition in Care Homes** 73
Kezia Scales

5 **"The Will's There and the Skill's There": Prison Mental Healthcare** 105
Melanie Jordan

6 Institutional and Emotion Work in Forensic Psychiatry: Detachment and Desensitisation 137
Ada Hui

7 Community Mental Health Teams: Interacting Groups of Citizen-Agent? 167
Hugh Middleton

8 Handling Role Boundaries: A Basic Social Process Underpinning Decision-Making in Mental Health Teams 199
Melanie Narayanasamy

9 Mental Health Uncertainty and Inevitability 221
Melanie Jordan

Index 235

Notes on Contributors

Jenelle Clarke is a Research Fellow, University of Nottingham. She has BAs in history and writing/literature and an MA in social research. She currently explores the role of social networks in applied healthcare research as a research fellow at the University of Nottingham. Jenelle recently completed an ESRC-funded PhD entitled 'Where the Change Is: Everyday Interaction Rituals of Therapeutic Communities' as a student in the University of Nottingham's Institute for Mental Health. Her primary research interests include community approaches to mental health, personality disorders, everyday social processes, the sociology of emotions, and implementation science.

Andrew C. Grundy is a Research Associate, University of Nottingham. He is a long-term mental health service user working as a research associate in mental health in the School of Health Sciences, University of Nottingham. He is often invited to work on research projects because of his lived experience of mental distress. His main research interests are in understanding concepts of mental health service provision from the service user and carer perspective. He teaches patient and public involvement (PPI) in clinical research.

Ada Hui is a Teaching and Research Associate in Mental Health, School of Health Sciences, University of Nottingham. She is a registered mental health nurse and holds a PhD in sociology and social policy from the University of Nottingham. Her ESRC-funded PhD was entitled 'The Use of Coercive Measures in a High Secure Hospital: Expressions of Institutional and Emotional Work'. She has a diverse range of research interests most notably affiliated with sociology and mental health. Her primary research interests include emotion work, institutions and organisational culture, decision-making, and ethical and moral principles in healthcare.

Melanie Jordan is an Assistant Professor, School of Sociology and Social Policy, University of Nottingham. She has been based at the University of Nottingham for several years now and has been involved in much research and teaching in fields of health and deviance. A medical sociology and mental health–focused PhD that was based in a prison kick-started this interest in health humanities and offender research. Melanie now lectures in criminology—often with a health and/or critical stance—and is especially interested in the utilisation of general social theory in tandem with contemporary frontline fieldwork evidence.

Hugh Middleton is a Clinical Associate Professor, School of Sociology and Social Policy, University of Nottingham, and Honorary Consultant Psychiatrist, Nottinghamshire Healthcare NHS Foundation Trust. For the last ten years, Hugh has held the unusual position of a senior academic in a reputed school of social science whilst continuing to contribute to the NHS as a consultant psychiatrist. He has supported the doctoral studies of several students represented in this volume and recently published a related work, *Psychiatry Reconsidered. From Medical Treatment to Supportive Understanding.*

Melanie Narayanasamy is a Research Fellow, School of Health Sciences, University of Nottingham. Melanie's research interests revolve around strategies to enhance health and mental health professionals' approaches to care, particularly for vulnerable patient populations, and interventions to improve person-centred care. Melanie developed her interests and research around mental health and services in the School of Sociology and Social Policy at the University of Nottingham and completed her ESRC-funded PhD in 2014, which developed a new social theory around mental health team decision-making. She is also a mental health campaigner who raises awareness about the stigma that often afflicts people with mental health problems. The work presented in this edition formed part of her doctoral thesis, which is available from the University of Nottingham e-thesis repository.

James Roe is a Research Fellow, University of Nottingham. He has a BSc in psychology and criminology from Keele University, an MA in criminology and research methods also from Keele University, and a PhD in sociology and mental health from the University of Nottingham. His ESRC-funded thesis was entitled ‘A Symbolic Interactionist Approach to Mental Health Assertive Outreach’. His primary research interests are in the relationships between staff and respective clients within health services and the criminal justice system and more broadly within the topics of self, stigma and identity, prisons, and sociological theory.

Kezia Scales is a Postdoctoral Fellow, Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina. In her research, Kezia examines the interconnections between the policy and regulatory context of long-term care, organisational structures and practices, and direct-care delivery and outcomes, with a particular focus on services for persons with dementia. She holds a master’s degree in comparative social policy from the University of Oxford and a PhD in sociology from the University of Nottingham, where the title of her doctoral thesis was *Doing What Makes Sense: Locating Knowledge about Person-Centred Care in the Everyday Logics of Long-Term Care*. Kezia has also conducted postdoctoral research at the School of Nursing at Duke University and in the Program on Aging, Disability, and Long-Term Care at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina-Chapel Hill.

1

Returning to the Fray: Revisiting What Social Science Can Offer Psychiatry … and Vice Versa

Hugh Middleton

Historical accounts establish without doubt that a set of social disruptions—variously described as madness, possession, lunacy, mental illness, mental disorder or mental health difficulties—are an inevitable feature of organised society. They also establish that time has seen a series of approaches to them come and go. That equally applies to the medical approach which has dominated Western practice for much of the last half century (Scull 2015). By accepting responsibility for "mental health difficulties", medicine has provided the field with a welcome certainty. As we outline, there are grounds to doubt the assumptions upon which this is founded, and so although "mental health difficulties" may be inevitable, there is growing uncertainty about how they might best be construed, conceptualised and addressed. That uncertainty could be an opportunity for social scientists of both practical and theoretical persuasions to return

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H. Middleton (✉)
School of Sociology and Social Policy, University of Nottingham,
Nottingham, UK
e-mail: hugh.middleton@nottingham.ac.uk

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to a field where they once made seminal contributions (see, for instance, Goffman 1961 and Rosenhan 1973).

Currently, psychiatry and social science have a fraught relationship. Although psychiatry could be a rich opportunity for social scientists to make singular humanitarian contributions and a field of research brimming with practical and theoretic challenges, the relationship between the two has been difficult for several decades. Anne Rogers and David Pilgrim provide a helpful account of its ebbs and flows by considering three areas: barriers to collaboration, stigma, and psychoanalysis (Rogers and Pilgrim 2013), and we begin by revisiting that discussion. Many of the difficulties reflect the fact that social theory and psychiatry seek to understand human behaviour and its difficulties by using entirely different explanatory frameworks, and from within entirely different institutional settings. Arguably, this has conspired to generate an unhelpful set of tribal distinctions which debilitate both as academic disciplines and limit the philanthropic contributions each could otherwise provide. There are good reasons to believe that reconciliation could and should be possible, and in particular that this offers rich opportunities for social scientists to re-engage; to return to the fray. There are widely expressed concerns about the nature and quality of provision for people with “mental health difficulties” that challenge conventional approaches and reach out for an alternative (see, for instance, Moncrieff 2009, Bentall 2009, Whitaker 2010, Watters 2010, Davies 2013, and Middleton 2015).

Barriers to Collaboration

One area that has benefitted from collaboration between the disciplines has been psychiatric epidemiology. Early ecological studies with their roots in the Chicago School of Sociology investigated interactions between the presence of mental illness and social location (Faris and Dunham 1939; Hollingshead and Redlich 1958). In the UK, there have been notable collaborations between psychiatrists and sociologically informed psychologists (Falloon and Fadden 1993), psychiatric social workers (Goldberg and Huxley 1992) and sociologists (Brown and Harris 1978). Many of the outcomes from these collaborations continue to be regarded as seminal contributions to the psychiatric literature and are routinely referred to in contemporary textbooks (e.g. Gelder et al. 2009). In recent years, carefully conducted cohort studies have enabled investigation of the social geography (Kirkbride et al. 2006) and the effects of social deprivation (Morgan et al. 2008) associated with the onset of psychosis. However, these have tended to follow a quantitative and positivist approach. They do not exploit the more constructivist traditions that characterise contemporary sociology. As a result they have not generated intellectually fruitful interdisciplinary ties. Rogers and Pilgrim reflect upon three elements of the background to this: shifts within psychiatry, shifts within sociology and the damaging effects of tribal distancing both of these have engendered.

Within psychiatry the growth of interest in pharmacological remedies during the 1970s and 1980s strengthened the hands of those invested in narrowly medical approaches to mental health difficulties. In order to satisfy regulatory authorities concerned with the licensing of medicines, mental health difficulties had to be classified as a set of diagnostic entities which could be subject to clinical trial. Funding generated by this market also altered the nature of academic psychiatry. During the middle years of the twentieth century, most American medical school chairs in psychiatry were occupied by a psychoanalyst. During the 1970s and 1980s, that figure fell abruptly to single figures (Paris 2005). In parallel, broadly communicated views of how mental health difficulties might be conceptualised shifted from that of psychological or emotional reactions set in the contexts of personal, relational vulnerability and vicissitude to that of the results of faulty biomedical mechanisms. Biomedical mechanisms are clearly well outside sociology's legitimate spheres of influence and expertise, and as a result mental health difficulties became closed off as exclusively the concern of medicine and its academic associates.

During the same period, sociology itself was adopting epistemological positions which further widened differences in explanatory framework between the disciplines. Symbolic interactionism, ethnomethodology, social constructivism and in particular, in this context, espousal of Michel Foucault's form of post-structuralism all reflect a much more constructivist approach to knowledge than positivist, scientifically authorised medicine can comfortably accommodate. As a result, the association became much more that of a sociology *of* medicine than sociology *in* medicine, as initially distinguished by Anselm Strauss (Strauss 1957). Specifically in relation to psychiatry, social scientists' commentaries from this position became stereotyped as "anti-psychiatry". The term developed quite specifically out of associations between certain psychiatrists and more politically oriented commentators during the late 1960s, most notably R.D. Laing and Thomas Szasz, but it continues to be used as a call for tribal allegiance which shuts down otherwise potentially constructive debate (Craddock et al. 2008).

Laing's contribution was to encourage a focus upon seeking, acknowledging and responding to the individualised meaning of so-called abnormal mental states (Laing 1960). This was an explicitly constructivist approach to the experiences of those with mental health difficulties, and therefore a direct challenge to the ontological validity they are granted by the otherwise dominant, medical and neo-Kraeplinian position which argues that mental health difficulties are ontologically stable phenomena akin to biologically identifiable diseases (Compton and Guze 1995). These have become enshrined in diagnostic schemes such as the American Psychiatric Association's *Diagnostic and Statistical Manual* and Chapter V of the World Health Organisation's *International Classification of Diseases* (*DSM* and *ICD*) (American Psychiatric Association 1980; World Health Organisation 1992). This neo-Kraeplinian position was promoted by influential figures such as Sir Martin Roth, inaugural president of the Royal College of Psychiatrists (Roth and Kroll 1986), and it continues to weave like a golden thread through postgraduate psychiatric training where the ability to "diagnose" a mental health difficulty on the basis of diagnostic schemes such as *DSM* or *ICD* is a core curricular competency (Royal College of Psychiatrists 2013). Laing's approach was a direct challenge to these dominant interests. In addition, as an individual he was associated with wider social critique (Crossley 1998, 2006), and as a result he was stereotyped as an unrealistic ideologue promoting radical social and political change towards an anarchic or Marxist utopia.

Thomas Szasz maintained a vocal and persistent insistence that the concept of mental illness is unfounded for more than half a century (Szasz 1961). At heart, this is a semantic debate over what the terms "illness", "disease", "pathology" and "diagnosis" actually mean and apply to in differing contexts, but Szasz's resolute criticism of psychiatry as a legitimate enterprise understandably resulted in more visceral responses from within it. In fact, both Laing and Szasz expressly disavowed descriptions of themselves as “anti-psychiatrists”, but use of the term has had energetic adherents. It has played an important part in the tribal standoff and reciprocal stereotyping that characterise the relationship between psychiatry and approaches to mental health difficulties that do not espouse a medical, positivist framework. In Szasz’s case, the stereotype has been that of a harsh neo-liberal ideologue disengaged from the field in the form of an observer unconcerned for the suffering of those otherwise deemed to have mental illness. In Laing’s case, it is that of a starry-eyed left-wing idealist agitating for something that could only be realised by the collapse of society as we know it. To associate any substantive criticism of psychiatry with one or other of these positions effectively shuts down debate, and it is barely surprising that this hinders productive collaboration between those who might identify with orthodox, medical psychiatry and those who might want to make contributions to it but espouse different approaches to knowledge and a differing explanatory framework. Anyone who dares to suggest that the medical approach to psychiatry might not be the legitimate medical endeavour it purports to be is immediately associated with Szasz’s stereotype, and anyone who dares to suggest that psychiatry is primarily concerned with the maintenance of social order is immediately associated with Laing’s. This is clearly a sterile and unhelpful state of affairs.

Stigma

Erving Goffman’s reflections on identity and its sensitivity to social context cast a long shadow over the psychiatric literature. His study of ways in which incarceration as an asylum inmate could cause harm (Goffman 1961) played a critical part in shifting formal mental health policy away from dependence upon institutional care during the middle years of the twentieth century. That labelling or societal reaction might play a significant part in determining disability is widely acknowledged, and notable later contributions to this in the field of mental health difficulties have come from Link, Scheff and Thornicroft. Of these, the first and second acknowledge the ways in which deviances are identified and commonly amplified by societal reaction (Link et al. 1989; Scheff 1999), thus locating at least some of the processes generating mental health difficulties in the interaction between the stigmatised individual and those around them. Thornicroft writes from a different background and provides a more orthodox, psychiatric interpretation (Thornicroft 2006) which echoes the Royal College of Psychiatrists' Stigma Campaign (Crisp 2000). The untoward, unhelpful and unwelcome effects of stigmatising those with mental health difficulties are recognised but these are conceptualised as unnecessary and avoidable reactions on the part of the insensitive ill-informed. The part played by associates behaving badly towards one with mental health difficulties in generating or even amplifying their distress is overlooked. An individualised medical perspective is emphasised rather than an interactive one; the condition cannot be helped (other than by correct treatment) and those associated with a suffering person should behave more charitably. Interestingly, viewing a mental health difficulty as a medical condition rather than a social reaction appears to be associated with stronger rather than less alienating reactions (Angermeyer et al. 2013). Formal espousal of the considerable contributions labelling theory and the study of deviances make to these issues by orthodox psychiatry would amount to acknowledging the legitimacy of constructivist concepts such as labelling and deviance, and for many psychiatrists that would be another challenge to tribal allegiance. Significantly, better understanding and fuller acknowledgement of ways in which mental health difficulties can result in a spoiled identity is exactly what many who identify themselves as mental health service users call for and find most helpful (Romme et al. 2009). In other words, fully informed study of the social consequences of a mental health difficulty is being hindered by institutional and epistemological allegiances.

Psychoanalysis

As already noted, psychoanalysis abruptly fell from grace within mainstream US psychiatry during the 1970s and 1980s. Rogers and Pilgrim consider the position it now occupies in the disputed territory between psychiatry and sociology. They draw attention to the fact that it is a "polyvalent or open textured concept" (p. 32). A major contributor to psychoanalysis' fall from grace was its collective reluctance to rise to the challenge of a need for scientific legitimacy which was being offered by its more biomedical and behaviourist competitors (Paris 2005). On the other hand, although epistemologically alien to it in its concern with the exploration of inner worlds, interpretations of subjective understanding and the development of narrative, psychoanalysis does have its origins in the work of an explicitly medical personage and approach. A lithograph taken from Brouillet's *Une leçon clinique à la Salpêtrière* hung in Sigmund Freud's Vienna consulting room for the 50 years he practiced there (Morlock 2007) (Fig. 1.1).

Painted in 1887, *Une leçon* is one of the most well-known images of medical history. It depicts the renowned neurologist Jean-Martin Charcot demonstrating a case of hysteria to an audience of medical luminaries. It

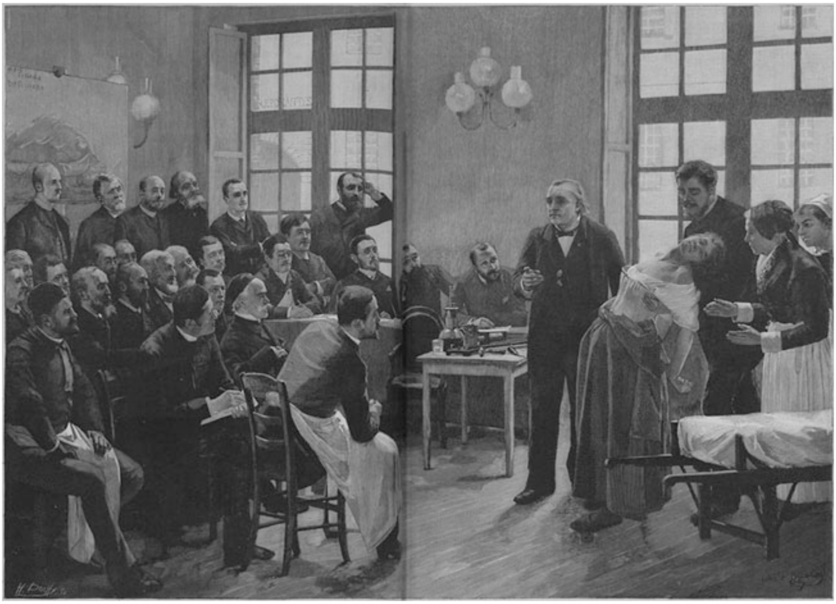

Fig. 1.1 Une leçon à la Salpétrière. Tableau de André Brouillet (Printed from a steel engraving by Dochy. Reproduced here with the permission of Brown University)

is clearly a case conference in which the “patient” is being exploited as a passive object of study. Early in his career Freud had travelled to study under Charcot, and this depiction of a psychological condition framed as a medical one clearly captured his imagination and quite possibly illustrates his determination to frame emotional and psychological difficulties as evidence of psychological disorder potentially accessible to treatment by an expert professional. It may be knowledge of this association that led Michel Foucault to comment:

> *To the doctor, Freud transferred all the structures Pinel and Tuke had set up within confinement. He did deliver the patient from the existence of the asylum within which his 'liberators' had alienated him; but he did not deliver him from what was essential in this existence; he regrouped its powers, extended them to the maximum by uniting them in the doctor's hands; he created the psychoanalytical situation where, by an inspired short-circuit, alienation becomes disalienating because, in the doctor, it becomes a subject.* (Foucault 1961 tr. Howard 2001: 264)

Although the subject matter of psychoanalysis might be the client’s inner life, their idiosyncratic interpretations and personal narrative, these are understood by the analyst as material to work on in much the same way a surgeon might work upon a diseased body. Their intrinsic validity as emergent properties of the individual’s social context is overruled in pursuit of the “normal”, and understanding of the client’s difficulties is restricted to one which focuses upon them as faults within the person at the expense of perspectives viewing them as a feature of active social interactions.

Contemporary psychoanalysts might argue that practices have evolved and that this is an unduly narrow and critical perspective, but it does illustrate the polyvalence of their craft and its uncertain location in the divide between psychiatry and social science. On the one hand, psychoanalysis shares sociology’s interest in the dynamic of relationships and influences upon them more than any other part of medicine. On the other hand, traditionally it has been regarded as a medical sub-speciality. It has suffered in terms of intra-professional esteem and policy support not because its practitioners are seen to belong to a separate profession, but because what they profess is seen to be “unscientific”.

Insofar as it can be understood as the origin of systematic thinking about unconscious, non-rational influences upon human behaviour, psychoanalysis has made landmark contributions to the study of mental health difficulties and how they might be provided for. Most mental health practitioners implicitly incorporate psychoanalytic perspectives into their practice, and as a result these play a considerable, albeit commonly covert part in what actually happens in the ward or the clinic. At the same time, psychoanalytic perspectives are denigrated as "unscientific" and marginalised by those seeking evidence upon which to base decisions about resource allocation and mental health policy. Psychoanalysis and other relational therapies may be eschewed, formally, as without an evidence base and therefore unjustifiable, but they make a considerable informal contribution to all aspects of psychiatric practice. This is acknowledged by experienced therapists when questioned about the origins of practices they embrace in everyday clinical encounters (O'Hara and Schofield 2008).

Acrimonious Divorce or Illicit Affair?

The covert part "unscientific" methods, constructed phenomena and untested techniques drawn from psychoanalysis and other sources play in the clinic suggests that in practice psychiatry depends upon knowledge drawn from a wider range of explanatory frameworks than a naïve and narrow scientific, evidence-based and positivist perspective can provide. Perhaps the relationship between psychiatry and such sources of knowledge, which of course include sociology and other social sciences, might be better characterised as an illicit affair than as an acrimonious divorce and irreconcilable separation. On the one hand, psychiatry presents itself as an explicitly medical discipline dominated by a biomedical discourse. In practice, it appears to operate by application of the same hierarchy of professions and inter-professional relations found elsewhere in healthcare, and on the face of it the systems world it occupies conforms to these stereotypes. However, the life world it engages with insists upon something quite different. Dressing up patterns of human distress, disturbed behaviour, confusion or despair as "diagnoses" to be "treated" is only helpful insofar as doing so supports and informs helpful interventions. The language associated with medical psychiatry is only valid insofar as it supports helpful conceptual frameworks, and these are only of any value if they stand up to critical scrutiny. Psychoanalysis and its many derivatives—“psychological approaches”, formulation, the interpretation of transference, acknowledgement of defensive posturing, malign dependency, projection and so on—are all integral features of all psychiatric settings. Many would argue these are integral features of all clinical settings, but it is explicitly in the psychiatric ward and clinic that these psychoanalytic derivatives are acknowledged as relevant by practitioners as they go about their business, whilst at the same time bowing to their inadmissibility into systems expecting to record a diagnosis and offer a scientifically evidence-based treatment. These more covert dimensions of psychiatric practice are, of course, covert rather than systematised because they are beyond the reach of research methods and explanatory frameworks openly espoused by modern medicine. That is not to say that more constructivist research methods and explanatory frameworks cannot inform psychiatric practice; indeed, the evidence is that much of psychiatric practice involves activities that would be best investigated in this way.

Critical Psychiatry

Rogers and Pilgrim conclude by making reference to critical voices from within psychiatry. Rather than trumpeting an explicitly controversial “anti-psychiatry” position, commentators such as Moncrieff, Bracken, Thomas and Timimi have provided critical reviews of the assumptions underpinning medical approaches to mental health difficulties. Insofar as critical analyses such as these are able to provide credible refutation of medical psychiatry’s underpinning assumptions, they offer a route to unveiling alternative accounts of what might really be going on in mental health services. An example of this has been Moncrieff’s and Healy’s able and irrefutable critical accounts of psychopharmacology. In both cases, writing with considerable authority they offer an account of the ways in which the development of drug treatments for mental health difficulties can be understood much more clearly as a process of commercial exploitation and propaganda than as a linear, scientific achievement (Healy 2002; Moncrieff 2009, 2013). Stripped of a "scientific" explanation couched in terms of corrections to abnormal brain chemistry, the not uncommonly helpful effects of antidepressants demand another explanation that can just as easily be understood in terms of the ritualised and symbolic effects of prescribing (Middleton 2015: 83–92).

These and related critical scrutiny of other assumptions underpinning medical psychiatry offer a structured way of considering how the relationship between sociology and psychiatry might move forward. To return to the analogy of an illicit affair, the relationship is already very much there and alive but currently it is covert and denied. In general, such a relationship is only illicit, covert and formally denied because it has to submit to another which claims greater legitimacy, perhaps, within this analogy, a marriage with considerable additional commitments such as children or property. The relationship between sociology, mental health difficulties and provision for them could be considered to have been driven underground by the overweening claims of science. Healy and Moncrieff have shown that these might have been overestimated with respect to drug treatments. If the ontological status of "scientific" medical psychiatry is not what it is generally assumed to be, then the field is open for other methodologies and explanatory frameworks to come out of the closet and make more open, transparent and recognised contributions to the field.

Current Status of Medical Psychiatry

There are indeed good reasons to argue that the ontological status of medical psychiatry is much less assured than it is generally held to be. If "medical psychiatry" is taken to mean the application of one or another evidence-based treatment in response to one or another of several differing discrete and identifiable conditions, then there is now considerable accumulated evidence that this is not an accurate way of understanding what is truly going on, in the clinic or elsewhere. Although most provision for "mental health difficulties" in the developed world is provided *qua* medical treatment of illnesses, there are serious doubts about the validity of this approach, and numerous expressions of dissatisfaction from amongst those who have received such “treatments”. These criticisms have been collected and reviewed (Middleton 2015). They can be thought of as findings from a natural experiment which has occurred during the last half century; one that has exhaustively tested whether or not a “medical” approach to mental health difficulties is a suitable way of describing what they are, how they are best provided for and how those who suffer might be better understood and assisted. Those findings can be summarily stated as:

- Currently influential classifications of mental health difficulties do not identify distinct disease entities as these are understood elsewhere in medicine.
- The search for targeted chemical cures for specific mental health difficulties has been unsuccessful. The full effects of psychiatric medication can only be understood by taking account of the indirect and non-chemical aspects of prescribing and administering it.
- Therapeutic gains attributable to mental health professionals are largely a result of the helpful and supportive relationships they develop with their clientele.

Insofar as they are supportable, these conclusions have a considerable effect upon the ontological security of “medical psychiatry” and the extent to which “science” and positivist approaches to knowledge are adequate ways of investigating the conditions it responds to and the “treatments” it employs. To refer back to the nature of the relationship between psychiatry and contemporary constructivist social science, the formal marriage which has driven it underground is less viable than assumed, and as a result the illicit but quite possibly very vibrant relationship is becoming free to emerge. This edited edition illustrates some of what can be achieved in this way, in the form of findings from a series of doctoral studies conducted by social science PhD students each working in a mental health setting. By way of setting these into a more specific context, some wider epistemological and conceptual implications of this “de-medicalised” position are offered.

Currently influential classifications of mental health difficulties do not identify distinct disease entities as these are understood elsewhere in medicine.

When terms such as “illness”, “disease”, “pathology” and “treatment” are used in medical settings, they convey very specific meanings all underpinned by a number of assumptions: that the condition is one that would appropriately benefit from application of the sick role, that it can be understood in an agreed way by applications of natural science, that the difficulties it comprises can be attributed to a specific cause and that helpful interventions are such because they address such causes. Mental health difficulties do not reliably fulfil these. As a result, responses to them often include inappropriate and unhelpful recourse to the sick role, expectations of therapeutic success can be unrealistic and delineations unclear. Mental health difficulties have fallen under medicine’s gaze in recent decades for a variety of reasons, and in many ways this has resulted in more humane “treatments” than hitherto. Furthermore, the paternalism that inevitably comes with a medical approach (to anything) legitimises a response to the dangers sometimes generated by particularly disturbed persons. Nevertheless, limitations of the sick role include equally unwelcome paternalism, which is commonly a source of frustration and dissatisfaction amongst those who experience it. Along with other emergent forms of impairment such as conditions requiring maintenance rather than treatment (diabetes), representing threat but not immanent disability (cancer in remission) or progressive and inevitable slow decline (osteoarthritis), mental health difficulties challenge conventional social models of illness and demand the development of new social spaces and frameworks. This is not unlike the sculpting of new physical and social spaces achieved in response to demands for rights amongst the physically disabled during the past century. Consider, for instance, the journey from widespread but paternal and limiting use of the term “cripple” as recently as the early twentieth century, to Paralympic Games at the beginning of the twenty-first. Understanding and facilitating this process in relation to mental health difficulties is a project which clearly holds considerable potential for social and political scientists.

The search for targeted chemical cures for specific mental health difficulties has been unsuccessful. The full effects of psychiatric medication can only be understood by taking account of the indirect and non-chemical aspects of prescribing and administering it.

Critical appraisal of psycho-pharmaceutical knowledge underpinning wide acceptance and the use of medicines to “treat” mental illness establish that these practices are difficult to understand in a pharmacologically conventional and mechanistic way. Scientifically identifiable properties of the medicines used by psychiatrists cannot be mapped on to abnormalities of brain chemistry associated with the conditions they are used to treat. Their effects, both helpful and otherwise, have to be understood with respect to the considerable chemical complexity of the human brain, and the symbolic consequences of drug-related effects upon subjectivity, and of receiving a prescription. Central to these are considerations of the drive to seek medical assistance with emotional or psychological difficulties in any one case, the response when that happens, more widely held views of the part medicine and medicines play in administering to the disturbed, the distressed and the confused, and the roles of commercial and professional interests in shaping these views. Great numbers of people take psycho-pharmaceuticals at considerable financial cost to public agencies and themselves, and at the risk of damaging side effects. These practices cannot be understood from a rational, scientific perspective. The drive to seek medical assistance with emotional and/or psychological difficulties can only be fully understood with reference to social constructions of what is and what is not “illness”, medicine’s wider social role, the effects of experiencing acknowledgement of suffering and other yet-to-be-determined features of the consultation. The so-called placebo effect is powerful, has a highly respected pedigree, is profoundly sensitive to the relationship between patient and practitioner and remains hugely under-investigated from a social sciences perspective.

Therapeutic gains attributable to mental health professionals are largely a result of the helpful and supportive relationships they develop with their clientele.

Systematic evaluations of psychotherapy outcomes from the 1930s onwards have repeatedly returned the same finding; the most powerful influence upon them is the quality of relationship that is experienced by the client. In particular, a relationship that is experienced as unconditionally supportive and truly accepting is likely to be therapeutic, whereas one which imposes sanctions and conditions is likely to be unhelpful (see, for instance, Middleton et al. 2011). The part played by a therapist’s formal technique, cognitive behavioural, psychoanalytic, humanist/existential and so on, is secondary and quite probably only relevant insofar as it provides a rationale client and therapist can share (see, for instance, Norcross and Lambert 2014). This is an important set of findings with specific implications for the provision of care for those deemed to have mental health difficulties, for a wider understanding of how these might be conceptualised, and for an understanding of what does or does not render well-being.

If the critical feature of a therapeutic relationship is the relationship itself rather than the therapist's technique (other than their skill in developing such a relationship), then there are questions to be developed and addressed about formal and informal responses to disturbed or distressed persons. Historically and conventionally, these have been to turn to "professionals" for assistance when the disturbance or the distress overwhelms the capacity and resilience of existing networks and relationships. If the most useful response to psychological difficulties is positive social engagement in the form of an unconditionally supportive and accepting relationship, turning to "professionals" has to be accepted as an imperfect, though perhaps, and under certain circumstances, inescapable, compromise. What determines the threshold at which this happens in any one case? How do notions of risk and expectations of predictability influence it? To what extent and by what routes does conceptualising the difficulties as "illness to treat" lower this threshold, and what interests might be furthered by such processes? Might the need for professionalised and costly mental health services be inflated by misconceptions of what is most helpful when individuals become disturbed, and how might relational and community resilience be nurtured to reduce dependence upon them?

From a naïve, causative perspective, if "mental health difficulties" are most helpfully relieved by an unconditionally supportive and accepting relationship, then perhaps this could inform understanding of how they might be generated? It is undeniable that a large proportion of mental illnesses are associated with an emotionally unsatisfactory childhood and/or adolescence (Jones 2013). The therapeutic part played by a helping relationship is commonly the provision of an opportunity to make sense or constructive meaning of personally historic experiences that have hitherto been found too unsafe to share and process. What are the limits, at a micro-social level, to the ability to share and process difficult experiences, and what determines those limits? To what extent are current discourses and social structures supportive of well-being if that is to be framed, as it conventionally is, as a state of self-acceptance, of being in positive relationship with others, of personal growth, of purpose in life and of environmental mastery and autonomy (see, for instance, Ryff and Keyes 1995)? To what extent do current discourses and social structures enable these experiences of life, or militate against them (Middleton 2016)?

All of these are questions that are relatively inaccessible to biomedicine and positivist approaches to knowledge but all of them are the stuff of theoretical frameworks and methodologies which foreground human relationships, social structures and elements of agency that determine them. As already noted, medical psychiatry does not have the ontological security it has assumed in recent years, and there is considerable legitimate space for other approaches to understanding and theorising mental health difficulties and responses to them. This is not a novel position but medical psychiatry has run a course and from many points of view it is beginning to be found wanting. This might be a time of shifting paradigm. An article generated by critical psychiatrists was published in the *British Journal of Psychiatry* in late 2012. It was entitled *Beyond the Current Paradigm* (Bracken et al. 2012). The *British Journal of Psychiatry* is circulated to the full fellowship and membership of the Royal College of Psychiatrists. The paper made just that point: that medical psychiatry has run its course, and in doing so it has revealed the shortcomings of its assumptions in much the same way we have outlined above; that a shift in paradigm to a more constructivist approach to knowledge and a more socially orientated field of enquiry is in progress. It was received by the journal's readership with little explicit dissent.

The seven case studies which make up the body of this edition are illustrations of how more constructivist approaches to investigating mental health difficulties and contemporary mental health services have been used, what they each established and how each has contributed to practice and social theory. Six are drawn from a set of funded PhD studentships that were able to exploit close associations between the University of Nottingham's School of Sociology and Social Policy and its Institute for Mental Health. One is drawn from a larger funded study which was conducted on a national scale. In order to illustrate the opportunities such approaches can offer to practitioners, policymakers and social theorists, each contribution has been structured in a similar way, with emphases upon practice and service settings, the analytic and theoretical frameworks employed and both practical and theoretical implications of the study's findings. Each is left to speak for itself but together they offer a wide range of insights into clinical practice and the institutions that house it, a variety of methodological and epistemological approaches to investigating them and some of the opportunities for theoretical developments this field offers. The book closes with a chapter drawing these elements together and offering some suggestions for future directions whilst also reflecting more explicitly on the notions of inevitability and uncertainly in the field of mental illness.

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2

A Symbolic Interactionist Approach to Mental Health Assertive Outreach

James Roe

Background and Introduction

Contemporary mental health policy encourages approaches that focus upon supporting autonomy and citizenship, *recovery* rather than symptom control. Despite this shift in policy focus, service users continue to experience the effects of stigma and labelling such as troubled personal and professional relationships, impaired views of their own self-worth and significantly limited aspirations and capabilities (Thornicroft 2006). In order to fulfil policy aspirations to support 'recovery' and thus the optimisation of autonomy and citizenship amongst those receiving mental healthcare, there is a clear need for research that focuses upon why this might be. These questions are at least, if not more, better addressed by the application of theory and methods drawn from the social sciences.

James Roe (✉)
University of Nottingham, School of Medicine, Nottingham, UK
e-mail: james.roe@nottingham.ac.uk

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As emphasised elsewhere in this edition, it is clear that since the 1970s psychiatry and the social sciences have diverged, both theoretically and methodologically. This divergence reflects and contributes to fundamental differences concerning the nature of mental health difficulties and the tasks of mental health service providers (Pilgrim and Rogers 1999). Whereas psychiatry has placed emphasis on diagnostic criteria, empiricism and positivist epistemologies, social scientists have focused upon the exercise of power, in particular dominance of the medical profession and the influence of pharmaceutical companies. They have preferred qualitative research methods and more constructivist epistemological positions. Furthermore, whereas psychiatry has accentuated the benefits that mental health services can bring, sociology has, since the 1970s, tended to draw attention to their problematic aspects and ways in which they can cause harm (Rogers and Pilgrim 2003). Landmark contributors to sociological perspectives of mental health difficulties and those who provide for them include Erving Goffman, David Rosenhan and Thomas Szasz. Broadly and collectively, they question the validity of medicine's authority to label an individual 'mentally ill'. They consider this to be a socially constructed identity developed within an institutionalised setting which is projected onto an individual by parties with control and power which then, in turn, is internalised by the individual themselves.

Using ethnographic data on particular aspects of patient social life in his seminal 1968 work, *Asylums*, Goffman identified the hospital as operating as an authoritarian system where its residents are compelled to redefine themselves as being 'mentally ill'. His main concern was with the development of relationships between individuals confined within, what he called, Total Institutions. Goffman (1968) defined a total institution as:

> *A place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.* (1968: 11)

Traditional mid-twentieth-century mental hospitals conformed to this definition, along with similar institutions such as prisons, monasteries and military barracks. Within such institutions a large group of individuals are situated in a place of residence and work, their private life is all but eradicated and communal. Activities are highly structured and the institution is overseen by an influential elite. Through ethnographic study of individuals resident in such settings and their behaviour with one another, Goffman came to the conclusion that specific roles are learned for those labelled as ‘mentally ill’. Individuals who are so labelled come to accept the label as their own self-image. Divisions that exist between ‘staff’ and ‘inmates’, coupled with a highly structured regime and little or no private life, result in the ‘mortification of the self’, whereby an individual has their old ‘self’ stripped of previous roles in the outside world and is forced to be reconstituted by the social arrangements and restrictions within the institution. One implication of this mortification of the self and reidentification, Goffman argues, is that the ‘mentally ill’ individual venture on a ‘moral career’ in which their self-identity is largely determined by those governing the institution. As he writes:

> *The self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it.* (1968: 154)

Therefore, for Goffman, life in a total institution results in an individual having their previous ‘self’ removed and being subject to a reidentification process whereby they learn to inhabit a new role defined by the ‘mentally ill’ label that is attributed to them. Although this work enjoys little contemporary respect in conventional psychiatric circles, it can be seen to have made a significant contribution to policy decisions which resulted in closure of the large mental hospitals typified by those within which it was conducted.

Rosenhan’s (1973) famous study *Being Sane in Insane Places* was also very influential, though perhaps in unintended ways. Stooges presented themselves at psychiatric facilities claiming to be suffering psychiatric symptoms, in this case hearing voices. In most cases, they were deemed to be suffering from schizophrenia and admitted to hospital. This illustrated the difficulty psychiatrists had in being able to distinguish between individuals with a mental illness and those without. It was received as a significant embarrassment by the psychiatric profession and made a major contribution to the development of descriptive psychiatric diagnostic schemes such as the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, now in its fifth edition (DMS-5; American Psychiatric Association 2013), and which continues to dominate professional psychiatric practice to this day.

The Rosenhan experiment demonstrated that once an individual is labelled with a psychiatric illness, their behaviour is subsequently interpreted by psychiatrists in ways that fit expectations affirming a diagnostic label. As he states:

> *Having once been labelled schizophrenic, there is nothing the pseudo-patient can do to overcome the tag. The tag profoundly colors others' perceptions of him and his behaviour*. (1973: 161)

An individual's behaviour is not only interpreted to fit the diagnostic label but also any behaviour which does not fit the label is overlooked and ignored. Similarly, unwelcome behaviour, such as anger, frustration or depression, was seen to be a consequence of the individual's pathology rather than as a result of the effects of the individual's environment and interactions with staff.

He describes how, once a label is attributed to an individual, that label can have strong influential effects and acquire a life of its own:

> *Once the impression has been formed that the patient is schizophrenic, the expectation is that he will continue to be schizophrenic. When a sufficient amount of time has passed, during which the patient has done nothing bizarre, he is considered to be in remission and available for discharge. But the label endures beyond discharge, with the unconfirmed expectation that he will behave as a schizophrenic again. Such labels, conferred by mental health professionals, are as influential on the patient as they are on his relatives and friends, and it should not surprise anyone that the diagnosis acts on all of them as a self-fulfilling prophecy. Eventually the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly*. (1973: 6)

Thus, besides questioning the validity of 'expert' opinion and diagnosis due to psychiatrists' inability to identify individuals feigning a mental illness, Rosenhan's study also resonates with Goffman's work. It draws attention to ways in which the label of being 'mentally ill' leads to a change in the individual's own behaviour and self-perception in response to expectations and assumptions on the part of mental health professionals.

Thomas Szasz (1920–2012) focused more specifically upon criticising the role of the medical profession, in particular psychiatry. He considered this to be a pseudoscience akin to astrology. In his seminal work *The Myth of Mental Illness*, he argued that mental illnesses are merely fake diseases established by those with power to perpetuate the need to contain individuals they consider as threatening to society. Szasz believed that psychiatry was merely a tool of social and political control over a victim labelled 'mentally ill'. His view was that 'mental illness' is nothing more than a metaphor accepted as fact. He suggested that whilst we find and categorise physical illnesses in an individual when their bodily functioning deviates from anatomical and physiological norms, we identify mental illnesses when an individual's behaviour deviates from current ethical, political and social norms (Szasz 1970, 1974). Szasz emphasised the tenuousness of links between a bodily and a mental illness, as he argues in his television set (TV) analogy:

> *(B)odily illness stands in the same relation to mental illness as a defective television receiver stands to a objectionable television programme. To be sure, the word 'sick' is often used metaphorically. We call jokes 'sick', economies 'sick', sometimes even the whole world 'sick' – but only when we call minds 'sick' do we systematically mistake metaphor for fact; and send for the doctor to 'cure' the 'illness'. It's as if a television viewer were to send for a TV repairman because he disapproves of the programme he is watching*. (1960: 11)

In this way, he was strongly critical of a medical approach to the domain of 'mental illness', suggesting that not only is it illogical to use a doctor to fix the mind, but the concept of being mentally 'sick' derives from those holding it exercising power to control individuals who deviate from the 'norm' and are considered a threat to 'normal' society.

A different sociological perspective upon 'mental illness' is that epitomised by the work of George Brown and Tirril Harris. This focused upon the social *causes* of mental health difficulties. In their classic work exploring the onset of depression and social adversity, they provided evidence suggesting that rather than something inherent in the individual determining the onset of depression, life experiences and emotional and cognitive responses to them make a strong contribution (Brown and Harris 1978). They identified a number of social factors amongst young women that lead to the onset of depression when they act together. These were *provoking agents*, such as bereavement, *symptom formation* factors, such as past bereavements or previous depressive episodes, and *vulnerability* factors such as the absence of employment, death of her mother at a young age and a poor relationship with husband/boyfriend. Whereas some women, who would be categorised as *vulnerable,* may well become depressed, the absence or less intense experience of *symptom formation* factors would result in the women able to overcome grief and despair (Brown and Harris 1978). Though this body of work was hugely influential at the time, since the 1970s, sociological concerns appear to have shifted away from the lives of those suffering from mental health difficulties towards social aspects of the general population's mental health concerns: psychological distress, and the impact of generic life events upon stress and coping mechanisms (Cook and Wright 1995: 95). Nevertheless, Brown and Harris' work stands as an additional example of ways in which the occurrence of a 'mental illness' and its consequences are commonly the outcome of complex interactions between the individual and their social context. An important contribution to that is the nature and conduct of services provided to address them.

Although there are now few institutions akin to those described by Goffman, other less overt institutions are identifiable. Community mental health services are one such. The nature and conduct of these *new* institutions are under-explored from a sociological perspective, and as a result, there are significant deficits in our knowledge of ways in which they address, provide for and affect individuals served by them.

One exception to this, though conducted in a non-mental healthcare setting, is Philip Strong's (1979) *The Ceremonial Order of the Clinic*. Influenced by Goffman's notions of ceremony and identity and by using his frame analysis method,[1] Strong (1979) examined the doctor–patient relationship in paediatric clinics in Scotland and the United States. In particular, he explored the underpinning rules that direct these interactions, identifying four different 'role formats' or forms that medical consultations can exhibit: bureaucratic, clinical, charity and private. It was the bureaucratic role (the ceremonial order), exemplified by tight medical control and by impersonal treatment due to the volume of trade and limited time, and backed up by collegial expertise as opposed to individual concerns that dominates these interactions. He demonstrated how routinely repetitive encounters between individuals exhibit this dominant form, which is maintained due to the perceived balance of interests and resources available to parties involved. In particular, he concluded that this particular form becomes a way in which things *ought to be solved* as opposed to one of several *possible ways* in which to solve things. He argued that the creation of such forms in these interactions isn't necessarily something new:

> *The original negotiation may have taken place many years, decades or even centuries ago, and current users may remain unaware of the political and historical reality which they embody*. (Strong 1979: 193)

Although focused upon children's clinics, Strong's bureaucratic format can be applied more widely within the medical arena where, as he emphasises, individuals are perceived as subordinate. There are clear parallels between this work and the experience of mental health service users. Responsibility for the definition of health problems and their corresponding treatment has fallen into the hands of the health professional (Peplau 1987). This traditional approach towards illnesses, known as the *Medical Model*, views the human body as a complex mechanism and describes how particular physical symptoms and physical syndromes can be diagnosed and treated. This standpoint assumes that the relationship between a 'doctor' and 'patient' can be allied to a technical expert and a client who has an abnormal object in need of repair but it is blind

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[1] The idea that during social interactions, individuals define situations through particular frames in which their experiences are organised (Goffman 1974).

to the effects of this upon the client's self-perceptions and experiences of identity (Goffman 1968). How the distressed, anxiety provoking, confused or threatening are construed and construe themselves mirrors or at least indirectly reflects prevailing discourse concerning such phenomena and the institutional arrangements put in place to provide for them. Interactions between such individuals and the institutional context within which they are accommodated play an important part in determining their social identity, whether personally or publically experienced. A full understanding of the detrimental effects stigmatisation and other adverse consequences of just *being* someone with a mental health difficulty have upon an individual requires theory and method that consider social micro-processes occurring within interactions between mental health service users and professionals, in particular approaches which inform the construction of social identity. One such approach is the application of symbolic interaction, which was used in this study to frame interactions between members of a particular community mental health team and their clientele.

Symbolic Interaction

Symbolic Interaction (SI) offers a theoretically robust framework with which to study social interactions that make up the work of community mental health teams and their effects upon the construction of clients' identities. It is explicitly an approach to analysing how meanings are developed and expressed through interactions within a defined social context, and as such it is clearly applicable to the defined social context of community mental health practitioners interacting with their clients.

SI was developed by Herbert Blumer (1969) as a systematic sociological theory and research approach. It is based on three premises:

- Individuals act toward things on the basis of the meanings that those things have for them.
- The meanings of these things are derived from, or arise out of, social interaction that an individual has with other individuals.

- These meanings are handled in, and modified through, an interpretative process used by the individual in dealing with the things he encounters.

SI attempts to understand complementing perceptions of how individuals interpret and make sense of the world, and therefore understand how and why people act collectively in the way they do. From this perspective, the collective generation of meanings through interaction is understood as a primary determinant of how individuals who are operating together in a particular social field engage with it, and one another in the ways they do. In relation to community mental health service practitioners, SI offers an opportunity to consider how they interpret their roles. This is central to how they organise their work and interact with clients. How practitioners understand their roles and experience the culture that defines their work and broader 'understandings' of their clientele are critical determinants of what they do, and therefore how they act towards them. In turn, these actions and discourses reflect emergent meanings of clients' behaviours and propensities that become reified in the course of interactions between practitioners and their clientele.

Published accounts of the use of this approach in exploring the nature of disabilities experienced by people with 'mental illness' are few. Moreover, explicit examination of the underlying meanings attributed to the needs, risks and potential of individuals labelled with mental health difficulties is virtually absent in mental health literature. This is also the case for an examination of how therapeutic interactions with mental health professionals are governed by symbolic meanings and as a result, what indirect effects these have upon their clients' understandings of themselves, their social position and their capabilities. These are all components of a self which can be more or less disabled by such influences, and therefore vulnerable to inadvertent harm. A small number of studies have used SI to consider Alzheimer's disease (Gubrium 1986; Blum 1994; Hayes et al. 2009), nurse–patient relationships (Byrne and Heyman 1997; Jackson and Stevenson 2000) and experiences of depression (Karp 1994; Lewis 1995). However, these are mainly one-sided and do not focus upon the effects of services and wider influences upon patients' senses of self. The very small number of studies that have attempted this confirm the considerable potential this approach can have for understanding how the development of stigma and/or the progress of recovery might be influenced, in particular by inadvertent actions on the part of professionals and the services they provide (Lewis 1995; Larsen 2007).

In practice, the application of a SI framework depends upon the identification of symbolic objects that influence interactions between individuals. SI proposes that the social world is made up of socially constructed objects that can be considered to be anything 'that is pointed or referred to' (Blumer 1969: 10). These objects can, therefore, take a concrete or physical form such as a chair, be social, for example, a friend or particular individual, or they can take the form of an abstract concept, such as compassion. These types of objects, initially described by Blumer, have been further classified by Charon (2010) who listed the following as possible objects: physical natural objects, human-made objects, animals, other people, the past and future, our self, symbols, ideas and perspectives, and emotions (Charon 2010: 47).

From this particular theoretical standpoint, all objects—whether they are physical objects, individuals or abstract concepts—are not seen as fixed, in terms of how they are perceived but as social objects that are continuously being defined and redefined by those who interact with them. Individuals define the meaning of an object according to the use they have for them through the process of reflection, and therefore react according to the meaning of an object dependent on their definition of them, their symbolic nature, the context the object is in, the purpose of the act within this context and actions of other individuals towards the act, as well as our goals in the particular situation. As stated by Charon (2010: 45), 'We give them names, but, more important, we learn what they are good for, how they are used'.

Within the specific context of a community mental health team, how participants symbolise and create meaning for identifiable social objects becomes an integral part of understanding how practitioners and clientele perceive this social world, make decisions, and reflect on and predict situations they encounter. It also reveals the underpinnings of their individual and collective motives, expectations and, ultimately, consequences for the 'recovery' of service users.

Service Setting and Conduct of the Study

As already mentioned, contemporary mental health policy encourages approaches that focus upon supporting autonomy and citizenship, *recovery* (Deegan 1988) rather than symptom control. In response, there has been considerable investment in community-based teams in order to support and deliver a more socially informed approach towards mental health difficulties (Department of Health 1999). One of these services, Assertive Outreach (AO), provides for those identified as at risk of dangerous or self-injurious behaviour and helps individuals to maintain compliance with medication and supports related carers (Department of Health 2001). The team delivers an array of psychosocial interventions coupled with intense practical support. Practitioners of the team focus on engagement with clients and stress the importance of strong rapport with clients to be effective. Clients of the team are usually identified as ‘hard to engage’ and referred by other mental health services on account of complex needs that may include long histories of severe and enduring mental illness. They tend to be assertive individuals who are reluctant to be labelled as ‘one with mental health difficulties’.

The study took place in the context of a single AO team serving the population of a small market town and its surrounding rural environs. The study was approved by National Health Service (NHS) Research Ethics procedures. The team comprised some 8 practitioners providing for between 40 and 50 clients at any one time. This represents a fairly high staff to client ratio, reflecting the perceived intensity of the work expected of the team. Consistent with the wider emit of AO teams (Department of Health 2001), staff placed emphasis on assertive engagement and the maintenance of contact with clients through the delivery of varied interventions in community settings.

The central concern of the study was to consider how users of a community mental health service were viewed by professionals from two perspectives: first, reflections in the habitual discussions and working practices of team members and second, formal recordings in the form of case notes and other documentation. This was considered to be an approach towards understanding how clients’ identities were constructed, shaped and experienced. A combination of ethnographic fieldwork and documentary analysis was used to provide underpinning evidence. This was with a view to triangulating observations drawn from habitual discussions and working practices of AO team members and what was recorded more formally as case notes and other documentation. These sources were collected during a period of embedded observation of the team's activities and conversations and scrutiny of relevant documents within the team's base. Analysis involved integrating these two sources of data around developed and active meanings and the interactions they reflected. The meanings and interactions of interest were those concerning relationships between the team and individual clients and the results these have upon clients' understandings of themselves, their capabilities and prospects.

Ethnographic observations were collected as reflective notes made, either out of sight of the participants or at the end of the day. They included detailed descriptions of events and incidents that had occurred during the day, including individual quotes. Initially, case notes (of clients who had formally consented to this) were read as a story of their engagement with the team. Subsequently, significant events, incidents, quotations and descriptions were extracted to portray the evolution of each client's documented identity in relation to the team and its parent mental health service more widely. Using this approach, it was possible to gain an understanding and investigate symbolic interactions between practitioners and those they were charged to provide for. By exploring and inspecting these sources of information, it was possible to identify symbolic objects, and how, where and by whom these were developed provided a framework for considering how actions carried out by the AO team towards their clientele. In particular, it was possible to illuminate how constructed meanings developed for various aspects of the team's activities; how purpose, daily routines, responsibilities and engagement activities interacted with constructed meanings derived from perceived characteristics and traits of individual service users; and how this interaction shaped clients' perceived and experienced identities.

Five individual cases studies were considered in this way, using Blumer's exploratory and inspection techniques to reveal symbolic objects significant in understanding the interactions between each one of them and mental health services. Data from the case note review revealed how symbolic objects individually pertinent to each had emerged during the course of their care. Observations of the team revealed how practitioners understood and responded to client-specific objects and revealed pertinent symbolic objects arising out of their own social, material and contractual environments, and how these influenced their interactions with clients. In this way, a number of influential symbolic objects came to light which were contributing to individual and collective views and expectations held by the team concerning individual clients. Furthermore, a number of symbolic objects emerged that were related to the manner in which therapeutic engagement between practitioners and clients was being conducted. Thus, the work identified *case-specific objects* (understood as characteristics of an individual client) and *institutional objects* (reflecting aspects of the institutional environment pertinent to the way in which care has been delivered).

An Illustrative Case-Specific Object: High

High is the name of an abstract object given to describe the perceived current mental health status of a client. For most members of the team, the concept that a client is *High* has a particular meaning with implications for how they might engage with them.

During the period of observation with the AO team, a number of telephone conversations were overheard between an AO team member and individual clients. The team appeared to collectively hold a construction that when they interpret a service user to be in a high phase of their illness, they would become very difficult to engage with and are almost unmanageable. On a number of occasions, the team were observed receiving phone calls from service users who were obviously distressed due to the volume and speed at which they were talking on the phone. During these calls, the team attempted to remain calm and reassure the service user that they were doing all they can to support their needs.

The symbolic meaning of *High* is one that does not simply refer to an individual being inebriated or intoxicated. Rather, the team appear to have collectively constructed a meaning for *High* that is used when they consider a service user to be in a *High* phase of their illness. Overall, this meaning that has been created for the abstract concept *High* is one that represents the AO team's portrayal of an individual being unpredictable, posing a potential risk to themselves and others due to this unpredictability, becoming more difficult to engage with due to their bizarre behaviour and actions. Being *High* acts as a defining feature of a particular phase of an individuals' mental health condition.

An Illustrative Institutional Object: Social Outings

The activity of AO team members in taking clients out for coffee or on varying types of shopping trips, for example, grocery shopping, clothes shopping, is a dominant form of engagement that is used by the AO team as a way of providing and maintaining regular contact with a service user, as well as acting as a social outing or activity.

Generally speaking, *Social Outings* hold a meaning for the team as a way of feeling secure in their perception of themselves as service providers who are tasked with providing regular engagement and aim to stabilise a client's lifestyle. To a certain extent, the meanings behind these activities are similar to those as used in an everyday context, that is, to catch up since their last interaction, to discuss possible events in the local area, current affairs and various other topical issues. However, a contrast can be drawn between the everyday meaning of a shopping trip with someone and the constructed meaning that can be seen in this particular context. This interpretation goes further into their construction of particular clients as the experience of *Social Outings* was also symbolic of certain service users' reliance and dependency on the team. *Social Outings* held a pertinent meaning for the team that helped define interactions between them and their clients. Initially, taking clients on shopping trips can begin during the first stage of the team's engagement with a given person. In the case of one particular client, this occurred when they were discharged into the community and thus to the team's caseload. At this time, it was reported that this individual lacked basic provisions in terms of food at their home. This was originally viewed as such a basic and necessary need that the team carried out shopping for them as a way of making their move back home as comfortable as possible. Over a short period of time, this quickly sat at the forefront of their engagement with this individual, and the meaning held by the team for these shopping trips began to be shaped around something different. They developed the impression that the client was nervous and uncomfortable with the idea of moving home due to fears of loneliness. These regular shopping trips began to be construed by the team as a method by which they could provide regular engagement with him and also allow them to feel secure in the knowledge that they had an adequate supply of food.

Over time, through their interaction with this individual over this object, it is evident that the team constructed a meaning for *Social Outings* which symbolises reliance and dependency. The client became viewed as far from an independent or interdependent individual. Furthermore, they reacted negatively, even apparently aggressively, to refusals or the rescheduling of trips and they came to be seen as taking advantage of the team's generosity, over-needy and ungrateful. On the other hand, this also perpetuated the nature of the team's engagement, as they continued to either take them shopping or carry out similar tasks.

Overall, *Social Outings* were an activity that team members regularly used as a dominant form of engagement with clients. The meaning that generated for this activity amongst the team was that it represented a way of providing regular contact with a client which can also serve another purpose and have consequences for how an individual client might be identified.

Interactions Between Institutional and Case-Specific Symbolic Objects

The interplay between case-specific and institutional objects provided valuable illustrations of how case-specific symbolic meanings reflected ways in which the AO team were obliged to carry out the institutionally defined tasks inherent in their role. This is illustrated once again by the ways in which *High* and *Social Outings* reflect particular meanings derived from institutional objectives, requirements and objectives that are placed upon the team.

High can be seen as a direct reflection of how the team understand the purpose of AO. As discussed previously, this meaning represented their view of an individual demonstrating unpredictable behaviour, posing a potential risk to themselves and others due to this unpredictability and viewed as becoming more difficult to engage. Consequently, what had developed over time was that the team had come to associate certain behaviours and actions with an individual being *High*. Their reasoning for doing so can be found in the meaning that has been constructed for one of the purposes of AO: preventing relapse. In this sense, the AO team interpreted a part of their role as that of identifying triggers and relapse signatures indicating to them that an individual is relapsing.

Similarly, this can also be seen with *Social Outings*. In the case of the client referred to earlier, a predominant feature of their early engagements with the team consisted of shopping trips. However, what is apparent is the way in which the meaning of *Social Outings* was constructed to represent a way of providing regular engagement and also security to the team that they were contributing towards stability within the client's lifestyle. This can be seen as a direct reflection of ways in which the AO team appeared obliged by the institutional needs set out for their role. The team came to place importance upon delivering support as a significant feature of their work, which has extended into supporting this particular client's physical health and well-being even though that was at the expense of the client's independence and autonomy and wider construction of them as a capable citizen.

This form of engagement was also found to be a method through which they could discuss any issues, of a personal nature, with the service users. Therefore, what *Social Outings* represented was a way in which the team were attempting to develop a relationship with a client. Developing a relationship is seen as an important aspect of the AO team's role for a variety of reasons but importantly because it provides a way in which the team can gather as much detail about the person as possible. Developing rapport facilitates this. It is seen as a way of gaining a detailed understanding of individual service users' behavioural nuances and their individual needs, consequently gaining trust, increasing engagement between the service user and services, and ultimately increasing service users' co-operation with the requirements laid down by the team for their behaviours and actions. In this way, another key purpose of the AO role is fulfilled.

By taking into consideration the implications and consequences of the interplay between these symbolic objects and their respective meanings, it was apparent that interactions between the AO team and service users were strongly influenced by institutional imperatives.

Ultimately, it was the interplay between these constructions and the consequential actions of the team that demonstrated how individual clients arrived at the AO team with a baggage of behavioural markers that had already shaped their social (or clinical) identity in the eyes of the team. This was apparent from the case note studies which illustrated how each individual client builds up a portfolio of constructed strengths and weaknesses, trigger points, risks and other behavioural qualities that profoundly influence the relationships they have with mental health services. These constructed behavioural markers were identified as service users having a *dependency on services*, demonstrating *undesirable behaviours*, posing potential *risks to self and others*. Likewise, *the influence of diagnostic labels*, as well as key influential institutional components such as the referral process, what makes an *eligible candidate*, similarly the influence and emphasis placed upon the identification of *relapse signs* and an individual's perceived level of *insight and capacity* are the key symbolic meanings that influence and direct these therapeutic interactions. Understood in terms of the wider organisational context, the strong influence of a medical model approach is clearly imprinted on these constructed terms, which demonstrates how dominant an influence it is, and how it impacts on the way in which clients are perceived and acted towards, even in the context of a community mental health team explicitly contracted to carry out psychosocial interventions.

Implications for Understanding Mental Health Service Practices

This study also demonstrated how aware and critical mental health practitioners were of the context within which they work. Although AO teams are underpinned by relatively new principles designed to build care packages around individually sculpted approaches, they continue to deliver care under well-established systems. Consequently, the social identities of those served became perpetuated by the organisational norms and values in which AO teams operate. Due to deeply embedded organisational and established practices, conventional activities with clients continue that may well be less ideal for the recipients. Whilst the team may have been underpinned by new principles, the fact that they deliver care under traditional well-embedded systems is a powerful constraint on what they do.

There are two distinct components that govern this working environment. Firstly, pressures derived from an organisational perspective, as well as concerns held by staff over the actual purpose of their role as an AO team member form one component. Secondly, there are specific techniques used by staff, including the part played by diagnostic labelling and the overall experience of the service user. These demonstrate the most dominant issues that exist within this environment.

Organisational Pressures

Due to the deeply embedded nature of the medical model in NHS practice, policy attempts to move away from this approach, as demonstrated with the AO team's centre of attention on relationship building, independence and autonomy, are ultimately constrained due to the existing organisational boundaries within which community teams carry out their activities. As well as emphasising relationship building and autonomy, the particular expectations of the AO role also emphasise aspects such as risk management and an assessment of insight and capacity, which creates an essential tension. In the data, as has been shown, it is often these latter aspects which win out or predominate.

What is significant is that it is the AO team who, like the doctors presented by Strong (1979), are the arbiters and negotiators of what is deemed clients' acceptable behaviour, conduct and actions. Furthermore, these judgements were made and upheld, again similar to Strong (1979), regardless of whether they were underpinned by a biological or other foundation. Additionally, collegial expertise was identified as a driver for persuasion in Strong's (1979) observations, and for the assertion of the doctor's own expertise. A not-too-dissimilar format was evident in observations during AO team meetings discussions.

Labels

It has long been recognised that simply being known as a psychiatric patient has adverse effects on an individual's reputation (Goffman 1963, 1968; Gove and Fain 1973). This is arguably related to perceptions of that particular branch of health services and what they are considered to be there to achieve. For instance, who a psychiatrist is, what role they conduct and what they represent are influential contributors (Thornicroft 2006). Looking more specifically at the labels used by professionals for mental health service users, whether formal and informal, previous studies have argued that service users who are perceived by staff as posing a challenge to their professional authority and therapeutic competence are likely to become identified as difficult or problem patients (Kelly and May 1982; Gallop and Wynn 1987; Breeze and Repper 1998).

Data from this study indicate that, although referral to an AO team often takes place when other modes of service delivery are seen to have 'failed', staff may relinquish control over a service user's plight by arguing, and justifying to themselves and each other, that the predicaments that service users find themselves in are their own doing.

> *It's because she always calls everyone up acting all aggressive, winding herself and them up.*
>
> (Participant Observation Record)

It is not the case that staff from within the team were operating oblivious to these potentially detrimental organisational pressures. AO team members were found to raise and voice particular concerns about their own role, in terms of their lack of fulfilment in their role, desires for purposeful engagements with service users, and concerns that their role or status as an AO team member ultimately is not specialised but comes down to acting as a go-between, or intermediary.

Members of the AO team were frequently observed referring to their role as providing a service that is positive, optimistic and forward thinking—one that is based on developing a strong rapport and relationship with the service users. However, it is too simplistic to infer that a generic role facilitates a user-focused approach. Based on the data, it could be argued instead that such a generalist role has resulted in feelings of confusion as to the ethos behind their position, whether they are there to step in or step back:

> *Do we allow clients to become chaotic, and then take responsibility?*
> (Community Psychiatric Nurse, Observation Quote)

This frustration is then exacerbated by the emergence of some feelings of resentment at having to participate in supposedly meaningless tasks such as taxiing service users around. Also, the amount of time spent with service users, although not quantified in this study, was perceived by staff as being restricted by bureaucratic pressures and time restrictions placed upon the team. Furthermore, despite the AO teams' valiant attempts to engage with service users in a manner that encouraged and facilitated social inclusion and independent and interdependent living, service users arrived at the team with the baggage of past-patient characteristics which portrayed and depicted them as a challenging mental health service user. By the very nature of AO teams as a final attempt to support an individual in a community setting, such a portrayal is unfortunately inevitable and very 'sticky'.

This, from one perspective, is the result of the referral process by which each new client is presented to the AO team. Previous studies have shown that referral processes to community mental health teams have to adhere to particular risk concerns and are therefore under particularly strict constraints due to a high number of received referrals and the slow turnover of service users (McEvoy and Richards 2006). Therefore, clients referred to the AO team are identified and described with particular reference to these concerns about risk, as demonstrated by the language used. This study has added the finding that, as a result of the process their referrals follow, significant aspects of service users' social identity as understood by the AO team are already constructed by the time they 'arrive'. This reflects the very nature of how certain individual characteristics are interpreted in a mental health context. These might be a dependency on services, tendencies to act in a bizarre manner or posing a risk to self and others. Service users have to be defined as problematic in order to get an AO referral in the first instance, and this then forms a lens through which subsequent behaviour is viewed.

How Might Symbolic Interaction Contribute to a Better Understanding of Psychiatry

As a society, the way in which we interpret and react towards those who experience difficulties associated with their mental health is a consequence of an ongoing socially constructed process. This assumption makes no attempt to detract from the distress experienced by individuals, as this is both real and unique to that individual. Within the AO team that was the focus of this investigation, this socially constructed process has been shown to be a reflection of institutional constrictions, boundaries and obligations derived from the development of meanings and expectations of AO and its location within wider psychiatric service provision. Social identities of individuals served by AO are perpetuated by these embedded organisational norms and values in which teams operate. As a result, building care packages around individual-led approaches, whilst being a more appropriate method to support individuals who experience such distress, may still falter in the current system. Whilst the AO team may have been underpinned by new principles, the fact that they deliver care under traditional well-embedded systems is primarily what constrains them.

This chapter has presented, in summary form, findings from an investigation of the work of an AO team using the framework of SI. By placing micro-processes at the forefront of data collection and analysis, SI is a relatively novel conceptual and methodological approach to mental health issues. This research aimed to make an original contribution to previous literature by using tools from this tradition to identify ways in which contemporary practices and conventions may (deliberately or inadvertently) contribute towards service user identity. More specifically, there was a need for the explicit examination of the underlying meanings of the needs, risks and potential of an individual labelled with mental health difficulties, as this is virtually absent in mental health literature. This study has allowed a perspective upon this that foregrounds it as a set of social interactions wherein symbolic meanings are generated that form the currency of those interactions. SI offers a theoretical framework with which to study the developed meanings of objects, whether they be material, social or conceptual, and to study ways in which those meanings contribute to the forms collective actions take. In this study, that has been applied to an exploration of how those identified as suffering serious mental illness and their activities are construed whilst attempts are made to facilitate their residence as citizens. Contrasts have emerged between well-meaning intentions of practitioners and stated policy aims, and institutional imperatives that identify clients as risky or vulnerable individuals in need of paternalistic care and containment. There is nothing particularly novel about this finding but the application of SI provides a structured way of investigating how this happens and opportunities to study the process in more detail. Doing so could reveal much more of the same and provide valuable further insight into how mental health difficulties undermine not only the well-being of those afflicted but also the ways in which their social identities are influenced and spoiled by that status. SI could also, conceivably, support the identifying of symbolic meanings and interactions around them that truly facilitate the growth of independence and autonomous citizenhood. An area where that might be applied is amongst those who have successfully relinquished the status of 'psychiatric patient' such as many represented by active service user organisations. What alternative meanings for distress, anxiety, anguish and confusion have these groups generated and used as a collective, less damaging way of understanding such experiences? SI emphasises the contextual nature of meaning and in so doing offers opportunities to study relationships between developed and actively employed meanings and the contexts from which they have emerged. If there is a constituency that does well in terms of 'recovery', then the language and other symbolic interactions within it merit careful investigation.

What Can the Study of Mental Health Services Offer SI?

This study also drew attention to the extent to which interactions between a formally defined group of practitioners and their clients are as much if not more determined by how practitioners experience and understand their roles as 'employees' as they are by how they understand themselves as practitioners or even as healthcare advocates. The context of which mental health services is a part is an arena within which these conflicts abound. Several other contributions to this volume arrive at much the same conclusion. SI offers a way of exploring how co-constructed meanings govern the social world but what is observed and how it is interpreted are both very heavily determined by features of the social world under investigation. Mental health services offer a particular form of social world in which tensions between one role (responsible employee) and the symbolic meanings of objects identified with it, and another (carer/advocate) with its own symbolic objects are clear and apparent, and therefore offer a setting in which to investigate how objects acquire and establish significant meaning in a more pluralist situation. The way in which wider society reacts to individuals experiencing mental health difficulties is one that has been shown to be socially constructed, rooted in history and in current times affected by the media, professional opinion and politics. Various interest groups are involved with their own motivations, in particular pharmaceutical companies and the medical profession. The categorisation of mental illness can be seen to be largely created for convenience to these interest groups. These are time dependent, as shown with the continuous changes to categories and definitions of mental illness throughout recent history. The mental health field offers a rich opportunity to those interested in researching these constantly evolving meanings and their related processes.

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3

The Role of Everyday Interaction Rituals Within Therapeutic Communities

Jenelle Clarke

Introduction

Characterised by a cluster of symptoms including relational instability, emotional deregulation and risky behaviour such as self-harm and suicide attempts (Stalker et al. 2005), personality disorder is among the most challenging disorders to confront modern mental health care. Perceptions regarding clinical treatment and effectiveness are mixed (Gask et al. 2013; Roth and Fonagy 2005; Manning 2000). Psychopharmological treatments in particular show little evidence of treatment effectiveness (Gask et al. 2013; Roth and Fonagy 2005; Roy and Tyrer 2001; Sanislow and McGlashan 1998; Soloff 1994). Individuals with a diagnosis of personality disorder (PD) and borderline personality disorder (BPD) often experience stigma and isolation from their social networks, including family and friends, health professionals and the generalised public.

Jenelle Clarke (✉)
Research Fellow, University of Nottingham, Nottingham, UK
e-mail: jenelle.clarke@nottingham.ac.uk

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Interpersonal relationships are marked by difficulties in communication and emotional regulation. PD/BPD diagnostic categories suggest that service users struggle to build healthy relational attachments (Gask et al. 2013; Stalker et al. 2005; Ramon et al. 2001).

Therapeutic communities (TCs) have developed as a therapeutic intervention that specialises in helping those with a diagnosis of PD learn healthier ways of relating to themselves and others. They are planned social environments that aim to provide a safe setting whereby troubling relational patterns can be explored, often through reprising interpersonal dynamics found in family relationships (Jones 1976). By using a variety of therapeutic approaches, the community, comprising both staff and clients, works as a whole to address issues of mental distress. Additionally, TCs value the input and therapeutic intervention of staff members, and client members are expected to take an active role in their own and others' therapy. TCs understand that social relationships can contribute to some forms of mental distress and they value the potential for social support to restore individual mental health (Boyling 2011; Johnson et al. 1999; Pilgrim 2001; Castillo 2003; Stalker et al. 2005).

As first established by Durkheim, the association between social support and mental health has been well documented (Pilgrim et al. 2009; Berkman et al. 2000). Just as it is understood that those experiencing mental distress often have fewer close relationships and perceive that their social support is inadequate (Kawachi and Berkman 2001), it is also acknowledged that within therapeutic interventions, social support has been found to be an important factor in aiding personal change (Pilgrim et al. 2009; Haigh 2005; Corrigan and Phelan 2004; Lapsley et al. 2002; Hogan et al. 2002; Davidson et al. 1999). Drawing on these theories, TCs argue that time spent outside of structured therapy sessions is as important as formal group work in facilitating personal insight. From the perspective of TCs, everyday social encounters, such as meal times and smoking breaks, provide an opportunity for an individual to experience positive changes that may manifest in a variety of ways, including feelings of hope, increased self-understanding, having life purpose, enhanced interpersonal relationships, improved behavioural patterns and a sense of living a flourishing life (Jones 1968; Dunstan and Birch 2004). Indeed, Jones (1976: 22) writes that 'interaction between individuals forms the basis for the future processes of change through social learning and growth'. Furthermore, as Mahony (1979) acknowledges, it is not the therapy sessions that provide the only opportunity for growth but the informal, everyday encounters and interactions with others can be therapeutic as well. Therefore, understanding everyday social interactions and their meanings is key to understanding the process of personal change in those experiencing mental distress.

Whilst there are have been numerous studies focusing on treatment effectiveness (c.f. Dolan et al. 1996; Lees et al. 1999; Chiesa and Fonagy 2000; Armstrong 2005; Hesse and Pedersen 2006; Freestone et al. 2006), outcomes and service delivery, there have been relatively few studies that explore the interactions between client members during informal times. Thus, it is not well understood how informal times contribute to the process of change. This chapter therefore explores the role of everyday social interactions, such as the way people relate and communicate to one another during meal times and smoking breaks, within two adult democratic therapeutic communities (TCs) for individuals with a diagnosis of PD. The aim of the chapter is to explain the mechanisms of everyday interaction rituals (IRs) in order to understand how everyday social interactions facilitate personal transformation. Theoretically, it adopts interaction ritual theory as first suggested by Durkheim (1912/2001) and Goffman (1967), and expanded upon by Collins (2004), to address how individuals use social interactions to facilitate self-transformation. Interaction rituals are defined as mutually focused social interactions that produce long-lasting emotional feelings (emotional energy), solidarity and group symbols. Everyday interaction rituals are full of complex social mechanisms, including the role of emotions and power, which help generate personal change in TC client members.

This chapter is based upon a PhD within the social sciences entitled, 'Where the Change Is: everyday interaction rituals of therapeutic communities'. The thesis is concerned with how everyday social interactions outside of structured therapy times facilitate personal change in TCs. The chapter begins by outlining the clinical setting of the two TCs, defining the theoretical focus of interaction rituals, presents the clients' experiences of times outside of structured therapy and analyses the mechanisms of these interactions in relation to change. It considers how everyday encounters established a sense of inclusion and positive emotional feeling between members. IR theory stresses the role of positive emotional energy, such as feelings of confidence and enthusiasm within interactions (Collins 2004). Despite a high prevalence of negative emotions within everyday encounters, such as anxiety, frustration, shame and anger, interactions within the TC revealed that client members continuously worked to transform negative feeling into a sense of belonging and long-lasting emotions such as confidence.

Life in Therapeutic Communities: The Clinical Context

The context for this research is two therapeutic communities for individuals with a diagnosis of PD and BPD. In the interest of maximising participant anonymity and confidentiality, the names of both communities are given pseudonyms in this research: ‘Powell’ and ‘Hawthorne’. Powell was a residential independent charitable organisation for women only. As a TC, Powell accepted private and National Health Service (NHS)-funded women from the UK. Hawthorne was an NHS day community for both men and women from within that NHS Trust. Both units were registered and accredited TCs with the Royal College of Psychiatrists (Community of Communities 2016). As such, they had to adhere to specific standards of therapeutic work that specifically acknowledged all social encounters as potentially therapeutic and recognised the role of client[1] members in their own and others’ therapy.

At both communities, membership fluctuated between 8 and 12 client members, aged between 21 and 60. Powell had 25 members of staff and Hawthorne had 10 members of staff. In addition to a diagnosis of PD/BPD, many of the clients had co-morbidity, including diagnoses of eating disorders, psychosis and multiple physical health problems. Several clients between the two TCs had spent various amounts of time on acute units under Section 2 or 3 of the Mental Health Act. The majority of clients had made multiple attempts and engaged in different forms of self-harm. The suicide therapeutic programme of both TCs was for 8–12 months, and as

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[1] TCs specifically use the terminology of ‘clients’.

client members described it, coming to the TC meant being 'committed' to 'working with the programme' for the duration of their therapy.

Daily life in both communities was not easy and the choice of a TC was a difficult option for therapy. Powell Graduate member 'Lori' remarked that it was as a 'huge sacrifice' to join a 12-month programme. Client members explained they had families, some with partners, dependent children or parents, education and jobs outside of the community. All areas of their life were impacted or interrupted during their therapy. Moreover, the clients considered a TC the most intense form of therapy, and several saw their respective TC as a last chance of having a 'better' life:

Mary (Hawthorne interview): I think I came to the TC because it was fulltime treatment and I felt like an hour or two months apart was never going to get anywhere.
Erica (Powell interview): And I kind of just knew I had to do something to, so I wasn't going to end up going into hospital for the rest of my life.

Clients were therefore aware they were choosing a tough form of therapy and, once in the communities, reported that the therapy was 'exhausting' and harder than having a full-time job. They described life in the community as filled with continuous analysis where anything could be brought to group for discussion and where they had to manage very intense and variable emotions. In addition, the topic of change in the communities was a frequent item of discussion. Clients often feared they were not changing enough or in the areas they had set out to address upon arrival. Despite their fear at their own lack of change, clients regularly highlighted to one another how they were changing and how different they were from when they first arrived. Change, and talk of change, was always a presence within the communities. Their comments, and clients' own reflections on personal change, often included increased confidence, decreased anxiety, more accepting of themselves and increased feelings of hope. Personal change is therefore subjective and closely linked to emotions. Moreover, talk of personal change and practicing changed behaviours occurred in everyday social encounters within the TCs, such as over meal times and during grocery shopping. Understanding the mechanisms of these moments is therefore imperative to understanding how clients experienced therapeutic transformations.

The Importance of Interactions: Interaction Ritual Theory

The focus of this research is on explaining the mechanisms of social encounters in facilitating personal change. Instead of placing the individual at the centre of the transformative process, it is the interactions between individuals that are of importance. Such a focus on interactions is linked with microsociology and, in particular, Goffman (1967), Mead (1934) and Collins (2004). Placing interactions before the individual in microsociology is linked to Goffman (1967), who highlights that it is misleading to have an individual-driven focus precisely because individuals do not develop and change in isolation. Goffman and Collins both argue that focusing on the individual before interactions risks reifying individuals and stripping them of their uniqueness. Moreover, in TCs, a primary focus on interactions is especially relevant because TCs openly acknowledge the role of others, staff members and peers in the personal change process. Individuals and social identity are therefore not excluded from the process, or denied their importance in exploring change within the community; but they are not the foremost focus of attention. Rather, it is the everyday interactions that are the lens through which the individual, change and the TC are viewed.

However, not every community social encounter is necessarily significant in the role of personal change. The use of interaction ritual theory is therefore useful in both identifying and distinguishing relevant interactions. In this research, the definition and use of a ritual is the one outlined first by Durkheim (1912/2001), extended by Goffman (1967) and synthesised by Collins (2004). A ritual is therefore 'a mechanism of mutually focused emotion and attention producing a momentarily shared reality, which thereby generates solidarity and symbols of group membership' (Collins 2004: 7). Rituals are specific kinds of interactions that are always in motion. Key to interaction ritual theory is that they are not produced in isolation of one another as each ritual either builds upon a previous successful ritual or bears hallmarks of a failed ritual that has been recreated or reproduced. They have a past, a present and a future as they are social interactions held together by 'chains' that connect them to past and future rituals (Collins 2004). Thus, rituals are not fixed or static and their level of stability is in part dependent upon the participants engaged in the interactions. Additionally, as Cheal (1992: 367) argues, rituals 'signify social structures, that is to say, patterns of relationships and the cognitive categories and emotional commitments upon which they depend'. Rituals also reveal 'individuals' unobservable, internal states of being' (Cheal 1992: 367). For this study, a focus on rituals highlights the process of individual change that is externally worked out in relation to others.

Interaction rituals contain four ingredients: bodily co-presence, barrier to outsiders, mutual focus of attention and a shared mood (Collins 2004). Together, these ingredients produce four outcomes: solidarity, emotional energy, symbols of the group (sacred objects) and standards of morality (Collins 2004).

Ingredients and Outcomes of Rituals

The first essential ingredient of an interaction ritual is bodily co-presence; rituals have to occur face-to-face. Goffman argues that face-to-face requirement is needed because individuals use others' reactions to decide their own responses. These responses can be either conscious or unconscious. Collins, writing several decades later, mainly adheres to this bodily co-presence requirement, though he does acknowledge that the increasing advances of technology may include interaction rituals (Collins 2014).

Secondly, rituals need to include a boundary between who is included and who is excluded. For the purposes of this chapter, insiders include TC client members. Thirdly, Collins argues that individuals involved in a ritual need to be mutually focused on a common object or mutually engaged in a common activity. Individuals communicate their focus of attention to each other, either verbally or through other bodily ques. The mechanisms of shared attention involve attention to the activity or object at hand, and also the awareness of each other engaged in the ritual. As with bodily co-presence, individuals will make adjustments in relation to one another as their attention becomes more focused. Also, like bodily co-presence, shared attention can be conscious or unconscious.

Shared attention then gives way to the fourth ingredient, a shared mood or emotional state. Collins stresses that the third and fourth ingredients are the central ingredients as increased attention will generate a greater emotional experience between individuals, which strengthens their sense of solidarity. Moreover, the emotional state will become central to members' conscious awareness.

Once all the ingredients are in place, successful rituals generate four main outcomes. Firstly, rituals produce group solidarity, the feeling of belonging to the group. Secondly, rituals generate emotional energy within each participating individual. Emotional energy is long-lasting emotional feelings that individuals retain after the ritual has finished. Emotional energy is different to the emotional mood of the group that consists mainly of transient emotions such as joy, anger, shame, pride and happiness (Collins 2014). This emotional energy feeds back into the shared emotional mood, a key indigent in producing and sustaining the ritual. In the main, positive emotional energy is needed in order to create a sense of belonging and sustain feelings of group membership. Rituals that generate primarily negative feelings and emotions will lack a commitment to the ritual because participants will either abandon it or create a new ritual that produces more favourable emotions. For TCs, emotions are particularly relevant as an inpatient psychiatric unit is full of varying and intense emotional responses.

Thirdly, interactions rituals create symbols that are representative of the group. A symbol can be an object, an idea, gesture, words, or visual image. Collins (2004: 49) links symbols with Durkheim's 'sacred objects' and highlights that members will treat symbols with care and respect, defending them against attack (real or perceived). Fourthly, members experience a strong sense of morality from belonging to the group, participating in the ritual and valuing the symbols.

The definition of rituals is important because it is what separates a ritual from mere routine. Both rituals and routines involve individuals, groups and interactions, and both are repeated. What distinguishes a ritual from a routine is the shared focus of attention and emotion (Payr 2010). In rituals, participants each focus on a common object and share a common emotional mood (Collins 2004). Routines, in contrast, lack shared attention and emotional dynamics. Even in a group context, there will be little cohesion as participants act as individuals rather than a group. Rituals become routine 'when they lose their symbolic strength' (Payr 2010). Successful rituals are those rituals that members seek to repeat, and also those that hold symbolic value and draw participants together through shared attention and emotional outcomes. Moreover, members will adhere to the rituals and justify their use and their symbols to not only outsiders, but to each other. However, even when a ritual is repeated, there is variation in each ritual occurrence as it is impossible to produce the exact same combination of shared attention, emotional energy and entrainment. Thus, whilst the structure and form of a ritual may stay more or less consistent, the emotional mood and level of entrainment will vary.

Both Turner and Stets (2005) and von Scheve et al. (2014) note that Collins's theory, though very comprehensive, is difficult to test systematically and empirically due to its complexity. However, several researchers have applied Collins's framework in diverse contexts including charity groups (Summers-Effler 2010), restorative justice (RJ) groups (Rossner 2011, 2013; Sherman et al. 2005), violence (Collins 2008), sports (von Scheve et al. 2014; Cottingham 2012), science and technology (Vertesi 2012; Parker and Hackett 2012), education (Milne and Otieno 2007; Olitsky 2007; Hallett 2007), business (Goss et al. 2011), food service industry (Hallett 2003), religion (Heider and Warner 2010; Collins 2010), military (King 2006) and technology (Ling 2008). Whilst Turner and Stets (2005) make a valid critique that most research uses Collins's framework to interpret interactions in existing communities, situations and organisations, the studies are very useful for strengthening and expanding IR theory. Nonetheless, IR theory has not been widely applied to mental health and, to date, has not been used in TCs. Using this theory within communities for individuals who are actively experiencing varying degrees of emotional and mental distress highlights that the theory needs expanding to more thoroughly clarify the role of negative emotions in psychiatric communities.

Methodology

This research is primarily concerned with *how* everyday social encounters, such as meal times and grocery shopping, play a role in facilitating change. As informal rituals, both meal times and grocery shopping are everyday rituals that occur multiple times throughout a client members' duration with a TC. To address the central research questions, this study used narrative ethnography to analyse the process of personal change. A focus on narrative within the ethnography reflects the everyday storytelling processes that occur during informal rituals and how these stories and encounters in turn contribute to the wider community narrative (Bruner 1997). Using a narrative ethnographic approach is distinct from much of narrative research that relies solely on recollected accounts of suffering, distress and recovery. Experiences of distress and personal change in action are very different to recollected narratives and require different methods and analysis (Tibbetts 2004; Larsen 2007). The inclusion of observational data draws on Gubrium and Holstein (2008), who call for observational techniques alongside narrative interviews. In addition, Baldwin (2005) argues that using observational data with episodic storytelling can enable and empower some mental health service users to share their story and have their voices heard.

As a narrative ethnographic study, this research used participant observation, narrative interviews with client members and semi-structured interviews with selected staff members. Participant observation was carried out for approximately four months, respectively, within each TC. Between the two sites, 87 days, totalling 746.5 hours, of observation were completed. Particular focus was given to the times spent outside of structured therapy and involved activities such as eating meals with the community and joining in client member smoking breaks. Narrative interviews, ranging from one to two hours, were conducted with 18 current client members and three graduate members. Some of the interviews occurred during a single sitting and others were conducted over multiple days. Additionally, seven semi-structured interviews, ranging from one to two hours, were conducted with members of staff to contextualise the participant observation data and client member interviews. The study was ethically reviewed and approved by the University of Nottingham, NHS Research Ethics Committee, the ethical governing body of the charitable host organisation, and had NHS Research and Development approval for the NHS community. All participant names in the research have been assigned pseudonyms to protect confidentiality and anonymity.

In order to explain the mechanisms of everyday rituals facilitated therapeutic change in the TCs, two ritual forms are presented: meal times from Powell and grocery shopping from Hawthorne.

Everyday Rituals: Meal Times

At Powell, whilst breakfast was self-serve, lunches and dinners were cooked by the TC's hospital kitchen Monday through Friday. On the weekends, lunches and dinners were the responsibility of the community to prepare, with clients taking turns to cook weekend dinners with support of staff. Lunches and dinners were always 30 minutes in length followed by 15 minutes of 'meal support'. Formal meal support took place in the community lounge with a staff member to specifically discuss any difficulties that arose during the meal. Informal meal support was in the dining room, also with a member of staff, and involved sitting and talking at the table. Meal times were a 'protected time' and no one, staff or client member, could leave other than to use the toilet, located immediately across the dining room. Due to the number of clients with disordered eating, portion sizes were controlled. In order to 'model positive behaviour', staff ate the same amount as the clients, and everyone had to ask permission from all the others at the table if they could not finish their meal.

Meal times often contained a high level of negative emotions. The issue of food was also very problematic for some of the clients and could range from the quality of the hospital food, to food and eating itself being triggers for unhelpful past experiences, including verbal, physical and emotional abuse and neglect regarding food. For some clients, eating meals, especially in front of others, was stressful. During an interview, Kristen explained:

> I find it hard eating in front of people and stuff like that. I have to sit at the end of the table because I struggle to sit in between two people and stuff like that. And um voices that I have make it really hard to eat as well and because they say stuff like I'm a fat pig and I eat like a pig and stuff like that, so.

There was a certain intimacy and vulnerability in meals together, in allowing the community to see how one ate and how quickly food was consumed. In addition to Kristen, 10 other clients stated that meal times were one of the most difficult components of community life. Other comments included:

Erica: Yeah the meal plan is really hard to adjust to, especially if you've got like disordered eating or eating disorders it's you know it seems a *huge* amount of food.
Amanda: So you know you sometimes you'd be just choking the food down because you just wanted it to be over.
Carolyn: As soon as I finish my meal I want to get up and leave.

In terms of social rules, whilst staff and clients stated that seating in the dining room was unassigned, most clients had their usual seat, or area, of the table that they sat at. This was particularly highlighted when newer members joined the TC and the seating pattern shifted. Though this was mostly unspoken, one client commented to me just before we entered the dining room on the day of a new client's admission, 'I hope the new client doesn't sit by me'. Almost all of the newer client members sat at the top of the table, closest to the door, whilst older members congregated down towards the bottom. Even older members who had habitually sat at the top of the table every day for every meal suddenly moved to the bottom of the table. Rarely, however, was this change discussed. Entrainment and solidarity in the TC were therefore not automatic, but took time to build. When a new member joined, it took a few weeks for the newer client members to become entrained with the community and for solidarity to begin to build amongst all members.

Conversations around the table ranged from the intense and serious to joking around. Meal times were a place to hear episodic stories from both staff and clients. Eating meals with the TC highlighted how the client members interacted and supported one another, and also revealed how they were changing over time:

> Conversation around the table feels up beat. There is talk about Margaret's (nurse) dog, cooking, food, etc. Andrea eats very, very slowly whilst starting intently at all those around the table. She has a napkin in front of her with writing on it. I see that it says, 'I DO deserve to eat'. Staff later tell me that Tessa wrote it for her. This is because Andrea has voices telling her that the food is poison and that she doesn't deserve to eat. Yesterday Tessa had suggested cheerleading statements at dinner reminding her that she deserves to eat. Tessa said that eventually it will be helpful to put it in her own handwriting but for now, having a member of the community write it out may help […].
>
> Andrea gets up to throw out her juice. She sits down and then asks Julie if she can have some of her fruit smoothie. Julie nods and brings the drink containers out of the fridge so Andrea can choose her flavour. With Julie standing next to Andrea, I could see the contrast between them. Julie is much more engaged, speaking to people at the same time, making eye contact easily around the table. Andrea in contrast is staring rigidly with her eyes wide, her movements deliberate and slow. Almost painful to watch, as in you could see the effort behind every motion. But Julie's manner is relaxed. It strikes me because I remember how Julie's movements used to resemble Andrea's and how different she is now. At one point Anna moves down to sit near Andrea and speaks to hear in low, soft voices. I cannot hear what they were saying but Andrea manages to eat. (Day 35, 06/02/2012)

When client members were struggling at meal times, it was often the clients who responded first to support one another rather than staff. Tessa, Anna and Julie supporting Andrea was therefore a common occurrence. Support was fluid and often the person supporting needed support herself during the next meal. Because so many of the clients struggled at meal times, there was a shared solidarity of distress. Though clients could at times be judgemental or even administer peer pressure to insist that clients finish their food, in the main, the clients were understanding of others' difficulties. Moreover, a client could appear fine one moment, and then struggle the next with staying present or eating her food the next. Sudden outburst of emotion, including tears, anxiety or even complete emotional withdrawal accompanied many meals. Whilst meal times did produce negative emotions, these emotions were often negated by the positive emotions of support that some clients received, the sense of moral rightness that came from adhering to the TC's values and feelings of belonging to the group. Moreover, negative emotions could generate solidarity if members continued to share their attention and emotional responses with the group. If a member withdrew, the TC would often work to restore the cohesive feeling amongst members. For instance, Martha reflected upon the clients:

> They are, they have become a lot more flexible and tolerant and uh gentle about um following the meal plan and supporting and helping those people who come in here who really struggle with the eating.

Solidarity therefore was established through drawing members into the community, not isolating them through punitive practices or negative emotions. Even though client members struggled with food, they were able to offer support to each other, thus building emotional entrainment. The negative emotions that often accompanied meal times could therefore be transformed into tolerable, if not positive, emotions that enabled client members to physically eat and interact with one another.

Everyday Rituals: Grocery Shopping

Hawthorne had a weekly shopping trip led by the clients to get food for the community. During a community meeting, it was agreed that one member of staff would join the shopping group. In addition, Hawthorne clients were divided into work groups of two to four members to cover duties such as shopping, cooking and cleaning. Groups rotated each week and clients stayed in their respective groups for their duration in the TC. Therefore, each week a different group of two to four members shopped with a member of staff at the local supermarket. As with all other aspects of community life, the shopping trips were seen by the TC as an opportunity to build life skills through daily living. The actual experience of food shopping varied and sometimes included interactions that broke down into arguments.

Below is an excerpt from a shopping trip at Hawthorne before it was agreed that a member of staff would accompany these outings. Three client members, Heather, Daniel and Carl, and I attended. This outing started as difficult. Staff were unable to get the shopping money from their NHS service in the form of notes; instead, the clients would have to pay for the shopping with coins. The staff were angry at the service as the clients felt that shopping with coins would make them stand out as mental health patients. After initialling refusing to go shopping, the shopping group agreed to go. However, once inside the shop, the three of them began arguing immediately about which item to get first on the list, about whether to get the cheapest items and whether to purchase items not on the list:

> Whilst they had carefully planned the meals and all the ingredients they need before setting out, Heather insists that they change around the days they do meals and also what they need. Her voice is very high pitched, loud and breathless. Daniel suddenly stands directly in front of her and tells her to calm down, take deep breaths whilst he demonstrates by inhaling and exhaling slowly and steadily. She nods swiftly and then sails off to look at something. Daniel rolls his eyes.

> Then an argument starts with the vegetables and gets more pronounced in the deli-meat section. The problem is that Carl wants to buy the cheapest of everything. Daniel refuses saying that “they won’t eat it!!”
>
> Section after section they argue. Everything from whether to get eggs (“We have a load of eggs” Daniel and Carl practically shout. “Yeah! But they are all getting used today, aren’t they?!” retorts Heather in an equally loud voice) to what type of bread, what type of pineapple slices, whether milk is really needed, etc. The arguments continue about cheapest versus quality.
>
> The last big argument is over sausages. Heather wants to get veggie sausages to have on hand because often a non-meat option is not available for her (a vegetarian). But it’s not on the list, as both Carl and Daniel tell her. Plus it would look like she got something just for her. So she suggests getting meat sausages as well. But it’s not on the list. This goes on for about five minutes, all three of them speaking in raised voices.
>
> Then Carl mutters to me about how he “fuckin’ ain’t doing this again” meaning the shopping and that he is really irritated about getting something not on the list.
>
> When we are finished paying with our coins, we head out the doors and there is yet another argument about whether to hand carry the bags to the car or return the cart in the car park. Daniel who is pushing the cart opts for the latter. (Hawthorne, Day 2, 21/05/2013)

Throughout fieldwork, I was interested in how disagreements within the community, particularly between client members, were addressed in the moment and then interpreted by others in the community. In this case, I watched how three clients would come together, argue, break apart but come back together again. Daniel, Heather and Carl remained emotionally in sync with one another, with Daniel even stopping the ritual to help Heather relax her breathing, and at each step in the argument, the three of them were matched in their tone, pace and style of speaking. Their sense of rhythm was *agitato*, yet they remained together throughout the trip. Once we returned to the community, the shopping trip was discussed during the afternoon meeting and members were able to express what they found stressful or difficult. Various staff and client members provided feedback as to how it could have been handled differently. For instance, though we were unaccompanied by a member staff on this outing, the TC later agreed to have a member of staff present on future shopping trips to enable a richer reflection and discussion with the community as a whole.

Arguments and disagreements, such as with shopping trip, were often allowed to manifest in order for the community to talk about them all together during a community meeting. During his interview, Brian from Hawthorne reflected:

> I've seen a lot of arguments (slight laugh) in my time here. A lot of arguments. People walking out, people almost like come to fist fights, throwing stuff, yeah, I've seen that a lot.

As his comment illustrates, social situations in the TCs could generate strong negative emotions. The role of negative emotions is crucial within TCs. TCs perhaps differ from other social groups in that negative emotions have an explicit role in the community. As Matthew, clinical psychologist at Powell explained, 'When you start working on the past, it starts uncannily to play out in the present in the community'. This interplay between past and present then formed part of the group therapy. As such, negative emotions were encouraged to surface and play out during interactions so that they could be explored as a community. However, the support, and the coming together of community members, to discuss and work through difficulties, often balanced the presence of negative emotions. Remaining entrained together, and discussing the difficulties as the shopping group did upon their return to the community, enabled the sense of solidarity to remain between members. Moreover, in terms of personal change, negative emotions could also prompt reflection upon clients' own behaviours. As Mary reflected:

> Seeing that angry person push everybody away and stomp around, […] it made me realise that when I'm angry, it makes you very hard to approach.

Thus, the expression of negative emotions was often a motivator for community members to draw together and offer support through discussion, rather than to isolate. Both conversations of support and disagreements between community members can therefore occur in successful rituals if group solidarity remains intact.

The Importance of Interaction Rituals

TCs value all forms of social encounters in communities as potentially therapeutic. Clients, especially in a TC setting, spend large components of their time outside of structured therapy. However, at both TCs, staff and clients struggled to articulate how these times contributed to the process of change. Given the current, and understandable, emphasis on outcomes and clinical effectiveness, it appears that everyday encounters are not fully acknowledged, reflected upon and conceptualised as a component of therapy. Therefore, the application of social science theory and method can illuminate a significant, yet little understood, area of mental health practice. I would argue that the time spent outside of the structured therapy groups was clearly important for building trust, working through misunderstandings and disagreements, and getting to know others. In both communities, clients would receive feedback, compliments and would push each other and be pushed back through daily conversations with one another and staff members. This type of support was deeply valued by clients from Powell and Hawthorne, as they stated the positive benefit of being in the community, including comments such as:

Lori (Powell graduate group member): I don't think I'd be here, honestly, if I didn't come here. So yeah, it's a cliché, you know, changed my life, but it did, it did. Saved my life.

Amanda (Powell graduate group member): Am I living a better life than I had before here? Damn right I am! I was on a deprivation of liberty, I couldn't go for a pee without somebody being stood outside of the door, and now I'm living in a [independent] flat, I have four hours of support a day but that's worked around where *I* believe it works, um and I've got my freedom.

Brian (Hawthorne): If I didn't get referred here I could've ended up killing myself and it not working. So literally this place kind of saved my life.

It must be acknowledged however that TCs are not alone in this tendency to underestimate the impact of the everyday. For example, Berwick (2013) argues that healthcare in general has become too outcome focused at the expense of everyday processes. I would add minimising the role of times outside of structured therapy risks undervaluing smaller but significant changes. A micro-sociological focus on the importance of everyday interactions therefore has particular salience for mental health settings. Moreover, a focus on the big outcomes, such as significant reduction in self-harm or disassociation, may lead to some clients feeling that they are not changing according to others' expectations. This occurred at Powell whereby staff felt that one client in particular was not changing. The client herself reasserted their statement but went on to identify areas of change in her interview with me. Applying a sociological perspective to therapeutic practice enables a clear analysis of the social mechanisms and importance of times outside of therapy. Understanding the specific role that everyday social interactions play in facilitating change may enable clients and staff to value the emotional changes that clients make, such as increased feelings of confidence and self-acceptance.

Everyday IRs such as meal times and grocery shopping had the potential to generate feelings of solidarity and belonging. The role of emotions is closely linked with solidarity but, like grocery shopping at Hawthorne, many of the rituals in the TC produced strong and often negative emotions. TCs absorb the negative emotional energy and, through solidarity, translate these feelings into positive emotional energy of belonging and inclusivity. As Matthew, clinical psychologist from Powell, said acceptance, which includes solidarity with others, forms a part of the 'treatment' within TCs. That acceptance occurs *through* negative emotions suggests that negative emotional energy plays a significant role during the process of change. Furthermore, it is significant that these instances occurred in everyday moments outside of structured therapy.

In IR theory, emotions play one of the most central roles (Collins 2004). Along with shared attention, members share a common mood (positive or negative) that in turn produces individual emotional energy, which is akin to Durkheim's (1912/2001) 'collective effervescence' (Collins 2004; 2014). Successful rituals will result in positive emotional energy, such as confidence and enthusiasm, whereas failed rituals will leave individuals feeling flat (Collins 2004, 2014). For Collins (2004: 9), emotional energy is pleasurable and 'highly rewarding'. Collins (2004) does distinguish between emotions such as shame and anger that are transient and emotions that are sustained over time as emotional energy. Nonetheless, defining emotional energy as a pleasurable emotional feeling may seem to limit the role of negative emotions within interactions. Instead, it may be more helpful to expand the definition of emotional energy to include how negative emotions, such as those experienced in TCs, still build positive emotional energy and, ultimately, contribute towards positive personal change.

When all members in the TC participated in everyday interactions, they had the opportunity to gain solidarity with one another as they worked towards an explicit goal of personal change. If solidarity and entrainment were consistently maintained, and quickly restored when broken, then members would tolerate the presence of highly negative emotions. However, I would disagree that successful rituals lead to feelings of enthusiasm, as I did not observe feelings of enthusiasm, nor did any client report feeling enthusiastic throughout my time with either community. Rather, the solidarity clients experienced enabled them to tolerate negative emotions within the TC. Therefore, clarifying the role of negative emotions to explain *how* negative emotional energy can be transferred into positive emotional energy of confidence would strengthen IRC theory by allowing difficult and intensely negative emotions to exist within rituals and be transformed into positive feelings through inclusivity and solidarity. In other words, positive emotional energy can provide a continuous sense of trust and belonging that enables individuals to engage in emotionally difficult encounters, such as the interactions within a TC.

Conclusion

There are two main contributions of this research for TCs, IR theory and social scientists. Firstly, this chapter addresses the gap in understanding how informal and everyday social encounters are used as a mechanism of change within TCs. Using a sociological theory and method explains the mechanisms at work during times outside of structured therapy and highlights the importance of these times for generating therapeutic change. Secondly, IR theory has not been applied widely to the field of mental health. The study therefore informs social theory by examining the tensions and some limitations of using IRC theory within a mental health context. It suggests clarifying how negative emotions can generate positive feelings of inclusion and solidarity and can promote positive change. This chapter is relevant for identifying how everyday encounters contain complex social mechanisms that can significantly impact upon individuals.

TCs have long acknowledged that times outside of structured therapy are important for facilitating personal change (Jones 1968; Main 1977; Haigh 2013). However, this 'little understood process' of social learning (Jones 1968: 70) has remained underdeveloped in terms of its importance in facilitating personal change. I argue that what occurs outside of therapy can be explained through an analysis of their social mechanisms. Everyday social encounters are vital opportunities for client members to deconstruct and reconstruct their sense of self, to learn to belong to one another and the TC, to change their expectations of social situations and experience transformative change. Equally, an understanding of times outside of therapy provides a potential opportunity for those within TCs to reflect upon some of the more problematic, inconsistent and contradictory aspects of life in community, especially in relation to power dynamics.

Additionally, this research demonstrates the important interplay between social theory and mental health practice. Both inform, critique and expand the other to build a stronger and more robust understanding of social phenomena such as therapeutic change. Further micro-sociological research exploring rituals in other mental health environments may be especially beneficial in understanding the social processes at work, particularly with individuals experiencing acute emotional and mental distress.

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4

The Dementia Experience: Sociological Observations on the Construction of Cognition in Care Homes

Kezia Scales

Introduction

Dementia is a priority mental health issue according to the World Health Organization (2008). More than 46 million people currently live with dementia worldwide, and this number is expected to increase to 131.5 million by 2050 (ADI 2015). Dementia is particularly prevalent in care homes,[1] affecting up to 80 % of residents (Prince et al. 2013); indeed, dementia has been identified as the strongest determinant of entry into institutional long-term care for those aged 65 and over (Alzheimer's Society 2007; Luppa et al. 2010).

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[1] In this chapter, the term "care home" will be used to denote residential long-term care facilities (with or without specialized dementia care units) that provide around-the-clock social care, such as washing, dressing, meals, and toilet care, along with qualified nursing care. In the United States, the terms "skilled nursing facility" and "nursing home" are commonly used instead, and various other terms are used internationally. "Resident" will be used here to describe individuals who live in care homes.

K. Scales (✉)
Center for the Study of Aging and Human Development and School of Nursing, Duke University, Durham, NC, USA
e-mail: kezia.scales@duke.edu

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Drawing on ethnographic research from two care homes, this chapter challenges the assumed correspondence between the *diagnosis* of dementia and the *experience* of dementia for care home residents, using individual stories to illustrate the contextual and relational processes which produce particular "dementia experiences". The analysis is guided by the theory of institutional logics, which helps to highlight the "situated identities, goals, and action schemas for decision making, sense making, and mobilization" (Thornton 2015) that comprise these processes and their outcomes.

The chapter begins by describing the historical emergence and evolution of dementia (and Alzheimer's disease in particular) as a category of mental ill health, with specific attention to the ongoing debate about disease pathology versus "normal aging". The increasing specificity of the *biomedical* understanding of dementia is then contrasted against *biopsychosocial* approaches, which consider dementia in light of "personhood", understood to transcend cognitive function alone. These approaches are discussed in the context of care homes in particular, which are "total institutions" (Goffman 1961) where maintaining personhood is especially challenging but nonetheless important. After describing the theoretical orientation and methodology of the research, the chapter presents and discusses two divergent "dementia experiences" to illustrate how particular logics and associated practices can produce different observed experiences for care home residents, regardless of their particular diagnosis.

The social construction of dementia is certainly not a new idea. Thirty years ago, for example, Gubrium (1986) used ethnographic methods to study how caregiving for persons with Alzheimer's disease is located within broader cultural understandings of aging and senility; he observed, for example, that "Alzheimer's disease" provided a unifying but reductive label which was used to explain diverse and often contradictory aspects of individuals' personalities and behaviours. By revisiting these ideas in light of recent scientific advances, this chapter serves to update our understanding of how diagnosis and definitions of dementia interact with context and practices to produce more or less "demented" outcomes. The chapter concludes by discussing the implications of this approach for both the provision of mental health care and the development of social theory.

A Brief History of Dementia

“Dementia” describes a number of neurological disorders with different underlying pathologies that cause progressive impairment in the cognitive domains of learning and memory, attention, executive function, language and communication, perceptual motor function, and social cognition. Types or causes of dementia include Alzheimer’s disease, vascular dementia, frontotemporal dementia, dementia with Lewy bodies, Parkinson’s disease, Huntington’s disease, Pick’s disease, and Creutzfeldt-Jakob disease. Predominantly affecting older people, dementia serves as a leading cause of disability, dependence, and institutionalization (Prince et al. 2013, Alzheimer’s Society 2007).

Given the prevalence and impact of dementia, it is no wonder that it has been declared a priority mental health issue by the World Health Organization (2008). Although this designation reflects an invigorated research and treatment agenda, dementia itself is not new (as well described by Berchtold and Cotman 1998, from whose work the following synopsis has been distilled). In the seventh century BC, Pythagoras described the last stages of the life cycle as the *senium*, or “old age”, characterized by decline of physical and mental capacity and return to “the imbecility of the first epoch of the infancy”. Centuries later, Plato and his student Aristotle echoed this correspondence between old age and mental failure; Aristotle wrote that among older people “there is not much left of the acumen of the mind which helped them in their youth, not the faculties which served the intellect, and which some call judgement, imagination, power of reasoning and memory”. Later still, the Roman physician Galen categorized *morosis*, or dementia, as a distinct mental disease, but aligned it with the “inevitable infection” of older age. In short, for many centuries, old age and cognitive impairment were considered coterminous, with implications for the present-day positioning of older people with and without dementia diagnoses (Holstein 2000; Ballenger 2000; Whitehouse and Maurer 2000).

However, a dramatic shift in the understanding of dementia occurred in the early twentieth century. The shift was precipitated by Alois Alzheimer’s identification of a new “disease” as presented by Auguste D., a 51-year-old woman admitted to the Municipal Asylum of Frankfurt with symptoms including memory loss, confusion, anxiety, suspicion, and behavioural problems. Two factors distinguished her case: first, her relatively young age, and second, thanks to new developments in histopathological techniques, the discovery on autopsy of neurofibrillary tangles in her brain, along with the neuritic plaques that had already been associated with dementia. This discovery, named by Emil Kraepelin in the following edition of his authoritative textbook on clinical psychiatry, as "Alzheimer's disease" (AD), served to distinguish "presenile" AD from aging-related dementia.

This distinction between presenile and senile dementia proved difficult to maintain, however, with increasing evidence that the hallmark 'plaques and tangles' of AD did not correspond consistently to age or disease severity. Indeed, the plaques and tangles pathology is observed to some extent in the majority of older people, including many have not manifested clinical symptoms of dementia, and also in patients with other, non-senile clinical conditions (Berchtold and Cotman 1998; Ballenger 2000). In the 1970s, therefore, the age criterion for AD was dropped, leading to a sharp increase in the diagnosis rates; now, AD is considered to account for over 80 % of dementia cases worldwide (Kumar and Singh 2015), and is broadly feared as the catalyst of inevitable cognitive decline and disability in older age.

In recent decades, in the context of rapid population aging and associated increases in the prevalence and impact of chronic, age-related conditions, research on the diagnosis and treatment of dementia has significantly intensified. This has led to the identification of a number of genetic and clinical biomarkers of dementia (Boenink et al. 2011) and several treatment options, although these options are still palliative rather than curative, associated with modest improvement at best, and largely beneficial within the first few months of administration only (Casey et al. 2010). Reflecting the increasing specificity of the biomedical understanding of AD and other dementias, the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5®; APA 2013) distinguishes minor from major neurocognitive disorder for the first time; previously, minor or early-stage dementia would not have been considered possible to diagnose with sufficient precision to warrant a separate entry.

Significant benefits accrue from earlier and more accurate diagnosis of dementia (Dubois et al. 2014), including accelerated treatment, improved advance care planning, and, potentially, reduced age-related stigma, as memory problems and other symptoms of cognitive impairment are attributable to disease rather than personal failure or incompetence (Bartlett and O'Connor 2010; Boenink et al. 2011). However, an absolute focus on identifying and measuring the signs and symptoms of disease risks "biological reductionism" (Ballenger 2000), whereby an individual is defined and treated exclusively in terms of their dementia diagnosis—or *assumed* diagnosis, as shown below. Challenges to biological reductionism in dementia come from a number of fronts, but will be discussed here under the umbrella of "personhood".

Personhood in Dementia

In the liberal tradition, an individual's personhood, which is essentially their value as a human being, derives from their claim to individual rationality and autonomy: *I think, therefore I am*. In this "hypercognitive" (Post 2000) framework, persons with dementia risk losing the claim to personhood as their disease progresses and cognitive deficits accrue. Over time, they become positioned not as autonomous persons but as dependent bodies requiring management and care (Sabat 2001; Innes 2002) or, worse, as "empty shells" (Bryden 2005) enduring a "living death" (Woods 1989).

By contrast, proponents of personhood in dementia argue that personhood derives from more than the discrete cognitive functions that are measured by tests such as the Mini-Mental Status Exam (Folstein et al. 1975) or identified as darkened areas on a PET scan. As Sabat (2001) argues: "Persons cannot be understood simply as being the sum total of an arbitrary list of measured cognitive functions any more than they can be understood as being simply the sum of certain anatomical parts, chemical components, or neuropsychological mechanisms and events". Instead, according to this approach, personhood derives from the relational, emotional, embodied, and interconnected ways that each person occupies and navigates their particular social world.

One of the leaders of the "personhood movement" (Leibing 2006) in dementia was social psychologist Tom Kitwood (1997), who defined personhood as "a standing or status bestowed upon one human being, by others, in the context of relationship and social being". Challenging the "standard paradigm"—the biomedical approach which frames dementia as a direct, inevitable, and irrevocable outcome of neuropathological changes—Kitwood suggested that each individual's experience of dementia is produced through the dialectical interaction of neuropathology and social psychology. Therefore, he argued, personhood is not inevitably lost as the disease progresses; but it *can be* and frequently *is* undermined, more or less deliberately, by malignant practices within the individual's environment, such as infantilization, stigmatization, and objectification. Conversely, personhood can be supported and maintained through positive psychosocial practices of "recognition, respect, and trust" (Kitwood 1997). This focus on the enabling/disabling elements of the psychosocial environment resonates with the social model of disability, which posits that unsupportive situations and conditions, rather than impairment in and of itself, produce disabled experiences.

The following excerpt from Alzheimer's case notes (cited in Maurer et al. 1997) illustrates how the "personhood" approach can enhance understanding of an individual with dementia:

Alzheimer: *What did I show you?*
Auguste D.: *I don't know, I don't know.*
Alzheimer: *It's difficult, isn't it?*
Auguste D.: *So anxious, so anxious.*
Alzheimer: *[I show her three fingers.] How many fingers?*
Auguste D.: *Three.*
Alzheimer: *Are you still anxious?*
Auguste D.: *Yes.*

In this session, Alzheimer repeatedly attempted to plumb the depths of Auguste D.'s memory loss and confusion through "reality orienting" questions (Spector et al. 2000). The anxiety that she exhibited may be interpreted, through the biomedical lens, as symptomatic of her disease, but may also be understood as a reaction to her social surroundings;

specifically, removed from the context or relationships that might have protected her sense of identity or self-worth, she may have been particularly destabilized by the repeated questions that she was unable to answer. In other words, the very questions that were designed to measure her condition may have exacerbated her "symptoms".

Indeed, the personhood approach suggests that many "behavioural and psychological symptoms of dementia" (BPSD)—which are estimated to affect up to 90 % of persons with dementia (Cerejeira et al. 2012) and considered to be one of the main triggers for admission into institutional care (Freer and Badrakalimuthu 2011)—should instead be interpreted in context as meaningful expressions of needs, preferences, and/or experiences (Osborne et al. 2010; Stokes 2008; Kovach et al. 2005). When a person with dementia repeatedly tries to stand up and walk, for example, this may be labelled as "wandering" within the biomedical paradigm. Alternatively, the action may be interpreted as signifying a particular intention (such as the intention to disengage from a given social situation); the difference, when compared to someone without dementia, is not a difference of intention but of justification, as the person cannot articulate their reasons or rationale. Failure to address the underlying intention or "unmet need", according to this argument, may intensify the action which is thereby, in a self-fulfilling cycle, even more likely to be interpreted as "abnormal" or "pathological". Problematically, these aggravated "behaviours" are then often managed with antipsychotic medications, despite the lack of evidence for their effectiveness and increased risks of adverse outcomes among older people (Banerjee 2009; Sink et al. 2005).

The idea that personhood can be preserved in dementia, which shifts the emphasis from (aspirational) "cure" to (ongoing) "care", has been captured and promoted as "person-centred care", which has been operationalized in different care models (e.g., Eden Alternative 2014) and quality improvement tools (Chenoweth et al. 2009; Edvardsson and Innes 2010) and inscribed in numerous national dementia strategies and other policy and practice guidance. The NICE/SCIE (2006) clinical guideline on dementia care, for example, specifies the following principles underlying person-centred care: the human value of those with dementia, regardless of age or level of impairment; the individuality, unique personality, and life history of those with dementia; the perspective of persons with dementia; and the potential for relationships and interactions with others to promote well-being. Underlying various person-centred approaches is the shared assumption that "even among those people with advanced dementia, there is still potential to enhance or promote mental health rather than just treating or managing the symptoms of mental illness" (Milne and Dening 2011).

In conclusion, the personhood approach considers the "dementia experience" in biopsychosocial terms, highlighting the ways that persons with dementia can maintain dignity, value, and meaningful social roles, relationships, and activities in supportive, enabling environments. This has particular ramifications for care homes, where up to 80 % of residents have some degree of cognitive impairment (Prince et al. 2013).

Dementia and Personhood in Care Homes

As well as high levels of cognitive impairment, care home residents often have complex physical health needs, and most require extensive assistance with activities of daily living (ADLs). The resident case mix in care homes is increasingly frail, dependent, and cognitively impaired, as people remain longer in the community and/or are discharged from hospital "quicker and sicker". Overall, approximately 291,000 older people live in care homes in England and Wales (ONS 2014), and 1.4 million residents live in nursing homes in the United States (CDC 2015).

Preserving personhood can be particularly challenging in care homes, understood as "total institutions" (Goffman 1961) which displace individuals from the socio-material surroundings that previously preserved and reflected their history, identity, and social personae. Hyde and colleagues (2014) describe the depersonalizing process of care home admission as "colonization", Goffman (1961) called it "mortification": the process by which individuals are required to shed aspects of their individuality and agency as they adopt the new and restricted role of "resident". Importantly, failure to fulfil the expectations of this resident role—whether through active resistance or confusion and lack of understanding—may be interpreted as symptomatic of disease, at best, or deliberate "intransigence"

(Goffman 1961) at worst. Thus, we can see that the personhood of those with dementia *and without* may be equally threatened in the traditional total institution.

In recent decades, proponents of person-centred care in care homes (known, more broadly, as “culture change” (Koren 2010) in the American long-term care context) have attempted to transform care homes into more homelike settings that are organized around individuals’ preferences and goals rather than organizational tasks and routines. These efforts have certainly mitigated the mortifying effects of care home life and led to improved outcomes, although changes have been limited by the challenge of operationalizing and implementing the abstract person-centred principles of human value and enduring personhood (Chenoweth et al. 2009; Shier et al. 2014; Bone et al. 2010; Miller et al. 2014). Part of the challenge is our limited understanding of the mechanisms by which personhood is supported or undermined in particular environments, beyond individual carers’ positive or negative “person work” (Kitwood 1997). The study described in the next section aimed to address this gap by describing how person-centred care translates into practice in care homes, using neo-institutional theory to orient observations and analysis towards relevant practices rather than individual actors. This approach, it will be shown, helped reveal how different experiences of dementia are produced within specific social settings, against the broader and evolving backdrop of biomedical specification of the disease.

Ethnographic Explorations of Practice

The doctoral study of knowledge translation about person-centred care from which this chapter draws was conducted in two care homes: Richardson’s, located in the northeast United States, and Forest Lodge, England.[2] The specific aims of the study were to describe how and by

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[2] This research was supported by a doctoral studentship from the Collaboration for Leadership in Applied Health Research and Care of Nottinghamshire, Derbyshire, and Lincolnshire (funded by the National Institute for Health Research). The research was granted ethical approval by the School of Sociology and Social Policy at the University of Nottingham in accordance with the University of Nottingham’s Code of Research Conduct and Research Ethics. Through separate

what means direct-care staff develop their understanding of person-centred care; to identify and examine the personal and contextual factors which affect knowledge translation among these staff; and to analyse what could be learned from their practices about the operationalization of person-centred care.

Knowledge translation refers to the complex and contextualized ways that practitioners acquire, synthesize, adapt, and apply or discard (rather than merely "apply") new knowledge or evidence in practice (Nutley et al. 2003; Glasgow and Emmons 2007). In order to highlight and understand the translation of knowledge about person-centred care into practice, data collection and analysis for this study was guided by "practice theory". Practice theory encompasses a variety of approaches that consider "practices" as the unit of analysis in social theorizing, rather than individuals or structures (Schatzki 2005); in other words, practice theories assume that the social world is (re)produced through actors' embodied, material, contextualized, and interconnected practices. The study was framed within Bourdieu's (1990) theory of the "logic of practice" in particular, which suggests that there is "reason immanent in practices" which derives from the interplay between each individual's internalized, socialized disposition (their *habitus*), specific *fields* of practice, and the various forms of *capital*, or assets, that individuals leverage in their struggle for position and authority within those fields.

To further understand the social forces which inform a given logic of practice, this study drew on the theory of "institutional logics" (Thornton and Ocasio 2008). Deriving from neo-institutional theory, this theory aims to describe the practices that emerge, often in contradiction, from the main institutions of society; in modern Western society, these institutions include the family, state bureaucracy, and capitalism. According to this theory, each institution has a central logic that "guides its organizing principles and provides social actors with vocabularies of motive and a sense of self" (Friedland and Alford 1991). Aligning with Bourdieu's logic of practice, institutional logics theory assumes a recursive relationship

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application processes, it was also approved by the research governance committee of Forest Lodge, the UK case study, and the Social and Behavioural Sciences Institutional Review Board at the State University of New York at Buffalo. Pseudonyms have been used to protect anonymity.

between individual actions and social structures, rather than privileging one over the other; that is, the "actor's practical experience is a source and a building block of the institutional orders and logics, just as institutional orders and logics have some hand in shaping the minds of individuals and the behaviour of organizations through both symbolic and material mechanisms" (Thornton 2015). Importantly, the theory holds that in any given field, several different institutional logics may be discernible, generating different practices *or* different meanings for the same practices. Considering these logics helped identify a key source of sense-making and action within the "field" of the two care homes under study.

Ethnography was selected as the best method for gathering data on the contextualized practices of direct care and their associated logics. Broadly, ethnography is a naturalistic method of studying the "situated rationality of action" (Murphy and Dingwall 2007; Foley 2002; Van Maanen 2006; Zussman 2004), which entails prolonged periods of fieldwork using different research techniques, including participant observation, in-depth interviews, and textual analysis (Agar 1996; Savage 2000; Wolcott 1999). By including two separate cases (Yin 2009), the intention was not to generalize but to identify and interrogate similarities and differences across the two sites, including with reference to the interconnections between national and regional policies and local practices (Flyvbjerg 2006).

I began fieldwork in August 2011 by completing the 100-hour certification programme which is required for certified nursing assistants (CNAs) in New York State, then conducted a total of approximately 8 months of participant observation in the two care homes, working about three shifts per week and writing up extensive field notes at the end of each shift. Towards the end of the fieldwork period at each site, I also conducted in-depth interviews with care assistants, nurses, and members of management. Alongside the participant observation and interviews, I reviewed a range of published materials and grey literature on person-centred care and care homes—including marketing and training documents, newsletters, and posted materials from each facility, as well as academic and policy documents—to gain a broader perspective on the practice context.

When fieldwork concluded, I conducted thematic analysis (Braun and Clarke 2006) of the collated field notes and interview transcripts to build an understanding of how person-centred care translated into practice at the frontlines of care delivery at each care home. The secondary analysis conducted for this chapter focuses, in particular, on how institutional logics informed the logic of practice related to personhood and dementia in the two settings.

The Practice Settings: Forest Lodge and Richardson's

Forest Lodge and Richardson's were both medium-sized facilities located in small towns which served predominantly white and middle-class individuals from the surrounding area. Both were privately owned, although Richardson's was a family business, while Forest Lodge was owned by a corporate provider. Both were highly rated facilities which had explicitly embraced the principles of person-centred care.

Forest Lodge

Forest Lodge was a 65-bed[3] skilled nursing and residential care facility located in the leafy suburbs of a small town in central England. After coming to the brink of closure in the previous decade, the facility had been bought and transformed by a large corporate care home provider. Forest Lodge had a secure dementia unit (Vintage Vale) which will be the focus of the discussion here; there was also an independent living unit and a skilled nursing unit, where many of the residents had dementia as well as more complex healthcare needs.

Vintage Vale itself was laid out in a T-shape, with a central hallway of bedrooms splitting off to the left and right. To the left were bedrooms, a sluice room, and a toilet; to the right were more bedrooms and two large common rooms. All bedrooms were single occupancy and most had ensuite toilets. One half of the first common room was furnished as

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[3] Bed numbers and certain other identifying details have been approximated or amended for the purposes of anonymity.

a lounge, while the other half was given over to large dining tables and a corner kitchen. Beyond was the second common area which had more seating, a television, and double doors to an enclosed garden; these doors were often propped open in warm weather. The hallways and lounge areas contained quite a lot of "stuff", including musical instruments; pegs of scarves, bags, and hats; shelves of games, puzzles, and "rummage boxes"; dolls, stuffed animals, and their furnishings; a faux storefront stocked with vintage products; and an old-fashioned railway bench and bus stop.

The parent company of Forest Lodge was well recognized for the person-centred dementia care model delivered through their Vintage Vale communities. The key elements of the model, which resonate with the above discussion of personhood and person-centred care, included providing an environment adapted to the needs and comprehension of each person with dementia; recognizing each individual's history; providing meaningful activities and opportunities; and promoting freedom rather than control. The company had worked with a dementia expert to develop a training package around these person-centred elements, the main aim of which was to teach staff to "get to know" residents and thereby learn how to recognize and address the underlying reasons for their words and actions.

Richardson's

A family-owned skilled nursing facility, Richardson's was located in the suburban environs of an attractive, relatively affluent small town. The 80-bed facility was laid out in two wings with an added rehabilitation unit. Between the two wings was a large, bright room called the "lounge"; this room included a sitting area, a dining room which connected to the kitchen, and a wall of windows overlooking the small central courtyard. Almost all bedrooms were double occupancy; privacy curtains could be pulled around each bed when giving personal care. Each room shared a small ensuite toilet with the adjacent bedroom.

The administrator at Richardson's recalled first hearing about the Eden Alternative, which is a leading model for person-centred care in the United States and internationally, more than a decade earlier, when several staff members had attended a training event. Subsequently, within the past several years, almost half the staff from Richardson's had been sent on the Eden 3-day training course (which amounted to approximately 80 people from across departments). Person-centred changes which had been implemented included the adoption of a facility dog, the introduction of restaurant-style dining with increased meal choices, and the use of consistent assignment to facilitate relationship building between direct-care staff and residents. The next step for implementing person-centred care, the administrator suggested, would be to replace the traditional, institutional corridors with smaller, homelike units; however, funding for such renovations was neither available nor anticipated.

Results: Institutional Logics of Institutional Care

From the literature and the ethnographic findings, three "institutional logics" were identified as most salient in care homes; these can be described as home, medical institution, and business logics. The logic of the *home*, which aligns closely with the logic of person-centred care, is associated with the private sphere; familial relationships; independence and freedom from bureaucratic control; and norms of care and reciprocity. Care homes with skilled nursing are also *medical institutions*, however, and therefore associated with norms and practices related to physical health and, perhaps secondarily, mental health; bodily comfort and cleanliness; and, also, consistent documentation and quality control. Although these medical practices are certainly not antithetical to the home logic, neither do they entirely correspond to the latter's emphasis on flexible, individualized patterns of daily life and the development of meaningful, sustained, and reciprocal personal relationships. An important difference between these two, broadly speaking, is that the medical logic is informed by the medical model of disability, with the biological basis of infirmity/impairment as the point of departure, whereas the social model of disability, which focuses on the enabling or disabling effects of the individual's surroundings, has more salience in the home (Williams and Busby 2000).

Finally, whether public, private, or non-profit, nursing homes also operate according to a *business* logic—influenced by the logics of the state and market—in order to provide an acceptable standard of service using the resources available and according to external accountability mechanisms. Managing the workforce to deliver this service with optimum efficiency and effectiveness is paramount, and the impact for workers is an emphasis on fulfilling job descriptions, demonstrating competence in recognized job skills, meeting targets, and so on.

Broadly speaking, direct-care staff at both Richardson's and Forest Lodge shared a similar responsibility for reconciling, through their "sayings and doings" (Nicolini 2011), the different priorities that each logic entailed, for example, with regards to balancing autonomy against safety, medical needs against individual choices, and group or organizational needs against individual preferences. However, notable differences were observed across the two care settings. In the following sections, two individual and highly abridged stories are described to illustrate the different "dementia experiences" produced through different instantiations of institutional logics. It must be emphasized that, because this research study focused on staff rather than residents, these stories are neither clinically precise nor subjectively informed; they are invoked exclusively to highlight logics and practices rather than individual experiences or outcomes.

Story 1: Promoting Personhood

The first example concerns Nell, who lived on Vintage Vale, the secure dementia unit at Forest Lodge. I met Nell on my first afternoon, when I sat down next to her at one of the tables in the dining area. A small woman in her eighties, neatly dressed and styled, she was warm and responsive, chatting graciously as if we had just been introduced at a cocktail party.

Another care assistant (Trisha) soon joined us in that first conversation. She told me that Nell liked to play the piano, then prompted her to play for us:

> *So the three of us, along with another resident, walked down the hallway to the piano. Nell sat on the bench and waited while Trisha switched the piano on at the keyboard and at the wall, then said, "what shall I play?" Then she played Danny Boy and a couple of others, surprisingly well though demurring afterward about how many wrong notes she'd hit. Trisha and the other resident sang along when they could.*[4]

I ended this field note by reflecting that the scene felt "*so natural and not forced*", in other words not contrived for the benefit of a visitor like myself. Indeed, over the following months, I observed Nell playing the piano a number of times, sometimes alone and sometimes with a member of staff.

As I spent time at Forest Lodge, I developed the impression that Nell enjoyed a quiet, comfortable life on Vintage Vale. She had her own, large room with a sitting area and two closets filled with countless coordinating outfits. Her door remained unlocked and she moved about the unit independently and on her own schedule. Although it was often unclear what "reality" she was perceiving—in terms of time, place, and players—it was usually possible to join her on common ground, as illustrated by the following field note:

> *Nell walked in [to the lounge] very soon, carrying her handbag and papers, and came up to me, giving me a hug which made my day. Later she came in with two hats [taken from the pegs in the hallway], one straw sunhat and one dark green velvet cowboy hat with a pattern of stars on – she took a seat and spent quite a long time trying to the two on, one at a time, telling me that the saleslady had said she could bring both of them home to decide between them. The green hat was too large, so she kept putting it on and wobbling her head so that it slipped to the side or down over her eyes – demonstrating that it was too big – but then said a couple of times, "I just can't say no in this hat!" She said*

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[4] Quotation marks in field note excerpts indicate the verbatim wording of research participants; otherwise, the conversations described in field notes have been paraphrased.

> *it wasn't right for a wedding though, because it was black – but then said something about funerals, how she'd been to too many of them, she'd told her father that it was getting her down, that she wasn't going to anymore.*

First, I could join Nell in admiring the hats and "deciding between them". Furthermore, with more personal knowledge about Nell by then, I was able to pick up on and ask her about the allusion to funerals; specifically, I knew that she used to play the organ at the church, which may have explained why she had attended so many funerals. I had gained this "life history" (Mckeown et al. 2010) knowledge through talking to Nell and from the other staff, who engaged with Nell frequently and personally, as described in the following field note:

> *Lidia [the activities manager] said that Nell had had a really interesting life, and that she liked to talk about it – calling her over and inviting her to sit with us and tell us about her life. She started, "well I was prophesied by a woman on the market" – and we all took note … Then for almost the next 45 minutes, until 4 o'clock when it was time for Lidia and I to go, she told us stories, with prompts and questions from Lidia mostly, sometimes from me. Her storytelling was absolutely captivating, funny and full of clever images, and every so often Danielle or Bev [two other care assistants] – who weren't directly involved in the conversation – would interject or react to something she'd said.*

There were some "depersonalizing" moments in this conversation, particularly when Lidia told me, as Nell was still speaking, that her storytelling had been much more linear when she first moved to Vintage Vale than it was now. However, overall, even when her stories failed to link up or her observations did not correspond to our acknowledged "reality", Nell's personhood was maintained on Vintage Vale through her supported engagement in meaningful activities and social relationships.

Story 2: Assuming Impairment

The second example concerns Nell, who arrived as a new admission towards the end of my fieldwork at Richardson's. I first learned about her during "shift report", as the nursing staff shared what they knew about her so far:

> *Melinda [a CNA], standing on the other side of the desk, said "is she a couple of French fries short?" Nancy [a licensed practical nurse] said, "they told me she's 'alert times three*[5] *but oh no, she's not", describing the questions she'd asked about her age, address, etc. which she'd gotten all wrong. "Then she said to me, 'don't ask me any more questions because I can't answer them'", Nancy said, which she said was fair enough, "you're 99". She was happy to let it go. At some point Melinda reaffirmed, "yeah, a couple of French fries short of a Happy Meal!" One of the nurses from the day shift said, "she's going to be a corker" when she settles in, "she can tell you the whole history of [this town]!"*

This exchange suggested that Noreen was constructed as someone with diminished capacity from the moment of admission, regardless of her transfer notes. "*They told me she's alert*", said Nancy, but "*she's not*", since she failed to correctly answer a number of orienting questions. Acknowledgement of Noreen's (intact) local history knowledge failed to disconfirm this assumption of cognitive impairment.

During that first shift, Noreen did seem quite confused. For example, when my CNA partner (Nat) and I took her to use the bathroom, "*she sat on the toilet, wondering and praying aloud in a constant monologue about what we were doing to her and why*". Towards the end of the shift, I wrote:

> *[Noreen's] light was on constantly tonight, and all of us – not just Nat [my partner] and I, but also the other aides – were in and out of her room almost in rotation, reporting each time a different (and often contradictory) request: lights on, lights off, blankets on, blankets off, etc. … One time when I went in to see what she wanted, Noreen asked for glaucoma drops for her eyes. I went to ask Nancy whether she was supposed to (or could) get eye drops, not expecting a positive response, and was surprised when Nancy said yes right away.*

When considering how recently she was admitted, Noreen's confusion and erratic requests appear to reflect her acute anxiety about finding herself in a completely new "home" environment. During that first shift, however, she was generally perceived as exasperating and impossible to please. This appears to have conditioned my own sceptical response to her

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[5] "Alert and oriented times three" means that a person can correctly answer questions about their name, their present location, and the date.

request for glaucoma drops, which I was prepared to dismiss as irrational until, to my "surprise", the nurse confirmed its legitimacy.

Over the next few days, changes were made to Noreen's care which materially limited her autonomy and independence. First, after physical assessment, she was required to wear "hipsters", which are elasticated briefs with pockets on both sides to accommodate hard-plastic hip protectors. Noreen complained extensively about "*these boards*", as she called them, which produced a new level of dependence, as the hipsters were too unwieldy for her to pull on and off unassisted. Second, staff began "parking" Noreen in a wheelchair in the hallway between mealtimes, as described in the following note:

> *I went to check on Noreen who was sitting in her wheelchair by the nurses' station. She was saying in her characteristic non-stop monologue style that she needed the bathroom but no-one was helping her, indicating that she was stuck in the chair, showing me how her feet were up on the pedals so she couldn't get out.*

Although she was not overtly restrained, Noreen was positioned so that she could not get up by herself. She was kept in the wheelchair within view of the staff for safeguarding purposes, ostensibly, since she was considered a "falls risk", but she found this surveillance bewildering since she had previously been living independently at home. Overall, although apparently precipitated by the abrupt change in her social environment and daily routine, Noreen's confusion and distress served to substantiate the initial assessment of her cognitive incapacity and, in turn, her dependent positioning and compromised personhood.

Logics of Dementia and Personhood

These two stories are different in many ways. Nell was a settled resident on a specialized dementia unit in an English care home (Vintage Vale); Noreen was a new admission onto a general skilled nursing unit in a nursing home in the United States (Richardson's). The majority of the residents on Vintage Vale were mobile, even if many needed prompting or direct assistance with activities of daily living; whereas most residents at Richardson's required a much higher level of assistance and therefore represented a "heavier" caseload (in the nursing home vernacular). I have bracketed these differences and many more, both individual and organizational, in order to specifically consider how their different "dementia experiences" were produced. In broad strokes, Nell appeared to maintain her personhood, including her dignity, autonomy, and social engagement, despite her diagnosis of dementia, whereas Noreen's personhood was undermined through the assumption of cognitive impairment (and related practices) on admission, regardless of her case notes.

How might these "dementia experiences", which do not relate directly to dementia diagnoses, be understood through the lens of institutional logics? First, it was evident that the discourses associated with each institutional logic were inconsistently available to the staff at each care home. On Vintage Vale, direct-care staff invoked the language of person-centred care—which maps to the "home" logic and the associated norms of identity, independence, and relationships—with relative confidence, reflecting their shared training and reinforced messaging from their nurse managers. The following comment from Hayley, an experienced carer, exemplifies the type of rationale that I frequently heard from carers on Vintage Vale:

> *I mean I'm learning about person-centred care every single day, just as much as probably everybody else is here. … Put them first, you know, make sure that they're comfortable, make sure that they're living in their home, the way that they want to – they're basically letting us into their home, we have to treat it like it's their home, treat them with respect.*

By contrast, person-centred language was not as clearly available to staff at Richardson's. As one CNA described her understanding of person-centred care after it had been discussed in a recent in-service training:

> *It was useful but it was all different, all these words thrown in instead of just coming out and saying what you're supposed to be saying. … It was kind of confusing.*

This lack of familiarity with the language of person-centred care reflected a broader divide within Richardson's between those on the administrative side, who were very articulate and enthusiastic about person-centred care, and the nursing staff, including floor nurses and CNAs, most of whom had neither received the Eden Alternative training nor attended subsequent monthly "culture change" meetings.

Furthermore, more or less fluency with the language of person-centred care appeared to be associated with fluency of actions related to promoting resident choice, independence, and so on. For example, in her interview Hayley went on to say:

> *[T]he biggest thing is choices, like, taking a tray of food, but if it's fish and it's sausages, take them both on a tray and say "which one would you prefer?" And if they can't speak and they point to that one, then you give them that one and you know they've chosen that one … you haven't just assumed that's what they want. The biggest factor in, in care work is assuming that you – assuming you're doing the best for them when, really, you're just taking away their independence.*

By contrast, the following field note describes how Nat, my CNA partner from Richardson's, characterized with frustration her experience with Noreen on the first shift:

> *She told me several times how difficult [Noreen had] been … [telling me that] she was "in there with her for half an hour last night", trying to get her ready for bed: "you want to let them do it for themselves – but then you put it in front of them and they say, 'what am I supposed to do with this?'".*

Nat's comments suggested that she was familiar with the principle of autonomy, but that she did not have specific language and expertise to translate it into practice. This contrasts with Hayley's comments above about facilitating residents' choice and supporting their independence within the limits of their capacity.

The different use of language was iteratively associated with different care practices across the two sites. On Vintage Vale, a number of practices reflected the logic of home and personhood, including the creation of Memory Books, which were scrapbooks of photos and biographical notes created by carers through conversation with residents and their families; the explicit use of biographical knowledge about residents to tailor communications and interventions; the common practice of knocking on bedroom doors and greeting residents when entering the lounge to acknowledge the space as their home; and the consistent emphasis on choice and independence. For example, when one nurse oriented me to the breakfast routine on Vintage Vale, she described the habits and preferences of each resident in the dining room but, as I wrote in my field notes, "*she said several times, as she gave me guidance about who might have what, 'but ask them, they'll tell you, it's their choice'*". In another instance, when a care assistant showed me how to assist Nell in the shower, I wrote in my field notes that "*she said more than once that 'she can do it', and told me that we should encourage as much independence as possible*".

In contrast to these instantiations of the home logic, the medical logic appeared much more salient at Richardson's. Consistent with the business logic, as well, the emphasis was on maintaining residents' safety and physical well-being, as exemplified by the use of hip protectors and a wheelchair for Noreen, and documenting these practices in fulfilment of regulatory requirements and to avoid potential financial or legal repercussions. These imperatives are illustrated by the following field note about a resident, Oscar, who ate his dinner too slowly one evening:

> *When [the other CNAs and I] were taking residents back to the unit, one male resident who sits by himself still only appeared to be halfway through his meal. Isobel [a nurse] said that we could bring the tray back with him to the unit – "you're not supposed to do that but just say I said you could and it'll be okay. … I don't want to sit out with him here for 12 hours while he finishes". I asked Ilene [a CNA] if it was ever permissible to leave a resident in the dining room on their own, if they are independent, and she said no, because anything could happen, they could choke or (lowering her voice) "have a coronary out here or anything".*

In this situation, according to the home logic, Oscar might have remained in the lounge to finish his meal in his own time. The medical logic, however, suggested that he could not be left "unsupervised" in case of an accident; this logic positioned residents largely in terms of health risks and prioritized the safeguarding responsibilities of staff. Given the pace of practice, staff did not have time to wait with Oscar; therefore, they felt they had to choose between taking his meal away unfinished or allowing him to eat the rest in his bedroom. Thus, although the lounge was comfortable and well appointed, most residents only went there for the relatively brief duration of meals and organized activities, as they were dependent on staff for both transport and supervision. Most residents, like Noreen, spent the time between meals in their rooms or lined up along the corridor on each wing, neither practice facilitating meaningful activity or engagement.

Importantly, but unsurprisingly, the *reconciliation* of different logics appeared critical to the provision of personalizing and personalized care. For example, although the "home" logic appeared to produce a more enabling outcome for Nell than we saw with Noreen, there were also increasing concerns that some residents on Vintage Vale were suffering from an overemphasis on values such as choice and independence, at the expense of consistent medical care. For example, allowing residents to get up in their own time each morning had potentially negative implications for their nutritional intake, medication administration, provision of personal care, and/or night-time sleep patterns. As newer members of the nursing team promoted the medical logic, some of the more seasoned care assistants expressed concerns that their effort and expertise in fulfilling the home logic was under threat. From this tension might arise dementia experiences that look quite different from the sketch developed here. At Richardson's, the medical and business logics aligned to produce an apparently disabling experience for Noreen, but helped ensure her safety during the acutely disorienting and therefore risky admission period. Over time, as she became more integrated into the daily life of the nursing home, we might have seen a better balance of logics in Noreen's treatment, with more positive implications for her psychosocial as well as physical well-being.

Conclusion

This chapter has presented two divergent scenarios of cognition and well-being. The first scenario suggested that, when the disease experience is understood in an intersubjective and situated way, persons with dementia can still experience independence, dignity, social inclusion, and meaningful activity in supportive social conditions. The second scenario, by contrast, suggested that the assumption of cognitive impairment—if based on a narrow definition of capacity that is measured in terms of discrete cognitive functions without attention to psychosocial context, and even in the absence of a specific dementia diagnosis—can lead to the loss of independence and dignity, social exclusion, and inactivity.

The chapter opened with a brief historical overview which showed, in broad strokes, how understanding of dementia has shifted and narrowed over time. Originally and for many centuries, cognitive decline ("senile dementia") was considered an inescapable aspect of aging. From the discovery of Alzheimer's disease in the early twentieth century to the recent developments in screening, diagnosis, and treatment, however, the different forms of dementia have become understood in increasingly precise biomedical terms. The distinction made between minor and major neurocognitive disorder in the newest version of the *DSM-5* is one example of the direction of travel in the science of dementia.

From this contemporary biomedical perspective, the scenarios presented here might be measured and interpreted in terms of the two individuals' disease trajectories and their associated symptomatology. Addressing Noreen's evident distress would require, from this perspective, the administration of medication and/or "non-pharmacological interventions", such as aromatherapy, music therapy, reminiscence therapy, or other therapies (Livingston et al. 2014). Nell, on the other hand, would be seen as relatively stable and requiring minimal intervention; her condition might be summed up as "pleasantly confused" (Tolson et al. 1999). To provide appropriate care for each of these individuals, according to this perspective, care staff should be equipped with sufficient disease-related knowledge to recognize and address the signs and symptoms associated with different types and trajectories of dementia. This chapter has argued, however, that assuming disease pathology as the primary source of distress or stability fails to acknowledge the conditions and practices that may have produced these situated experiences (which relates to the 'unmet needs' approach, e.g. Kovach et al. 2005).

This research was guided by practice theory, which posits that social life is the dynamic product of recurring practices—the "sayings and doings" of everyday life (Nicolini 2011)—which link individuals and structures in an iterative process of "mutual constitution" (Feldman and Orlikowski 2011). In other words, the social order, however fixed or stable it may seem, is continually created by social actors who are always already configured by that social order in which they are embedded. The analysis in this chapter drew particularly on institutional logics theory to help identify the specific rationale—the organizing principles, values, vocabularies, roles, and identities—that might help explain differing "dementia experiences". On Vintage Vale, we saw that the readily accessible logic of home and personhood enabled and validated care practices that promoted choice, independence, and relationship building. These practices appeared to help support Nell's personhood and minimize the potentially disabling effects of cognitive impairment. At Richardson's, the prevailing medical and managerial logics privileged safety over independence (to avoid injury and maintain efficiency), which legitimized practices that exacerbated Noreen's confusion, reinforced her treatment as cognitively impaired, and thereby iteratively produced a more "demented" outcome.

The importance of this theoretical and methodological approach is that it brings attention to the context of care, not just the disease process, without placing "blame" on individual caregivers. Stories of neglect and mistreatment of vulnerable people receiving care are all too familiar; one shocking example was the Winterbourne View care home scandal (Panorama 2011); another was Stafford Hospital (Francis 2013). These stories tend to generate indictment of the "monsters" (Foner 1994) who carry out such appalling practices. The institutional logics perspective, while not exonerating these individuals, draws attention to the logics of practice that constitute particular care contexts and upon which care staff rely for sense-making and action. That is, this approach suggests that poor care does not originate as individual intentions but emerges through the intersecting logics that enable and justify certain practices while foreclosing alternatives. Particular care staff did not deliberately decide to treat Noreen as incompetent; rather, they carried out particular practices which "made sense" (Scales 2014) in that context, but nonetheless produced (and justified) Noreen's dependence and distress. In a similar vein, Burns and colleagues (2013) describe poor treatment practices and outcomes in care homes as "wicked problems" that are intrinsic to the fabric of an institution, arguing that residents and care staff alike are “subjected to and limited by institutional practices restricting the potential to care”.

Attempts to improve care standards and outcomes must therefore take into account their underlying logics, and the tensions and contradictions between those logics. A question that has emerged through this analysis is: To what extent does the dominant logic(s) of practice support or undermine the personhood of individuals in a given setting? This question has relevance well beyond this study, as the discourse of person-centred care—which is based more or less explicitly on the idea that organizations should respond to individual preferences, goals, priorities, and capabilities, rather than vice versa—continues to gain purchase in policy and practice across health and social care domains (as described, for example, in these recent reports from each side of the Atlantic: Health Foundation 2014 and The American Geriatrics Society Expert Panel on Person-Centered Care 2016; the new Care Certificate for health and social care staff in the United Kingdom, as another example, includes person-centred care as one of its 15 competency standards). By considering the logics that inform particular care practices, including those carried out under the banner of person-centred care—logics which are instantiated in policies, regulations, and guidelines *and* in frontline practices—we can better assess to what extent those practices support the personhood of each individual or accomplish other aims related, perhaps, to managerialism or economic rationality. Focusing on the logics which produce certain practices is especially critical, it can be argued, in total institutions (including mental health wards as well as care homes) where individuals are, by the nature of the mortifying/colonizing process described earlier and their own physical and mental impairments, limited in their ability to advocate for themselves and to challenge the logic(s) which frame them as persons, as patients, or as bodies, and as more or less capable, competent, and/or worthy. The implications of this perspective, therefore, extend far beyond the care home environment in which it has proved so illustrative.

As well as highlighting how social scientific research may help understand and improve mental health policy and practice, specifically in dementia care, this chapter has also demonstrated the reciprocal value for social theory. By taking an ethnographic approach guided by practice theory, it was possible in this study to identify and explore the actions and interactions through which social actors at the "frontline" of organizational practices in this setting invoked, reconciled, and enacted different institutional logics. We saw, specifically, how nursing and care staff understood and used different logics in their work, arbitrating between those which contradicted each other. The "micro-foundations" of practice are an underexplored area in institutional theory and research (Thornton 2015; Bjerregaard 2011), a field which has tended to focus on continuity and change at higher levels of the organization and across organizational fields. This study has confirmed the value and importance of examining these institutional micro-foundations, however, by showing how "mundane" or everyday practices can, in aggregate, produce very different experiences and outcomes for individuals. Future observational studies in other mental health settings will be valuable for further developing our understanding of the iterative relationship between institutional logics, their instantiation in daily, frontline care practices, and their outcomes for care providers and recipients.

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5

"The Will's There and the Skill's There": Prison Mental Healthcare

Melanie Jordan

Chapter Overview

This discussion explores some of the data from a social science PhD whose fieldwork took place in a category B, adult male, local and remand prison in England run by Her Majesty's Prison Service (HMPS). Decades ago, in 1984, Jones and Fowles stated, 'The official view in British prisons is still that deprivation of liberty is the punishment—conditions in prison should not add to it. The state of the prisons does not bear this out' (p. 203); the contemporary prison system in England and Wales continues to experience issues (e.g. overcrowding) that affect conditions in the institution. Regarding mental health, Awofeso and Guggisberg (2011) highlight 'prison settings generally worsen the precarious health profiles of incarcerated individuals' (pp. v–vi), and report 'the experience of incarceration, it is widely acknowledged, is likely to exacerbate mental health

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Melanie Jordan (✉)
Assistant Professor in Criminology, School of Sociology and Social Policy,
University of Nottingham, UK
e-mail: melanie.jordan@nottingham.ac.uk

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problems' (p. 150). Mental healthcare is needed in prisons; nevertheless, 'the provision of healthcare services behind bars for these prisoners is not for the faint hearted, but it is uniquely rewarding' (Smith 2010: 33).

This debate analyses National Health Service (NHS) staff experiences of mental healthcare provision in a penal context and debates achievements, problems, and implications for future improvement. To summarise using a staff member narrative: '*The will's there and the skill's there, but …* '—staff are well trained and keen to provide outstanding healthcare but there are barriers impeding this aim. NHS mental healthcare in this prison is split into primary and second levels and patients/prisoners are referred to services according to severity and endurance of mental illness; generally, mental health services in prisons operate according to a principle of equivalence (i.e. care should be equivalent to that which is available in the community). However, the suitability of this principle and the achievement of this principle are both critiqued. For example, arguably the direct application of community mental health services to the prison population is mistaken, as issues of criminality complicate the situation (Steel et al. 2007).

Prison In-reach teams are intended to provide the specialist/secondary mental health services to persons in prison that are provided by community-based mental health teams to the wider population. Unfortunately, In-reach teams have been affected negatively by limited resources, constraints imposed by the prison environment, difficulties in ensuring continuity of care, and wide variations in practice (SCMH 2008). In-reach teams are now often termed 'Secondary Mental Health Teams'; however, the label In-reach occurs often, as participants utilise this term.

Staff in the prison argue mental healthcare is an important topic for research and development because the voices of patients/prisoners themselves are not easily or often heard:

Participant: *So often with services, it's all about the people who deliver the service … especially if the people in need [i.e. the patients/prisoners] do not, or cannot, ask for change.*

Bradby (2009) notes 'how the NHS is somewhat unresponsive to patient needs and changes in clinical practice' (p. 161). Although this may be the case across some parts of the NHS more generally, the participants in this healthcare setting are interested in both highlighting and responding to patient mental health need.

Overall, this work argues that for the NHS staff who acted as interview participants in this study the delivery of healthcare in a prison setting can be understood as an amicable collaborative endeavour where several overarching workplace goals are shared, to good effect, throughout the healthcare centre's staff membership. Two such intersubjective workplace aphorisms are analysed: '*To prevent anyone falling through the net*' and '*The will's there and the skill's there*'. The setting's working environment is explored, including the primary–secondary mental health service boundary. The required staff attributes for prison-based psychiatric work are discussed. Issues that affect the wholly apt provision of healthcare in the prison are narrated as structural and establishment related—and not social or cultural. Experiences of working with mental health patients are presented and analysed. Prisoners are conceptualised as healthcare patients and offender elements receive little attention in transcripts. The nature of penal healthcare is explored; the following themes are raised: primary task, ownership, pride, efficiency, enjoyment, communication, and multidisciplinary teamwork.

Overarching PhD

The title for the full doctoral thesis is *Prison mental health: Context is crucial*. The study devotes attention to social and institutional arrangements that permeate the prison locale and affect mental health and mental healthcare. Myriad issues regarding prison social environment, prison institutional set-up, and specific mental health requirements of patients/prisoners are addressed. The research is characterised as a policy- and practice-orientated exploratory case study and the principal study question is: How could prison mental healthcare be developed? There is a paucity of prison-based mental healthcare studies that assess policy implementation, policy effectiveness, the role of NHS commissioning, and the effectiveness of the provision in the prison context (Brooker et al. 2009), hence the justification for this work. In relation to the wider societal context, the concept of transinstitutionalisation (Prins 2011) and more general concerns about the location and treatment of those with mental illness within our society act as a guiding query for the research.

The PhD implements an inductive approach to the datum–theory relationship, a constructionist ontological position, and an interpretivist epistemological orientation. A full debate concerning the philosophical underpinnings of the study can be found in the original thesis. Regarding method, semi-structured interviews were conducted with healthcare centre staff, the secondary mental health team, prison governors, prison psychologists, primary-level mental health service users/prisoners, and secondary-level mental health service users/prisoners. Regarding numbers of transcripts, twenty-one interviews were utilised for analysis. This number of transcripts represents four patient/prisoner, twelve NHS staff, and five HMPS staff interviews.

Grbich (2007) considers the process of thematic analysis to consist of two complementary data reduction techniques: block and file, and conceptual mapping (pp. 32–35); both of these disparate yet complementary coding processes were utilised in this study. General social theory alongside medical sociology literature is used to frame study results.

The ethical and security guidance provided by the HMPS Psychology Research Ethics Committee was adhered to and all arrangements stipulated by the HMPS Research Contact at the prison were upheld, including the security governor's requests. Participant information sheets and consent forms were used. All participants attended interviews as volunteers, including prisoners; no coercion was deployed. Participants are assured confidentiality and anonymity. The work was labelled a service evaluation by a NHS Research Ethics Committee and the NHS Research and Development group. The overall governor at the prison approved the project and was also keen to act as a participant.

The PhD concludes that the penal milieu, in relation to an extensive variety of social and structural issues, impacts mental health and mental healthcare; these range from the overarching ethos of imprisonment right through to individual interactions in the setting. To précis, mental healthcare provision and receipt experiences and environments are important for clinicians and patients/prisoners alike; aspects of the prison cultural environment and aspects of prison institutional existence are salient. For further reading from the same author regarding this thesis, see Jordan (2010, 2011, 2012a, b) plus Wright et al. (2014).

Service Setting

This qualitative study was conducted in one prison. This analysis utilises data from interviews conducted with prison-based NHS clinicians including registered general nurses (RGNs), registered mental health nurses (RMNs), healthcare assistants (HCAs), In-reach team members (psychologist, psychiatrist, community psychiatric nurse (CPN)), plus varied administration and clinical management staff—all NHS staff. Both primary and secondary mental health staff are represented. Interviews with these NHS staff were conducted in the NHS Healthcare Centre (HCC) in the host prison. Multiple clinical and non-clinical meeting rooms were utilised. Interviews lasted between 30 and 90 minutes, were audio recorded, and were then transcribed verbatim within the prison. All of the themes discussed were first considered in relation to their relevance and fit across the HCC staff transcripts as an entire body of data (i.e. deviant case analysis). Where complication or deviation exists, this is debated in the main body of the debate; there is not a specific section dedicated to anomalies.

Analytical Themes and Findings

Across the interview transcripts, there is an agreement concerning—unacceptable—mental illness prevalence in the prison setting; this is then linked with a desire to address and resolve the issue. However, the nature of imprisonment is depicted as often detrimental to mental health by interviewees. In relation to published prevalence statistics, including substance addictions and personality disorder up to 90 % of prisoners have some form of mental health problem (CMH 2009 as sourced from Singleton et al. 1988). There are currently around 85,000 female and male persons housed in HMPS establishments across England and Wales, and these prisons often receive people from the community with poor mental health. 'Most prisoners with mental health problems have common conditions, such as depression or anxiety. A small number have more severe conditions such as psychosis' (CMH 2009: 2).

'There is a high prevalence of mental health problems in prisons and insufficient provision for these problems' (Nurse et al. 2003: 484). Prison healthcare services are in need of development (de Viggiani 2006). Rates of self-harm and attempted suicide in prison are high (CMH 2009). 'For some, being in prison will lead them to develop depression or anxiety' (CMH 2009: 2).

The Offender Health Research Network (2009) provides updated mental health prevalence statistics from 2009: Severe and enduring mental illness (SMI) is present in 23 % of the prison population; major depression is present in 19 % of the prison population; psychosis is present in 4 % of the prison population; dual diagnosis is present in 18 % of the prison population; substance misuse is present in 66 % of the prison population. Overall, 71 % of the prison population has a SMI, substance misuse problem, or both. Evidently, 'prison settings are a challenging environment in which to manage and deliver healthcare' (Powell et al. 2010: 1263).

The following discussions of achievements and challenges are split into eight subsections:

- Working with patients/prisoners at the Healthcare Centre;
- Working with patients/prisoners with mental illness;
- The working environment at the Healthcare Centre;
- Communication and co-operation amongst NHS staff;
- Overarching goal for the NHS staff;
- Enacting NHS change in the prison setting;
- 'Did Not Attend' as an issue for NHS services;
- Old guard *versus* new guard

Working with Patients/Prisoners at the Healthcare Centre

Participant: *I feel safe working in this environment. You're very well protected here. You've got so many options of how to get help from somebody. If you're working out in the community or in a hospital you don't have that same level of support from trained discipline staff. So in that respect, you know, we probably are safer in here.*

The NHS HCC staff involved in this study narrate a working life in the prison establishment that is permeated with the notion of security—in a positive sense. Security/safety concerns and incidences are accepted to occur in the prison as an institution—and staff are trained well for these occurrences—however, these incidences are narrated as somewhat distanced from the HCC and its day-to-day work with individual patients.

Participant: *Prior to working here, [it was] eleven years working in mental health on a community secure unit, and it’s much more secure here.*

Smith (2010), a prison-based RGN, conceptualises prisons as ‘self-contained communities, with a transient problematic population’ (p. 34) and an unpredictable working environment. Congruently, the transitory nature of this HCC’s patient base is acknowledged by its NHS staff. Patient turnover is high. Also, in relation to the unpredictable working environment narrated by Smith (2010), this is echoed in the interview transcripts too.

However, it is aspects of the institutional working environment that are recounted as unpredictable, and not the behaviour of, or the nature of work with, the individual prisoners (i.e. their patients) in the HCC. This distinction sets the tone, as some structural aspects of the workplace are considered problematic, whereas social aspects are narrated positively. Structural aspects often refer to prison regime, timetable, physical layout, resources, time to deliver healthcare, and so on, whereas, social aspects often refer to elements of social interaction and cultural norms, values, and practices in the HCC.

HCC staff depict their work in the prison establishment and their work with prisoners as comfortable, safe, and secure. Enjoyment is also expressed in relation to clinician–patient/prisoner interactions:

Participant: *I just enjoy being face-to-face with patients. Well prisoners, patients. I call them patients. I’m just … I just really like to be with them and to help them.*

Tuck (2009) notes forensic healthcare systems and healthcare organisational dynamics as complex, where the nature of the setting's working environment can create anxiety in its staff members. Interestingly, this emotion (i.e. anxiety) is not alluded to whatsoever by the HCC participants in this study—who work and practice in a custodial setting that provides healthcare for those with mental and general health needs. Therefore, in relation to the working environment, anxiety is absent from the interview transcripts, yet experiences of enjoyment and safety do exist.

Working with Patients/Prisoners with Mental Illness

Participant: *What I've always said is, half the prisoners in here shouldn't be in prison, it's not the correct place for them, as many have huge mental health problems. You don't realise until you work in a prison how many prisoners there are with massive mental health problems, and it's not the right environment for them, it's just not, and it's of no use locking them up here.*

'Prison nursing is demanding as it involves dealing with people who have multiple, complex needs' (Smith 2010: 35). Poignantly, where issues that influence mental health in a negative sense are raised, these are often framed as prison regime problems:

Participant: *Being locked up the hours that they are locked up, that's not going to be conducive to their mental health.*

However, in relation to NHS mental healthcare provision, HCC employees consider service provision to be excellent:

Participant: *Here, in this prison, in terms of mental healthcare, I don't think there's much more that could be done, if I'm honest. I think they receive excellent mental healthcare, if they need it. Very good primary, and then on to In-reach if they need it. I think, in terms of mental healthcare, access to services and the actual care is better in here than in the community.*

Mental health clinicians praise the current nature of mental healthcare delivered:

Interviewer:	*So, to discuss the primary mental healthcare that you deliver, which aspects do you think are working particularly well?*
Participant:	*All of it … Yesterday I had a clinic of three, they were all brought on time, they all had their allotted time each, it was just ideal.*

This interviewee, a RMN, narrates the importance of institution-related aspects to the delivery of effective and efficient mental healthcare. Above, it is demonstrated that when patients are escorted by HMPS staff to the HCC aptly in preparation for their allotted time, clinics run smoothly in a temporal sense. This facet of time appears important to the daily running of the HCC in the prison context; this is another structural element to service provision.

Prins (1995) argues, 'Those deemed to be mad and bad will always find themselves at the bottom of the social priority pecking order, because mentally disordered offenders, who often fail to fit neatly into societal categories, are the people nobody owns' (p. 44). Whilst this may be the case in other social, policy, or healthcare settings, this analysis does not fit with the NHS HCC in this study. The HCC staff do not narrate mental health patients (i.e. prisoners) as adopting a low social standing in the environment, in fact quite the opposite, as immense health-orientated concern and attention is expressed for, and devoted to, this group of mental healthcare users. Furthermore, a lack of ownership for these offenders with mental health issues does not exist; instead, pride is taken from the provision of mental healthcare. Therefore, although Prins's (1995) conceptualisation of mentally disordered offenders may be accurate in some settings, it is not the case for the HCC in this prison.

The Working Environment at the Healthcare Centre

Participant:	*There is always a good feeling here.*
Participant:	*It's happy. A good team environment.*

A healthcare setting's culture 'develops through social interaction, informal networks, and meanings created by workers, rather than through 'culture change programmers', away days, or mission statements' (Parkin 2009: 125, apostrophes in original). This subsection explores aspects of social interaction and workers' informal networks of healthcare practice in this study's healthcare setting.

In relation to service delivery, capability at work is professed by the healthcare clinicians involved in this study. NHS staff are content and sufficiently skilled to fulfil their ascribed roles. Proficient service provision is narrated in tandem with good safety nets:

Interviewer: *Prison reception screening has a few mental health questions, yes? Do you feel that aspect is working well?*
Participant: *I think it's fine. It seems to be working well. It kind of, you know, anyone who's already on psychiatric medication automatically gets referred to the mental health team anyway [In-reach], so it's quite, there's a good safety net there, especially for a general nurse like me [a RGN]. I feel quite safe with that whole process.*

Further to the interviewees' understandings of service provision as proficient and safe, one HCA narrates additional attributes required by prison healthcare staff:

Participant: *You've got to be concise and swift. Dealing with issues, but at the same time, being quite efficient.*

Efficient and concise work is required swiftly in this healthcare environment. When considered as a whole body of data, the interview transcripts for the study echo this labelling of important HCC staff characteristics. Moreover, and encouragingly, the narratives profess personal fulfilment of these abilities. Therefore, these notions of effectiveness, conciseness, and swiftness do not represent idealistic work goals; they are instead aspects of working lives participants consider themselves to fulfil appropriately. These service delivery characteristics are not restricted to clinical staff, they apply also to HCC staff who do not interact with patients practically in a healthcare sense (e.g. NHS administration staff).

To link this subsection regarding the HCC working environment and its subsequent, that explores communication in the setting, McMurran et al. (2009) state:

> Treating patients in forensic mental health services is a team effort with various professionals contributing in different ways according to their areas of expertise. … Everyone working with a patient communicates with other members of the team to ensure a consistency of approach with any one individual patient. Working as a member of an effective and collaborative multidisciplinary clinical team can by very satisfying (p. 104).

As McMurran et al. (2009) note, the following three features aid development of effective and satisfying team environments in forensic mental health settings: healthcare conceptualised as a team effort; diverse professional contributions valued; effective team communication embraced. As the next sub-section exemplifies, this study's interviewees do narrate working lives that feature these three facets.

Communication and Co-operation Amongst NHS Staff

Gojkovic (2010) explores both Serbian and English prisons and the mental health services provided therein. An important aspect of prison mental healthcare provision is the nature of collaboration: 'Interviewees emphasized the importance of communication and collaboration when dealing with a demanding and complex caseload' (Gojkovic 2010: 176). Congruently, informal yet frequent and amicable incidences of co-operation and communication amongst HCC staff are narrated by the NHS participants in this study. The notion of an amenable collaborative working environment in the prison's HCC is depicted:

Participant: *What I would do, anything, any problem I have with a clinic, or any of the referrals, if I don't fully understand things, I can always go to X [the team leader] or the RMNs, and we all work together.*

Tuck (2009) stresses that nursing work involves emotional stresses and that complex working dynamics manifest in these healthcare organisations; furthermore:

> Working in organizations, whatever their size or task, has an emotional impact on those within them and few organizations are more emotionally challenging than those tasked with the care of highly traumatized and traumatizing environments (p. 43).

Thus, in relation to this study's healthcare locale, what are the complex working dynamics that Tuck (2009) argues present themselves in such clinical settings? To summarise, although the clinical working environment in the prison establishment appears eventful, dynamic, and convoluted (in a clinical sense), these complexities do not appear to be experienced as negative via HCC staff. A multitude of HCC-based experiences, interactions, goals, roles, and responsibilities are narrated by study participants; however, these are not experienced as occurring in a complex, traumatic, or disconcerting fashion.

In relation to the working environment, effective teamwork appears important to participants. Communication and co-operation between NHS staff with disparate roles in the HCC is narrated as crucial to effective teamwork:

Participant: *It's a good working environment. It's a lot better than X prison, where all the work was done on the wings, and there wasn't a hub for healthcare staff [like there is here], so communication wasn't as good.*

Where necessary, RMNs refer mental health patients to In-reach; they act as service gatekeepers. This process appears to be working well and RMNs feel happy to seek clinical help and assistance from the In-reach team (who are experienced as open and giving in this respect by the RMNs):

Participant: *I've never had any noticeable problems with In-reach at all. I just fill the form in and send it off. If I've got queries I can ring them up, or just pop into the office for help.*

Moreover, the nature of co-operation between the primary-level and secondary-level mental healthcare clinicians is reported as amicable and trustworthy. This relationship appears to be a requirement for apt provision of prison-based mental healthcare. The prison setting requires this form or collaborative working between the two mental health occupational groups. Teamwork is conceptualised as each clinician possessing a body of knowledge that they implement in the workplace; however, this is not considered to be a knowledge base with distinct impermeable boundaries, as sharing is discussed positively:

Participant: *At the healthcare centre, the team works so well. We each have our own areas of expertise. We can pick up the ‘phone and ask, or we can pop next-door for advice and guidance, which we’ve done many a time. It works really well.*

McMurran et al. (2009) state the field of forensic mental health is affected negatively by previous high-profile incidents concerning mentally disordered offenders such as Michael Stone and Christopher Clunis; furthermore, ‘what appears to underlie many of these failings is the common factor of poor communication between the differing agencies and the professionals within them’ (p. *xi*). Conversely, in relation to this study, communication appears to occur frequently and effectively in this particular NHS healthcare setting.

When participants—who either belong to the In-reach team or work as RMNs—are asked to discuss the nature of the divide between the primary- and secondary-level mental healthcare clinicians, no acrimonious comments or professional hierarchical claims are professed; instead, the distinction is depicted as an effective boundary, as a mechanism for ensuring patients with certain levels of mental health severity typify the two patient groupings for the two levels of mental healthcare provided. The divide is narrated as a successful instrument to facilitate best possible healthcare routes for patients and appropriate patient groupings for the clinicians.

The subsequent quote, from a member of the clinical management in the HCC, details further the nature of the working relationship between primary and secondary mental healthcare in the setting:

Participant: *I think the model of care that we have is very good and the collaborative working between primary care and In-reach is really good: they can refer in, they can refer out, they can sit and talk about cases. They just work very well together. But also we've got really enthusiastic mental health nurses and I think that makes a massive difference. They enjoy working in the environment that they're working in and they have the opportunity to use their skills.*

This interviewee links the notions of successful multiparty clinical endeavour with the existence of enthusiasm in the workplace; this links this subsection concerning collaborative working practice with the following subsection regarding the workplace overarching goal.

Overarching Goal for the NHS Staff

Participant: *Nobody falls through the net, or hopefully nobody falls through the net.*

Overall, the NHS HCC in the prison appears to be geared towards excellent patient care first and foremost; patient welfare is the primary focus of the HCC, and this ethos permeates the everyday working lives of its staff.

Participant: *You've got to have a system of some sort so that you keep on top, be organised and have a system in place so that patients aren't falling through the net.*
Participant: *There are systems in place so that we don't miss anybody.*

Tuck (2009) debates the concept of 'primary task'. This term is analysed in relation to forensic health systems and healthcare setting organisational dynamics. The primary task of an organisation represents its primary pursuit (that must be fulfilled in order to maintain its survival). However, as highlighted by Tuck (2009), primary task is a convoluted concept that causes complications in organisations, 'as different individuals and departments within the organization may have different definitions of the primary task' (p. 45). However, the individual members of HCC staff involved in this study appear to share one overarching goal, or primary task, that is, *to prevent anyone falling through the net.* Tuck (2009) notes that, in addition, 'the views of the primary task held by those outside the organization may conflict with the views of those inside' (p. 46). Once again, however, this is not the case in this study as HMPS, the Ministry of Justice, the NHS, and the Department of Health would likely support and encourage this ethos—that permeates the HCC as a professional social setting.

In a confused system—such as Tuck's (2009) theoretical medium secure psychiatric facility—the 'ward manager described a sense of being pulled in every direction [without an overt primary task] … As a result he was unable to complete the tasks he planned to do each day and felt he was no longer able to see the "bigger picture"' (pp. 46–47; square brackets not in original, apostrophes in original). In this example, the absence of a primary task for members of the healthcare setting contributes to communication problems and low morale on the ward (Tuck 2009). This lack of healthcare staff internal stability, as debated by Tuck (2009), does not exist in this study's healthcare provision locale. The prison HCC staff narrate an intersubjective work goal (i.e. the concept of primary task exists): *to prevent anyone falling through the net.* This phrase is repeated often in the transcripts.

Lewin and Reeves (2011) explore ethnographically the nature of interprofessional relations in an acute healthcare setting and note 'interprofessional teamwork is widely advocated in health and social care policies' (p. 1595). However, Lewin and Reeves (2011) report 'the notion of teamwork, as a form of regular interaction and with a shared team identity, appears to have little relevance' (p. 1595) in relation to their fieldwork site. Whereas, the healthcare staff in this study's healthcare setting narrate the antithesis of Lewin and Reeves's (2011) findings, as teamwork is considered highly relevant—and this occurs amicably via regular interactions and the existence of a shared workplace purpose: *to prevent anyone falling through the net.*

To support this primary task analysis, Cashin et al. (2010) study forensic nursing practice in an Australian prison hospital and conclude nursing culture 'was found to be one of hope, although with no clearly articulated vision of nurse-hood or patient-hood and model within which to practice nursing' (p. 39). Therefore, Cashin et al. (2010) argue 'the ability to articulate practice is central to the development of mental health nursing in any context' (p. 39). This reflects positively on the HCC in this prison setting, as a communal workplace aspiration is articulated well.

This workplace goal is laboured here. It may seem unusual that the NHS HCC's group desire to prioritise ***patient*** care is highlighted as important. After all, NHS staff are usually expected to consider patients' welfare indispensable. Interestingly and conversely, therefore, it is actually the ***absence*** of custodial, punishment, ***prisoner***, crime, punitive, or security-orientated answers, narratives, experiences, ideas, roles, and responsibilities in the transcripts that is thought provoking. It is the paucity of criminality-related terms to conceptualise patients—and their relationships with patients—that is crucial for analysis here. The language utilised by HCC-based participants prioritises the notion of patient as social role, and not prisoner as social role—although this is actually the reason for these patients' current social location (i.e. in prison). Thus, the overarching work goal for these NHS staff is not surprising *per se*; however, when the treatment locale is considered, this dominant and powerful healthcare delivery goal gains increased significance.

The work of Le Grand (1997) is useful for inclusion here. Le Grand (1997) discusses welfare provision and policymakers' differing models of human motivation and behaviour in social policy–relevant situations. Notions of state largesse, public philanthropy, and social actors' self-interest and passivity are raised. Le Grand (1997) utilises three terms to categorise citizens: knights (i.e. altruists), pawns (i.e. inactive recipients of state charity), and knaves (i.e. egocentrics). In relation to preceding post–World War II UK welfare strategies, alterations have now occurred, 'from policies designed to be financed, and staffed by knights and used by pawns, to ones financed, staffed and used by knaves' (Le Grand 1997: 160); individuals are considered to be more likely self-interested than public spirited. However, 'our society regards altruistic or public-spirited behaviour as morally superior to self-interested behaviour' (Le Grand 1997: 162). In relation to this study, the HCC's team character and underlying approach to healthcare—as narrated by its employees—exemplifies an aura of altruism that is directed towards individual and distinct worthy social actors in need of, and deserving, healthcare. Moreover, these persons in need of healthcare are conceptualised as patients—their criminal justice system labels and offending behaviours receive very little, if any, attention from these HCC-based workers.

How patients are conceptualised by the staff members in the NHS HCC is of relevance here as, if we utilise the work of Taylor-Gooby et al. (2000) (that stems from the aforementioned Le Grand work), a link can be made between the HCC's overarching goal and the notion of patient need. Taylor-Gooby et al. (2000) argue professional cultures (in this instance it is the professional values of dentists that are explored) 'influence how practitioners understand their own interests and those of their clients' (p. 375). There is a relationship between the professional culture of a healthcare setting and clinicians' understandings of patients' requirements. Arguably, therefore, the overarching goal of this HCC is related to the healthcare setting's conceptualisation of its patients. Thus, that the security and custodial aspects of a patient's existence in the setting do not feature is important, as these prisoners are, instead, defined as patients with numerous and valid health needs who should be identified and offered healthcare: *to prevent anyone falling through the net.* To summarise, it appears there is a relationship between a shared overarching goal for a setting, its conceptualisation of involved social actors (e.g. patients, or consumers, or criminals), and then a setting's outputs—in terms of service provision (whether this be healthcare, or consumable items, or punitive action). Positively, this relationship in the host prison's HCC seems to be generating a workplace milieu beneficial for patients/prisoners and their healthcare.

To finish this subsection, a reflection regarding pride, community ethos, and the notion *the will's there and the skill's there* is fitting.

The HCC is understood by study participants to be a physical site of appropriate healthcare expertise and apt healthcare delivery desire. *The will's there and the skill's there* appears to represent a shared attitude at this prison's HCC. This approach permeates both the social nature of the working environment and the approach to healthcare delivery adopted in this specific clinical setting.

Where clinicians narrate this workplace ethos, a sense of pride is also included in their accounts. Smith (2010), a prison RGN, states, ‘I am proud to say, I love my job’ (p. 35). Congruently, pride is exemplified via the narratives of the HCC staff in this prison study:

Interviewer: *Sounds like you take quite a lot of pride in your work?*
Participant: *I do, yeah.*

Jones and Fowles (1984) argue that the nature of the community in an institutional environment ‘determines the nature, number and quality of its staff’ (p. 201). Data exemplify a staff community that takes pride in creating a quality healthcare team with an underpinning nature that prioritises—primarily—individualised and best possible healthcare for patients.

Participant: *The group goal for best possible care is crucial. They get what they need. It’s a first class service, in my opinion.*

Enacting NHS Change in the Prison Setting

Where participants describe their work roles and responsibilities, the interview responses include a clear sense of pride. Moreover, evidence of autonomy coupled with flexibility in the workplace is exemplified—via a desire to develop work methods alongside the freedom to do so. These role and responsibility developments occur at both *individual* clinician/employee level and also at clinical/administration *team* level.

The interview quote below represents a team-level development example:

Participant: *… It’s just that kind of role, you know, we’re becoming, we’re kind of developing, and we’re quite flexible in terms of how we operate and how we refer to ourselves.*

The excerpt below is taken from an interview with a member of the HCC’s administration staff; this acts as an individual staff member example:

Participant: *I've been doing it for probably two years now, me being in charge of it, and I've developed it my own way to make it easier to follow, so that nobody falls through the net.*
Interviewer: *So that's really interesting that you've, in a way, been able to develop your own regime, your own ways of doing the jobs that you need to do. So do you feel that you have enough personal freedom, as it were?*
Participant: *Oh, yes.*
Interviewer: *So if you felt there was a better way of doing something you'd be allowed to do it?*
Participant: *I'd be allowed to do it … X knows she/he can trust me.*
Interviewer: *So you're given a task and then you can work out your own ways to complete it?*
Participant: *Yes.*
Interviewer: *So you don't feel like you experience any overt prison guidelines or constraints upon how you choose to operate?*
Participant: *No.*

This particular member of the NHS administration staff has the permission and freedom to alter work methods—in relation to prescribed work roles—as desired, and is trusted to do so.

Autonomy in relation to professional roles is professed:

Participant: *We have two very separate teams of mental health nurses [RMNs] and practice nurses [RGNs] and that means they can develop themselves and their own skills and their own roles.*

Autonomy coupled with ownership, in relation to roles, is discussed by participants. A three-way relationship appears to exist between ownership, autonomy, and trust. HCC staff are given ownership of their roles, provided with a suitable degree of developmental autonomy, and are trusted to implement these changes.

Interestingly, the excerpt above notes that overt clinical distinctions exist in the healthcare setting, that differing clinical roles are kept separate intentionally, and that these are narrated in a positive sense. Notably, teamwork and relationships between professionals are reported in an optimistic fashion, and this occurs in tandem with members of the HCC having distinct and defined roles and responsibilities. The differing skill sets of the members of the HCC (e.g. RGNs *versus* administration staff) are understood by staff; furthermore, these dissimilar bodies of knowledge are drawn on by the different staff members at the HCC.

In terms of the theoretical level of this understanding that is shared by staff in the HCC, this approach to the working environment does not occur at individual social actor level; instead, this working practice conceptualises HCC staff as professional and social groupings with clinical group titles (e.g. In-reach team, RMNs) with associated roles, responsibilities, and knowledge. De Dreu and West (2001) argue individual creativity and innovative ideas, alongside participation in team decisions, are positive aspects of organisations. Encouragingly, novel working methods and experiences of team inclusion are depicted via this study's participants.

Hannigan and Allen (2010) research myriad mental healthcare professionals' distinct clinical titles alongside the changing nature of their contributions to healthcare; fieldwork is conducted via two community mental healthcare teams in Wales. Developments in roles and responsibilities are assessed in relation to ongoing NHS policy developments. Hannigan and Allen (2010) conclude 'the roles of mental health professionals [are] become increasing blurred' (p. 1; square brackets added). Conversely, for the NHS staff participants in this study, clarity of work boundaries is experienced. This contrast represents an example that the provision of community mental healthcare and the provision of prison-based mental healthcare are somewhat dissimilar endeavours.

Relations between the prison establishment, its HMPS staff, and the HCC and its NHS staff also affect the working environment at the HCC. 'Prison nursing is often complex. Working for one organisation (i.e. the PCT) within another organisation (i.e. the Prison Service) can cause conflicts, especially where resources are concerned. We are expected to abide by all the Prison Service rules, and work within the service regime' (Smith 2010: 35). In this study, alterations and developments in the NHS HCC appear dependent on the HMPS situation and the co-operation of the prison establishment:

Participant: *The only thing that's, not particularly a barrier, but does slow things down, is working in partnership with the prison. Now there's a positive there, in a lot of ways we work very well together, but there are sometimes, conflicting ideas. Things that I might think are good ideas for my team here [in the HCC] might actually have a significant impact upon other departments in the prison or the prison regime, and that can make things [in the HCC] quite difficult to develop, sometimes. It's clinic times, timings of clinics, and access to patients [that are the issues] … more than strategic development.*

Notably, the HCC–prison working relationship is discussed in a well-balanced fashion here. The positive aspects are noted before issues that affect and can impede progress in the HCC. Poignantly, these matters are not depicted as impenetrable barriers, yet are conceptualised as occurrences that affect negatively the speed of change. The final section of the excerpt above reports improvement constraints are often not located at the management/strategic development level of the prison, yet are more micro-level and day-to-day regime. Constraints are discussed as procedural, resource, and routine related—and not in conflict with high-level management, development plans, or prison ideology.

HMPS staff as a resource seems to represent a significant constraint to developments in the NHS setting:

Interviewer: *Other interviewees who're involved in management in this prison, that I've spoken to, have reported something that's quite positive, and that's the autonomy and the capability in this working environment to change a procedure, if they wish, so, for example, if they are managing something but formulate an idea that they feel would work better, they feel that in this, highly regulated, prison environment they actually have the capability and freedom to enact changes, is that something that you'd echo, or not?*

Participant: *You do, to a certain extent, as you're very governed by prison rules. I mean, for instance, when I have visitors come in, or locum GPs, erm, you have to really follow the strict guidelines,* *and the problem we're having at the minute, although I know it's nothing to do with mental healthcare, we're having trouble with hospital appointments and escorts … we have to liaise with the prison to check there're enough staff, and they cancel, like they have today, erm, and then, it's just, we also have emergencies going out in-between. So, yes, I would say you can alter procedures in the NHS, but not if it involves the prison, as that's very restricted, many boundaries.*

Interviewer: *Do you think it's lack of officer staff as a resource in terms of the cancelled hospital escorts, or something else?*

Participant: *Yes. That's why we struggle. As each prisoner that goes out needs two officers. And then there's the risk assessment. So there's a lot of work involved in it. Because we have to complete a load of escort paperwork and a risk assessment, detail with the prison, and liaise with Security. The prison has to provide the officers to go, and, so it's all a bit of a nightmare, really.*

Attention is now devoted to a separate concern of the NHS staff interviewees. This topic relates to healthcare appointments that are scheduled at the HCC, yet that are subsequently not attended by the listed patient/prisoner.

'Did Not Attend' as an Issue for NHS Services

Participant: *Sometimes they come to the hatch on the wing and say they had a doctor's appointment yesterday but no one came to unlock them, so it's not necessarily their fault, but, you do often see on the system where it says 'refused' [i.e. a patient choice DNA].*

The HCC is attempting to reduce the occurrence of DNA recording. Time and effort on the behalf of NHS staff is evident:

Participant: *DNAs have been a problem. There seems to be a variety of reasons for that, and that wasn't always patient reasons. There* *can be issues around different officers [and escorts], no consistency. However, if the patient refuses to come there's nothing they can do about it. … Now when they've finished their appointment they [the prison officers that work in the HCC] take them [the prisoners] straight back to the wing, so they're not waiting around. So, for the patient that's coming to healthcare [the HCC], it's a more positive experience. So then the next time they don't mind coming, 'cause they know they're not going to be sitting in a chair for a couple of hours and missing gym. So, you know, it has been a problem, but it's been worked on, and there is a real improvement.*

Participant: *We send appointment slips out, the day before, so that they know the next day they've got an appointment, so not to go to work, or whatever. Erm, what we're trying to do is look on the prison system to make sure they've not got court or visits, or things like that. So we work round that as well, to reduce DNAs.*

Irritation is displayed where prisoners choose to not attend their HCC appointments:

Interviewer: *You mentioned DNAs. Why do you think these occur?*

Participant: *There are legitimate DNAs where they're at court or similar, but the ones that don't come for whatever reason, I don't know why, it really is annoying, and an absolute waste, and I hate it. There's enough people waiting, on the mental health side, for help and support and input, and then you've got some lackadaisical patient who's like, I'm off to the gym instead. It's infuriating.*

Gym sessions appear linked with patient choice DNAs:

Participant: *I think that if we're offering the service it's up to them whether they choose to take it up or not, but we're doing our best.*

Interviewer: *What are the general reasons for booking clinic time and then not arriving?*

Participant: *They might just go to the gym instead.*

The gym represents a highly desired and valued prison activity and locale for the prisoners interviewed in the overall study.

Furthermore, the excerpt above also displaces any DNA-related fault, blame, or responsibility from the HCC as a team/setting (*we're doing our best*) to the individual patient, as a result of choice to attend a gym session and not a healthcare appointment. This interviewee is keen to stress that the prison's HCC intends to provide the best possible healthcare services, and therefore in this instance, it is the patient's actions that affect delivery of care—and not failings at the HCC.

To reiterate, opportunities for exercise and gym usage (alongside visits) appear occasionally preferable to clinical appointments:

Interviewer: *DNAs, why do these occur, do you think?*
Participant: *I think they prefer the gym and going for exercise, plus visits, and things like that. We do re-book for visits and court, and the like. We don't re-book for gym.*
Interviewer: *Do you think anything can be done about DNAs?*
Participant: *I suppose we could be more flexible. I don't know how we could be more flexible. We could offer, I don't know, ask them what their preferred time would be, but I don't know, what if they all want the same time, to avoid missing exercise. Unless we altered our clinic times, but that wouldn't work with the prison regime.*

This RGN suggests increased flexibility may be an option to reduce DNAs. This displays a desire to decrease DNAs via a route that benefits prisoners first and foremost. This general approach to the delivery of healthcare is exemplified via the transcripts from the HCC staff as a professional grouping. The prisoners' health needs—and their more general needs, desires, and problems in the penal milieu—are important and influential for the HCC staff in this study. The excerpt also stresses, once again, the importance of gym usage for prisoners. However, the professed potential change to clinic times is then problematised, as it is believed that the HMPS regime may not allow for this proposed alteration.

Old Guard Versus New Guard

At the beginning of this subsection it should be noted that these two terms, 'old guard' and 'new guard', are not the interviewer's creation. Instead, these two age-related concepts—that pertain to HMPS staff—are introduced by study participants. (To add credence to this definition dichotomy, HMPS staff *themselves* discuss a distinction between traditionalist guards and newer recruits. It is not just NHS staff and prisoners who use these terms.)

Participant: *I would say the older ones [wing officers] don't understand mental health, and hold the attitude that prisoners are here to be locked-up and punished, and that's it. I know, from speaking to older officers, they feel that prisoners now get a lot of help and privileges and it's not always appropriate. I would say, yes, it's an age thing, definitely. The younger ones [wing officers] are more aware of how they can help them [the prisoners], more keener in terms of safer custody, to prevent violence and suicide in prisons generally … As you know, we had a prisoner who committed suicide recently, so it'll be interesting to see what happens there, as, apparently, he wrote a long suicide note blaming some of the officers, but I don't know if this is true, just heard it through the grapevine, as it were. Must be horrendous if you're one of the officers involved. I wouldn't want that on my conscience. So, I'd say the younger ones [wing officers] are better, yes, more sympathetic and empathetic [in relation to prisoners' mental health issues and resultant effects].*

Some officers are understood to be more empathic regarding mental illness and distress than others and the dividing line is often argued to be officer type—old guard or new guard.

The 2009 work published in 2011 by the Offender Health Research Network highlights that In-reach staff working with HMPS staff in terms of suicide/self-harm prevention and management (i.e. assessment, care in custody, and teamwork) is variable, plus involvement and responsibilities are confused.

Where NHS staff are questioned regarding the length of prison officer service, the below two extracts exemplify responses:

Participant: *It is the case [there is an age disparity]. They remember the old times, you know, way before methadone [often used in prisons as a heroin substitute/detox. medication]. They are not interested in healthcare whatsoever. They don't think they [the prisoners] should be entitled to it.*

Interviewer: *Is that problematic in your opinion?*

Participant: *Well, it's not right, as anyone could make a mistake and end up in prison, and they will need healthcare. But they've been here years, and that's what they've been told, and always done. That's how they had to be, before [the introduction of NHS healthcare to the prison system]. They were trained like that, and now we're telling them they need to change.*

Participant: *The old school, oh yes. I observed that from walking through the door on the first day. You've got the old school. Certainly you've got the new starters who do seem a bit more sympathetic and do seem a bit more switched on, really.*

Notably, this situation regarding length of professional career is not specific to the prison context alone. For example, Shaw (2004) demonstrates how well-established general practice doctors with a long history of clinical endeavour can often be seen as less tolerant than their younger colleagues.

However, in contrast to the age dichotomy narrated above, one RMN does *not* draw an age distinction between HMPS staff. Instead, a difference is highlighted between the overt hierarchical levels of prison service staff in the establishment. To summarise, wing governors and other senior member of HMPS staff are considered to be more interested in mental health, in comparison to frontline wing officers:

Participant: *The senior officers are much more, what's the word, more tolerant, more open to it [mental health issues and effects]. Less prejudiced.*

Here, seniority in the prison and hierarchical working roles are outlined as distinguishing features between prison service staff and their approach to prison mental health, and not age, as discussed previously.

The interview excerpt below aptly concludes this subsection, as it makes clear that the concept of a healthy prison is gaining momentum in HMPS and that the situation in relation to the importance of healthcare in the penal setting is proliferating slowly, yet positively and incrementally. Prison governing governor support is highlighted as existent and influential; however, the transfer of this agenda to frontline HMPS staff is depicted as a convoluted and time-consuming pursuit.

Participant: *I actually think, that, from a strategic point of view, certainly on the level of the [Governing] Governor, there is this real drive to promote healthy prisons. Promoting good mental health is really high on that agenda, which is great for us, but feeding that down through, you know, management level to prison officers, can be quite a long and difficult task. I think that it has improved, I mean, I've been here for X [several] years now, and I've noticed a huge improvement in the attitudes of the officers towards health. I just think that these things take time.*

But why are these interactions between staff and prisoners so important? Help seeking for mental illness is one good example. Mitchell and Latchford (2010) utilise a personal construct psychology approach and question adult male prisoners regarding mental health problems and help-seeking routes; their work highlights 'the importance of both formal and informal sources of help for mental health problems in prison' (p. 773). RMNs and In-reach clinicians provide the formal mental healthcare; however, prison wing staff could embody excellent informal sources of care for mental health service users in the prison context. However, decisions regarding prisoners' selected help sources are dependent on anticipated response, existence/absence of trust, and perceived skill level (Mitchell and Latchford 2010)—hence the salience of the old guard and new guard labels/understandings.

Winkelman (2009) addresses cultural competence in healthcare setting and lists 30 components of 'interpersonal difference in social interaction rules' (p. 97) (e.g. paralinguistic cues, kinesics (touch), negotiation approaches, metalinguistic messages, proxemics (space), conflict management). It is evident that sensitivity and responsiveness—in relation to interactions between patients and their carers (whether this be a NHS In-reach team member or a member of HMPS wing staff)—are beneficial in terms of therapeutic outcomes for patients. Moreover, Lester and Glasby (2010) note 'mental health is more than simply an absence of symptoms of mental illness or distress. Mental health refers to a positive sense of well-being' (p. 2). Here is where prison officers can further assist patients/prisoners. The nature of their relations and interactions with prisoners are influential and impact the imprisonment experiences of prisoners.

Conclusions

Overall, interviewees depict their working lives as an effective team pursuit that is conducted in a passionate manner. A shared notion of optimum health service provision exists. In relation to service delivery, capability at work is professed by healthcare clinicians.

The working environment is narrated as both effective and affable. The delivery of healthcare is conceptualised as a team effort necessitating diverse professional contributions and effectual team communication. Informal yet frequent and amicable incidences of co-operation and communication amongst staff subsist.

Efficient and concise work is required swiftly in this clinical milieu. Teamwork is conceptualised as each clinician possessing a body of knowledge that they implement in the workplace; however, this is not considered to be a knowledge base with distinct impermeable boundaries, as sharing is discussed positively.

The NHS HCC in the prison is orientated towards excellent and altruistic patient care; patients' welfare occupies the primary purpose of the setting and this aura permeates the everyday working lives of its staff. The absence of punitive, security, or offender-based comments in interviews is noteworthy.

A three-way relationship appears to exist between ownership, autonomy, and trust. HCC staff are given ownership of their roles, provided with a suitable degree of developmental autonomy, and are trusted to implement these changes.

Where issues that influence mental healthcare delivery are raised, these are habitually framed as structural (not social) problems; developments in the NHS HCC appear dependent on the HMPS situation (e.g. resources) plus the co-operation (and mental health knowledge and understanding) of the prison establishment and its staff.

Implications for Understanding Mental Health Services

- Unmet mental health need continues to exist in prisons and this warrants mental healthcare (although some prisoners' severe and/or enduring mental illnesses render the penal setting inappropriate).
- Prison mental health services represent excellent healthcare opportunities for those prisoners who have lacked access to services in the community.
- Prison mental healthcare requires a staff body capable of concise, effective, and swift work.
- It is important that mental health staff consider themselves appropriately skilled for their post.
- Amicable communication and cooperation amongst differing types and groups of clinical and non-clinical NHS staff is beneficial for effective teamwork and care delivery.
- Healthcare communication can occur affably when differing clinicians are respected as possessing dissimilar bodies of knowledge but where this is not boundaried (i.e. staff can ask other colleagues informally for advice but also have an influence on others' understandings).
- An overarching intersubjective workplace goal benefits staff (and patients, providing this primary task is positive in ethos).

- Effective team and individual changes within NHS settings can occur where permission, trust, ownership, and autonomy are granted and accepted.
- Service safety nets are required at several points in the prison mental healthcare system to prevent mental health needs being missed or dropped.
- Structural and resource barriers can impede developments to health services, even those that have cultural and managerial support.
- Where few activities are provided for patients in secure settings, it is worthwhile attempting to marry regime and healthcare timetables in order to reduce incidences of clinical 'Did Not Attend' recording.

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6

Institutional and Emotion Work in Forensic Psychiatry: Detachment and Desensitisation

Ada Hui

Introduction

Hospitals occupy unusual spaces. Similarly, healthcare organisations and healthcare professionals occupy unusual roles. Hospitals are caring, safe and nurturing environments but they are also places of death, illness and disease. These undesirable aspects serve as uncomfortable reminders of human fallibility and the limitations of healthcare. Publically, healthcare professionals are viewed as archetypal public servants who devote themselves to helping others. In reality they are often faced with difficult ethical and moral dilemmas. These become even more challenging amongst mental health services, where knowledge is less certain and practitioners are called upon to ameliorate a complex set of difficulties (Pilgrim and Rogers 2003; Middleton 2015). Although idealised mental healthcare espouses the values of person-centredness,

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A. Hui (✉)
School of Health Sciences, University of Nottingham, Nottingham, UK
e-mail: ada.hui@nottingham.ac.uk

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recovery and empowerment, practitioners are commonly called upon to contain and treat individuals against their will, often for indefinite periods of time (Alty and Mason 1994; Kaye and Franey 1998; Prinsen and Van Delden 2009). These contradictions are possibly most striking within the specialist discipline of forensic psychiatry, and especially within the high security hospital, where both care and containment are clear expectations, but their contradictions rarely acknowledged (Alty and Mason 1994; Kaye and Franey 1998; Kontio et al. 2010; Prinsen and Van Delden 2009; Tardiff 1984; Vassilev and Pilgrim 2007). The clientele of high security hospitals are referred to as 'patients' and they are provided for by healthcare professionals. The security arrangements of these hospitals however, are governed by the criminal justice system, the majority of patients are subject to court orders and related restrictions, and healthcare workers are expected to manage risk, safety and security (Alty and Mason 1994). Where patients' behaviours do not conform to expectations, restrictive measures are sanctioned in the forms of restraint, seclusion and segregation (Alty and Mason 1994; Department of Health 2008, 2011; NICE 2015). High security hospitals represent the most restricting of hospital environments, where healthcare professionals are tasked with looking after 'violent and dangerous' patients within contained places, whilst precariously balancing care, safety and security (Department of Health 2008).

Exploiting this context, sociological theories of institutional work (Lawrence and Suddaby 2006; Lawrence et al. 2009) and emotion work (Hochschild 1979) are used to draw attention towards conflicts and tensions that emerge between institutional expectations, organisational governance, individual emotions and actions (Hochschild 1979; Lawrence and Suddaby 2006; Lawrence et al. 2009). By analysing and exploring practices of forensic psychiatry through the lenses of institutions and emotions, the formal and informal roles of healthcare professionals are examined, and the impacts and effects these have on practitioners' abilities to care for patients are opened to critique. The challenges of forensic psychiatric work, personal and professional values and role conflicts are illuminated, and the relevance and applicability of social sciences' approaches to mental health practice are illustrated by investigation of real practice examples.

The Institution of Forensic Psychiatry

There is no official definition of forensic psychiatry. The institution is identified with the area where law and psychiatry meet. However, as with all pluralistic institutions, this is marked with inherent tensions which reflect 'more than one institutionally ascribed identity and more than one societally sanctioned purpose' (Kraatz and Block 2008: 71). Distinct institutional histories and competing priorities create tensions and conflict for those working within and confusion for those outside.

The forensic discipline has its roots in a legal paradigm which centres on crime, responsibility and detention (Gunn and Taylor 1993). Judgements are of criminal activity, and appropriate sentences serve as punishment. Alongside these sit considerations of risk, security and recidivism. Psychiatry, in contrast, is an arm of medicine, with concerns of abnormality, health and illness. The primary aim of psychiatry is to focus upon how illnesses and diseases are assessed, cared for and treated in ways that aid recovery and independence (Middleton 2015). Three important distinctions emerge from contrasts between these: (i) responsibility, (ii) role and (iii) context.

Responsibility

From a forensic perspective, those deemed responsible for their actions are considered to be punishable by law, and risk losing their liberty (Black 2003). From a psychiatric perspective, those considered to be of 'diminished responsibility' are to be cared for through assessment and treatment by healthcare facilities (Gunn 1994).

Role

Whether or not an individual is considered responsible for their actions has consequences upon their role; upon where they are incarcerated, ways in which they are perceived and how they are treated by society. Those considered responsible are identified as prisoners and deemed punishable.

Those considered lacking in responsibility are identified as patients and deemed deserving of care.

Context

Prisons are generally accepted as punitive places containing prisoners deemed responsible for their actions. Prisons inherently accommodate the ‘bad’. Psychiatric hospitals are considered a caring milieu which accommodates those considered ‘mad’.

Those who are ‘doubly deviant’ because they are considered both ‘mad and bad’ do not readily fit into either of these two disciplines or settings. The institution of forensic psychiatry serves to bridge these disparate disciplines in order to accommodate the needs of those who do not readily conform to either. Accommodating individuals in a secure hospital reinforces the legitimacy of such organisations, and reaffirms the institution that reflects their structures and processes. Those determining where individuals are placed within this range of secure facilities are considered experts within a specialist discipline. The connotations of a specialist discipline include knowledge, experience and authority. These reinforce and legitimise ways in which a person’s behaviours might be labelled and interpreted and, in doing so, further the legitimacy of secure psychiatric facilities.

The Organisation of High Security Hospitals

In England and Wales, secure hospitals are considered in terms of perceived needs for low, medium and high levels of security. Low security hospitals accommodate those who pose a significant danger to themselves or others, medium security hospitals accommodate those who pose a serious danger to the public and high security hospitals accommodate those who pose a grave and immediate danger to the public and who cannot be safely contained within places of lesser security (Rutherford and Duggan 2007).

Ashworth, Broadmoor and Rampton hospitals are the three high security psychiatric settings in England and Wales. They were variously commissioned in response to overcrowding in prisons and asylums, and a lack of suitable accommodation for the 'criminally insane'. Asylums were considered to lack levels of security necessary to accommodate those with criminal propensities, and prisons too punitive for those identified as 'patients', creating challenges for the placement of individuals who failed to conform to conventional criminal or psychiatric systems (Bartlett 1993; Hamilton 1985; Parker 1985).

Reflecting these hybrid origins, the UK high security hospitals have a history of being owned, managed and governed by the Ministry of Justice, the Board of Control for Lunacy and Mental Deficiency and the Department of Health (Bartlett 1993; Black 2003; Hamilton 1985; Parker 1985). All three are currently accommodated by a local NHS Trust and are governed by NHS policies and practices. However, all three also have mandatory security obligations and as such are not completely independent of the prison and legal systems. Although high security hospitals are commissioned to provide a 'distinct and separate environment from prisons', their security standards must conform to Category B prison standards drawn up by the National Offender Management Service (NOMS), and to ensure that these security arrangements are maintained appropriately, they are annually audited by the prison service. Due to the notoriety of some of their patients, the high security hospitals are also required to work closely with the HM Prison Service and Ministry of Justice in other ways (Department of Health 2008, 2010a, 2011).

As a result, although these hospitals' ethos should be therapeutic, emphasis continues to be placed upon risk, public protection and security (Boardman 2005; Department of Health 2000, 2008, 2010a, b, 2011). Despite a series of reorganisations and changes of emphasis, the very nature of their clientele has ensured that the high security hospitals remain delicately balanced between the ideologies of healthcare and of security.

An emphasis on security necessitates a highly structured environment with everyday reminders of the patients' status as someone compulsorily detained in an institution. Unsurprisingly, not all patients accept this readily or all of the time. For those who fail to comply with institutionally prescribed rules, regimes and practices, further sanctions are created to manage such contingencies. Within a high security hospital context, these include the use of coercive measures; specifically restraint, seclusion, segregation and forced medication. These restrictions are deployed to manage those unable to live peaceably in an environment specifically designed for those already deemed unable to live peaceably in either a prison or a conventional psychiatric establishment; individuals who might be described as 'deviant deviants'. Such coercive measures often raise ethical and moral concerns. If and when patients become increasingly challenging, imposition of such measures can become intense. There are no 'even-more-secure,' settings to turn to. As this happens, however, the risks and governance of such practices become ever more demanding and controversial.

Conflict between ideologies of healthcare, safety and security are present across all mental health services. Patients contained in high security hospitals are those identified as posing greatest risks, as well as being in greatest need of treatment and care. High security hospitals are therefore contexts in which the conflicts and contradictions between care and containment are possibly most pronounced and therefore most clearly illustrated.

Theories of institutional and emotion work provide useful ways in which to explore these conflicting values, principles and practices. Institutional theory supports the study of actions within organisations. Theories of emotion work support explorations of actions and emotions. Together, critical consideration may be made of recursive interactions between institutions, emotions and actions. That is, examining the impacts, influences and effects these have upon creating, disrupting or maintaining institutions (Lawrence et al. 2009).

Interviews were conducted with healthcare professionals to explore their experiences of working within a high security hospital environment. The interviews were conducted and analysed using a narrative constructivist grounded theory approach. Focus was upon professionals' roles and practices, particularly in relation to the uses of coercive methods. Narrative inquiry captured professionals' personal experiences, whilst grounded theory allowed these experiences to be analysed and considered in relation to the cultural context of the high security hospital. The following sections will outline the theories of institutional and emotion work used to frame these findings. These will be followed by the analytical processes of conducting, analysing and applying them in practice.

Institutions, Organisations and Actors

Theorising about institutional and emotion work is not new but considering them in tandem is, and doing that in the context of a highly specialised organisation such as a high security hospital is unique. Theorists define 'institution' as the 'rules, norms and cultural beliefs' that are specific to a particular context, place and time (Scott 2001: 48), the ideologies, philosophies and values of a specified group, subject or discipline. In this instance, the institution is forensic psychiatry. 'Organisation' refers to the 'social structure created by individuals to support the collaborative pursuit of specified goals' (Scott and Davis 2007: 11) and the physical context in which institutional ideologies are practiced and manifest and, in this instance, the high security hospital. 'Actors' refers to the people who populate an organisation, commonly employees and in this instance healthcare professionals, but where applicable 'actors' might also include others who are substantial feature of the organisation. Within a high security hospital, that must include its patients. Thus, generic use of the term 'actors' will refer to both healthcare professionals and patients, and 'healthcare professionals' and 'patients' will be used when more specific reference is needed. Theories of institutional and emotion work will each be considered in turn, allowing this combined framework to be applied towards the analytical study of the institution, organisation and actors within a high security hospital setting.

Institutional Theory

Institutional theories can be considered under two main headings: old institutionalism and new institutionalism (DiMaggio and Powell 1991; Hirsch and Lounsbury 1997).

Old institutionalism views organisations as 'closed systems' (DiMaggio and Powell 1991; Hirsch and Lounsbury 1997). Influences outside the organisation are rarely considered and socio-cultural influences beyond the organisation are largely ignored (DiMaggio and Powell 1991; Hirsch and Lounsbury 1997). Prominence is given to ways in which an organisation places constraints upon internal actors and their actions, while actors are perceived to lack agency and the abilities to think reflexively (DiMaggio and Powell 1991; Hirsch and Lounsbury 1997). This determinist perspective views individuals as products of their organisational systems, internalising and being conditioned by institutional norms and values of the organisation in which they are situated (DiMaggio and Powell 1991; Hirsch and Lounsbury 1997). Old institutionalism, favouring a determinist, closed system approach, thereby focuses upon the internal dynamics of an organisation, where the relationships between organisation and actors are examined in isolation (Hirsch and Lounsbury 1997).

New institutionalism, in contrast, views organisations as 'open systems' (DiMaggio and Powell 1991; Hirsch and Lounsbury 1997). Organisations are framed within wider socio-cultural environments and influenced by factors beyond the organisation itself (Handel 2003). This voluntarist perspective views actors as self-directed individuals having free will, autonomy and the ability to change their social contexts (DiMaggio and Powell 1991; Hirsch and Lounsbury 1997). From this perspective, organisations are viewed as formal structures with emphases placed upon studying the institutional influences, forces and pressures (DiMaggio and Powell 1991). New institutionalism, adopting a voluntarist, open systems approach therefore focuses upon the organisation in relation to their wider institutional environments and acknowledges actors as agents capable of change.

Institutional Work

The theory of institutional work developed by Lawrence et al. (2009), aims to unify and transcend old and new institutional schools of thought. Displacing such polarised perspectives, this approach to institutional work adopts a relational perspective towards finding a 'middle ground' where constrained agency manifests (Lawrence et al. 2009). Individual actors are embedded within their social context but remain able to respond to situational occurrences (Battilana and D'Aunno 2009; Emirbayer 1997). Thus, while individuals may be confined to their institutional contexts they are not rigidly confined. Neither do they have absolute agency or free will.

From this perspective, individuals are not only perceived to be shaped by their institutional environment but also able to shape it. Actions in relation to this are considered institutional work (Batillana and D'Aunno 2009; Berger and Luckmann 1967; DiMaggio and Powell 1991). Thus, in relation to individual action, institutions are viewed as being both simultaneously constraining and enabling (Lawrence et al. 2009). Unlike either the determinist or voluntarist perspectives, rather than viewing institutions and actions as *opposing* forces, institutional work, while adopting a relational perspective, advocates that one *presupposes* the other (Batillana and D'Aunno 2009; Lawrence et al. 2009). In doing so, the concept of institutional work highlights the recursive nature between institutions and individual action, broadening the scope of institutional studies through relocating the traditionally narrow focus on outcomes, to one inclusive of the actions, processes and sequences of events that lead to such transformations (Lawrence and Suddaby 2006).

This framework considers organisations to be embedded within parent institutions or sets of institutionalised rules. Organisations are permeated by, as well as permeable to, institutional rules and individual actions. They provide places for study which reveal institutional values and philosophies in action. Actions occur as practice and reveal individual agency within institutionalised and organised beliefs. In doing so, they both expose and reinforce these institutionally organised ideas. Actions are embedded within organisations as organisations are embedded within institutions. Relationships between the institution, organisation and actors are therefore equally situated, interactive and mutually reinforcing. Institutional work refers to the efforts, dynamics and relationships between philosophies, structures and actions. These are each considered permeable, interrelated and recursive such that institutions can be created, disrupted and maintained (Lawrence and Suddaby 2006; Lawrence et al. 2009).

In exploring the theory of institutional work, institutions, organisations and actions are all considered. The notion of work implies effort, intentionality and agency. What institutional work theory alone does not consider, however, are the impacts of emotions and actions upon the actors in influencing their work. Theories of emotion work offer a way of incorporating this into a strengthened framework applicable to the study of institutional settings where emotions might run high, such as mental health services and particularly secure and high security hospitals containing reluctant inmates.

Emotion Work

The ideas of Arlie Russell Hochschild are often cited as seminal to the study of emotion work. Hochschild distinguishes between the 'private' and 'public' presentation of emotion, akin to the Goffman's *The Presentation of Self* (Goffman 1959). Whereas Goffman uses the analogy of theatre and stage to explore everyday interactions—front stage to describe the visible social actions where a performance takes place; backstage where real feelings and hidden interactions may be revealed—Hochschild uses concepts of emotion work and emotional labour to describe the efforts required in presenting oneself in ways that are socially acceptable and indeed desirable within private and public spheres. She uses the term 'emotion management' to describe 'the management of feeling to create a publicly observable facial and bodily display' (Hochschild 1983: 7).

Hochschild's distinction between emotion work and emotional labour is based on context. She proposes that emotion work takes place in the private realm such as at home, while emotional labour is sold as a commodity and takes place specifically in the context of the workplace. The management of emotions is learnt through 'feeling rules', learning how one is supposed to behave in certain contexts, and thus requires individuals to act in ways that may be different to what they actually feel. Emotion work and emotional labour are therefore perceived as being greatly influenced by organisational rules and individual perceptions of organisational demands upon them.

Hochschild distinguishes between 'surface acting' and 'deep acting'. She defines surface acting as the superficial display of emotions using 'the ability to deceive others about how we are really feeling without deceiving ourselves' (Hochschild 1983: 33). Deep acting in contrast is where individuals induce feelings through imagination in a way that such feelings become deceptive to 'ourselves about our true emotion as we deceive others' (Hochschild 1983: 33). Surface acting relates to 'how people try to appear to feel' (Hochschild 1979: 560). Deep acting, in addition, refers to the effort required in 'how people try to feel' (Hochschild 1979: 560). Using the language of institutional theory, surface and deep acting may therefore be considered the processes and intensities by which an individual becomes increasingly 'institutionalised' as they depart from their personal values and internalise institutionally held expectations, norms and beliefs.

Emotion theorists argue that either type of acting can be destructive, both to the individual and the recipient of individual action, particularly where genuine feelings are necessitated as part of the workers' role (Hochschild 1979, 1983; Bolton 2005, 2009). Superficial acting results in the inauthenticity of one's actions. Deep surface acting has the effects of self-induced alienation and estrangement from one's genuine feelings, emotions and actions. Comparable to institutional theory, actors engaged in emotion work are seen to be influenced and constrained by their institutions and organisations (Hochschild 1979, 1983). Emotion work is performed in light of institutional expectations, whether these expectations are real or perceived by the actor. Emotion work is therefore most apparent when institutional and organisational expectations differ most prominently from personal values, raising questions and concerns about the validity of workers' emotional displays, and the authenticity of workers' actions (Hochschild 1979, 1983; Bolton 2005, 2009).

In bringing together theories of emotion and institutional work, it is recognised that emotions affect actions and actions affect emotions (Fineman 1993). This approach offers a much broader scope than a simple dichotomy between actors and organisations. Furthermore, by including the concept of institutional work, emotion work is no longer confined to the organisation itself, but is also seen to be influenced by wider environmental and institutional factors. By collectively considering theories of institutional and emotion work, emphasis is placed on effort whilst at the same time considering both emotions and actions as 'work'. Through viewing institutions and organisations as having both enabling and constraining effects of emotions and actions, emotion work within this context not only encompasses workers' management of their personal emotions in accordance with organisational and institutional expectations but also the emotions of colleagues and patients. As such, emotion work in this context may be viewed as being not only the management of personal feelings but also the displays of institutionalism and professionalism. Again, this is a highly suitable way of considering ‘work’ in contexts such as the conduct of coercive measures in mental health settings, particularly secure ones.

Applying Institutional and Emotion Work Theories

The recursive interactions between institutions, organisations and actions inherent in theories of institutional and emotion work highlight the importance of context—the positioning of an individual in relation to their physical and socio-cultural environments. This lends itself to a broadly constructivist grounded theory approach which recognises that although attempts can be made to study phenomena objectively, it is impossible to be completely value free. Instead, importance is placed on acknowledging and being sensitive to the particular time, space and situation that frame the phenomena under investigation. These are incorporated into the analysis and development of emergent concepts. Parallel to the recursive relationships between the institution, organisation and actors, a constructivist grounded theory approach views the relationships between theories, findings and analyses as interactive processes, whereby each informs the other (Glaser and Strauss 1967; Strauss and Corbin 1990, 1998; Glaser 2001; Bowen 2006; Corbin and Strauss 2008; Charmaz 2011). Against this methodological background, theories of institutional and emotion work have been used to:

(i) Examine the institution of forensic psychiatry
(ii) Explore the organisational arrangements of a high security hospital
(iii) Analyse the practices, processes and efforts of healthcare professionals required to manage their emotions and actions within a high security hospital environment

Interviews, Ethics and Analytic Processes

Twenty-eight interviews were conducted with healthcare professionals. These adopted a narrative, broadly constructivist grounded theory approach to enquiry. Exploratory questions were asked concerning respondents' experiences of working within a high security hospital, their thoughts and feelings towards the uses of restrictive or coercive practices, and more specifically, how these related to their roles. Respondents were predominantly staff nurses and nursing assistants but a smaller number of team leaders, ward managers, responsible clinicians, psychologists and social workers were included. All worked with male patients with a primary diagnosis of 'mental illness', as opposed to 'learning difficulty' or 'personality disorder'. All respondents work full time.

Ethical approval was granted by the National Research Ethics Service Committee. Participants were given information sheets about the study and any questions were answered before consent forms were signed. All interviews were digitally recorded and transcribed by the researcher. Digital recordings and transcriptions were kept in password protected, locked files in keeping with information governance regulations.

A narrative approach allowed participants greater freedom to speak about their thoughts, feelings and experiences concerning their work. Reflecting methodological strategies of emergence and the embeddedness of prior knowledge, the interviewer remained open to new ideas emerging from the participants' narratives, asked further questions about these ideas, whilst being aware of the framework offered by institutional and emotion work theories. Constant comparisons were made between data, analysis and theory. During this iterative process, the researcher became increasingly immersed in analytic inquiry, such that data and theory were mutually influencing and co-constructed. In adopting a reflexive approach towards the analytical process, field notes and reflections were recorded. These are summarised below.

Field Notes, Reflections and Observations

The investigator is a registered mental nurse but in order to work within the high security hospital, she was first required to undertake additional mandatory training. This was a one-week induction of education and preparation concerning the values and expectations of the hospital; the security measures, hospital policies and procedures, as well as physical training in personal protection and the management of violence and aggression.

This was followed by a four-week placement, where for the first time she experienced the intensity of the day-to-day workings of a high security environment. After one week of training, she was working 14-hour shifts, responsible for her own set of keys, the locking of heavily reinforced doors and high fences, with a mental list of do's and don'ts—the breach of these potentially resulting in instant dismissal. These, she was told, were things she would get used to.

Her time gathering data was an interesting experience. The first two weeks of attempting to collect data were perhaps the most challenging. She was working across four wards, each with different rules, routines and layouts. To complicate matters further, her role was not one of a 'typical nurse'—she happened to be a researcher with a background in mental health nursing who had chosen to study for a social science PhD. She had neither a conventional career nor a conventional role. Her background in mental health nursing certainly seemed to help in becoming an 'insider'; her role as a researcher, however, often meant that she was left on the 'outside'.

I was struck by the frequency at which individuals would talk to me 'off the records' whilst being reluctant to participate or be recorded 'officially'. Often, this was due to staff concerns at being identifiable. An anxious culture seemed to remain where being recorded was concerned. This was juxtaposed by the interviews themselves. During the interviews I was primarily struck by how open and honestly individuals talked about their personal feelings and emotions in relation to their work; how openly they expressed the fears, anxieties and anguish they face in being at work, and the potential risks and harm they subject themselves to on a daily basis. This was in stark contrast to my initial experiences of working in this environment and my observations of how members of staff behave amongst the general ward milieu. I had grown accustomed to observing individuals bantering, responding apparently fearlessly to alarms and incidents, sitting outside seclusion rooms appearing calm and collected, in what might generally be referred to as 'masculine' environment—one of bravado, machismo and an obvious body building culture. To listen to these 'hidden' feelings and emotions was therefore a privilege. As a researcher, I was given the rare opportunity to gather rich data within a unique environment. As a nurse and on a more personal level however, I often felt helpless. Despite being aware that individuals were not alone in *their feelings, I did not feel able to reveal this to participants at the time of the interviews, for fear of betraying what others had so honestly told me—the ultimate irony being that there were emerging parallels between the tensions I felt in relation to my 'work', the theories used to explore institutional contexts and the findings from this study.*

Actors' Roles and Experiences

Three main themes emerged from the interviews; isolation, formal and informal roles, and containing emotions in contained places.

Isolation

It was apparent that working in a high security hospital can be an isolating experience. Respondents described isolation in both physical and emotional terms.

Physical Isolation

Physical isolation was described through the language of the 'inside and outside'. A sense of detachment from the outside was described as influential in two ways. Firstly, in creating 'tighter bonds' between the workers and, secondly, as reminding them of the unusual places in which they work and that their roles occupy:

> *We are detached from the rest of the world. We're in our own little bubble, so I'm an expert [in here] but out there I'm a novice, I wouldn't know, I wouldn't cope out there (SN – male)*

> *We don't see what happens outside, that within other services we just don't see, we don't deal with (SN – male)*

> *I think it creates stronger bonds between people when you've been involved in them sort of incidents together. … I've got some friends that are in the army and*

> *they say, friends, you know, mates that they've made when they've been in war zones together, I mean, they say it's a relationship that other people can't understand, you know, I suppose it's like that but on a much extreme scale isn't it (NA – male)*

Emotional Isolation

Emotional isolation was revealed as two subthemes: emotional isolation from work and colleagues, and emotional isolation from family and friends.

Emotional Isolation: Work and Colleagues

Fear and anxiety were common amongst all of the respondents. Paradoxically, these were considered unacceptable public displays and those who displayed these emotions were spurned by observers. To reveal fear and anxiety was considered a weakness through which confidence, trust and respect between colleagues could be lost. Respondents described concealing these emotions, while trying instead to appear confident and in control.

> *I know people, I personally know people that are fearful, fearful of restraint, fearful of that kind of, "can I?", and when those incidences do happen, they shy away from being involved… some people sometimes develop an aversion, I know quite a few people here that have, and it's not healthy, it's not healthy, you're in the wrong environment to be here to develop an aversion to that (SN – male)*

> *I mean you hear of some people where if there's a situation some people just go and lock themselves in the toilet or just disappear… they're scared, so they just go and do a runner… they just run away and hide or whatever and bury their head in the sand and run away from it all (NA – male)*

> *Your heart's absolutely racing, you think, oh god, I just want to get it right (SN – female)*

> *What always plays on your mind is just to make sure you are doing things right, you know, it's a volatile situation whereby emotions are running high, up and down, but still as staff, you just keep on reminding yourself that, you know what, you have to do things right (SN – female)*

> *I'd have been very anxious and wanting to leg it, or fight or flight, whatever you want to say, but since I've been here, I won't say that I don't get anxious with the situation, but because it happens so regularly, my anxiety is nowhere near as high and I can, I would say, appear calm but like a duck under water, I'm going like mad (SN – male)*

Emotional Isolation: Family and Friends

On the face of it this suppression of emotions appeared to strengthen relationships between workers. However, in creating this façade of coping, respondents felt increasingly isolated from colleagues, family and friends. They spoke of 'outsiders' being unable to understand or comprehend the work involved in a high security hospital.

> *I mean maybe you might go home and talk to your family and friends about it… I mean, I don't personally… I don't, I like speaking to work, I think it's something that only people that work here can understand if you know what I mean, I wouldn't really try and discuss it with family or friends (NA – male)*

> *You can't really tell people that don't understand, so you can't take it home with you, because they don't understand the process, they don't understand the things that you're going through and that you're dealing with (SN – male)*

These feelings of isolation suggest the emergence of alienation and estrangement, both from the healthcare workers' personal self and also in relation to others. This distancing suggests work and effort in managing personal feelings and maintaining professional roles, whilst façades mask the tensions, conflicts and fragilities that accompany them.

Formal and Informal Roles

Respondents frequently described differences between policy and practice, as well as between training and reality. These exposed differences between institutional expectations and the realities of how these expectations were practiced. They alluded to formal and informal roles; what 'should be' and 'what actually occurs'.

Formal Roles

Respondent were adamant that their roles were of healthcare and those contained were patients.

> *We're nurses, we're not bouncers, we're not soldiers, you know, we're nurses… it's a very different role, but we're not prison guards (SN – male)*
>
> *We're dealing with patients not prisoners (SN – male)*
>
> *It isn't a prison, it's a hospital and that's the difference, these people are poorly you know, and we have to remember that (SN – male)*

However, the realities of working within a high security hospital setting frequently created tensions and conflicts between care and containment. Security imperatives contradicted and frequently undermined the supposed priorities of care.

> *It does clash, especially the balance between somebody being safe and secure and the interventions that as a nurse you need to do… in some respects it's about doing the nursing stuff when it's okay to do the nursing stuff, keeping everybody safe and secure and you have to forget that [nursing] intervention (SN – male)*
>
> *I think there's a real tension… I think there is this real custodial emphasis (RC – female)*
>
> *The security sometimes governs the nursing, if you know what I mean, so things that you might do in other hospitals, you have to do differently here because of the security measures (NA – male)*

> *The major issue with the job is maintaining security and safety essentially… maintaining the security and safety of all is the primary role of this, the nursing is secondary (SN – male)*

Informal Roles

Despite parallel obligations to forensic and psychiatric work within the combined discipline of forensic psychiatry, respondents continually sought to distinguish between the 'mad' and the 'bad'.

> *I think people, the more mentally unwell you are, unfortunately, the less you know what you're doing, in general terms, people who are more mentally ill than maybe just not a very nice person (NA – male)*

> *Very often it's the nature of the illness-if it's illness related. Sometimes it isn't illness related, it's behaviours that they engage in (SN – male)*

> *We deal with some very poorly people but we also treat some extremely difficult people that present with some terrible behavioural issues, so in that sense it's quite a challenging environment to be involved with (TL – male)*

Such judgements of patients, along with how practitioners interpreted and managed their roles, influenced their actions and emotions. Although it was formally recognised that care should be prioritised over containment, respondents acknowledged that individual differences meant that institutional ideologies were practiced differently by different people and also between different wards within the organisation.

> *I think you've got a sort of continuum expressing the two extremes that there are some staff who are very custodially orientated and can be quite negative about the patients – the kind of patients we get here and almost punitive towards them, so they're here to be told what to do and there's that end, and can sometimes be quite aggressive and unsympathetic, and then there's the other extreme which is the more therapeutic, which has to be balanced (RC – female)*

> *Different staff react to things differently, and the management, they make you work differently as well, like how the wards are run (NA – male)*

> *I think the challenges are how a restrictive environment still allows people to progress within those restrictions and to get the line right between putting boundaries in to keep people safe but then not becoming oppressive. So I think the challenge can mean the challenges that come from patients but can also mean the challenges that come from the philosophy of the environment (SW – female)*

Containing Emotions in Contained Places

Respondents spoke of challenges committing themselves to restrictive practices within already restrictive places. These were discussed in relation to restraint and seclusion which were practiced when patients did not conform to organisational expectations. These challenges were referred to in two ways; heightened emotions and emotional blunting. Each of these resulted in physical and emotional toll.

Heightened Emotions

There was a heightened sensitivity to emotions in relation to work within the high security hospital, which was commonly revealed through the language of preparedness, apprehension and being 'switched on':

> *When I first came to work on here, I found it quite daunting at times, the thought of being attacked, the thought of restraining patients… For want of a better phrase, I suppose I found it quite scary you know, it used to make me anxious… I'd feel anxious, my palms used to sweat… it would not be a pleasant experience really (NA – male)*

> *[It's] a constant state of, you know, like, just having to be prepared to whatever, which we tend to have on a daily basis anyway because of the types of patients we work with (SN – female)*

> *I always come into work and I always try and switch on, as soon as you come through the fence, you switch on, because it has the potential to be a very volatile place… you're alert, you're there, why are they doing this for, constantly*

> *questioning things and stuff like that, so that's what I do to try and keep myself safe, is being alert to what can go on (NA – male)*

Emotional Blunting

A lack of emotion became apparent through descriptions of becoming increasingly detached and desensitised from work and personal feelings. This was described in terms of self-preservation and professional integrity. Self-preservation amounted to distancing as protection from uncomfortable feelings that could arise from tensions between personal and professional values. Professional integrity referred to distancing in order to conduct expected duties and role.

> *You do get desensitised to it the more incidents you get involved in. If I revert back to the first incident when I worked on acute, I was shaking afterwards, sort of like what's happened there sort of thing, whereas now, you just kind of get on with it you know, I know that might sound a bit mechanical but that's how I react now (NA – male)*

> *You just kind of, like I say, develop a certain set of skills where you don't really let anything, you don't really let it bother you too much I suppose (NA – male)*

> *It doesn't affect you after a certain amount of time, you just have to, you learn to deal with situations and not let them affect you… I've got a job to do, it's another hat that I've got on, that I have to wear when I come to work… I can work around it by making sure that I'm coming here to try and do a job (SN – male)*

Physical and Emotional Toll

The tensions and obligations involved in balancing institutional expectations, organisational rules and personal values required work and effort. These were considered to be 'part of a job' and something workers 'have to make peace with'. However, they also took their toll, physically and emotionally.

> *You kind of have to take it in your stride, and I think there's a certain element where you have to make your peace with it… you have to make your peace with it irrespective of your feelings about it, and do it to the best of your abilities, you know (SN – male)*

> *It is part of the job, you don't enjoy it but you know it's there and you deal with it, try and make a bit of light of it afterwards, as a coping mechanism more than anything (NA – male)*

> *It's not the easiest of jobs, sometimes, it's very difficult to, when you have to be physically involved in restraining patients, that doesn't initially sit very easily with how you're first educated to what nursing is, it doesn't, you know, they don't sit comfortably together (TL – male)*

> *At this point, it's draining… I've had enough, it's repetitive, if I've been here a lot, it can seem quite soul destroying, it just gets too much to bear after a little while… you can only take so much, so much arguing, so much abuse, so much violence, so much of this every day before it starts wearing you down… I think it should be short term plan for staff as well as patients, a couple of years I think in this sort of environment (SN – female)*

> *It is a tough environment, you've got very difficult patients down there and you do have to be very careful of a) your own stress levels and b) the stress levels of other staff that you're with… I'm a big believer that in that really stressful environment, everyone has their shelf-life date (TL – male)*

Institutional Maintenance, Reinforcement and Reproduction

Conventional approaches to mental health difficulties, and services which respond to them, tend to focus upon the individual, without giving due consideration to their wider social, organisational and institutional contexts. A constructivist approach framed by institutional and emotion work theories has provided a way of doing that in a highly specific and informative context. By examining the discipline of forensic psychiatry at institutional, organisational and individual levels, some of the recursive nature of these influences is revealed. Within the context of the high security hospital, the institution and organisation are maintained through governance, policies and training. The care delivered within the hospital are governed by NHS regulations, whilst the security standards are audited by, and must conform to, those of the Criminal Justice System (Department of Health 2008, 2010 a and b). Policies set out ways in which staff must practice and reinforce the institutional expectations and rules they must abide by. The training, experience and indoctrination of staff within the hospital further endorse the principles, interests and ideologies of the institution. These each serve to legitimise the institution as a specialist discipline and the organisation as a necessary place of containment.

By scrutinising the practices of forensic psychiatry as encountered in a high security hospital, it is clear how this institutionally embedded organisation is maintained through regulatory mechanisms. As healthcare workers feel increasingly isolated, alienated and estranged from those who do not understand their work, feelings and roles, distinctions are made between the inside and outside. In turn, insular communities are formed within. These communities are both regulated by organisational rules and are self-regulated by how workers act and react towards the perceived expectations of them. These institutionally governed expectations, values and practices impinge upon and affect workers' emotions, actions, work and efforts.

The actions and physical work of healthcare professionals are highlighted through the everyday security practices and restrictive measures that are both sanctioned by the institution and depicted throughout the interviews. These do not always conform to the healthcare professionals' personal values, and where they do not, greater work and effort are required to conduct institutionally expected actions and practices. The emotion work of healthcare professionals in this context is illustrated through displacing personal emotions of fear, anxiety and apprehension, with institutionally accepted displays of confidence, coping and dependability. This façade enables healthcare workers to perform their professional duties by providing three main functions; i) the maintenance of institutional values and expectations, ii) the preservation of confidence and relationships between colleagues and iii) self-preservation.

By suppressing real feelings and instead displaying institutionally expected emotions, workers maintain an institutional veil. It is through these displays of confidence and bravado that relationships between colleagues were strengthened and reputations for dependability and reliability developed. These have the effects of being protected and looked after by colleagues. Through working on how they are supposed to feel, the worker becomes increasingly institutionalised and detached from conflicting personal emotions, but these achievements come, it would seem, at a cost.

The interviews revealed that those who are unable to manage their personal emotions either leave, are rejected by their co-workers, or become fatigued. Those who are better able to manage their emotions however, become increasingly institutionalised, isolated and removed from their personal feelings and values. In focusing their efforts on how they should feel rather than how they actually feel, the healthcare professional becomes increasingly detached, desensitised and emotionally blunted. Through the processes of institutionalisation, a lack of personal compassion, empathy and care ensues, and as a result the healer effectively becomes a custodian. The tensions between personal and professional values, the pluralistic institution of legal and healthcare work, judgements and labelling of the 'mad versus bad', along with individual interpretations of institutional values were exposed as a continuum between caring or more custodially orientated actions. These influences each have the effects of disrupting and reconstructing institutional ideologies in practice.

Implications for the Relationship between Psychiatry and Social Sciences

This particular examination of psychiatric practice using social scientists' lenses offers its own contributions to the edition's core questions: 'What does social science teach us about mental health practice?' and 'How has this investigation of mental health practice informed social theory, and what related opportunities does it suggest?'.

Theorising institutional and emotion work allows closer considerations of the relationships and interactions between the institution, organisation and actors. In doing so, attention is drawn towards understanding how institutions are maintained, reinforced and reproduced. By combining theories of institutional and emotion work as a framework for investigating professionals' experiences of working in a high security hospital three important themes emerge:

- On the surface, healthcare professionals working in a high security hospital organisation appear confident in their work. The fragility of the institution however, is exposed when staff reveal their real feelings towards their work and roles, and institutionally expected actions are revealed as a façade towards concealing private emotions
- The concealing of real emotions creates an institutional veil that masks the private despair and turmoil that healthcare workers frequently experience as a result of working time spent in this, or quite possibly related environments, where emotional work is particularly demanding.
- As workers become increasingly institutionalised and embedded within an organisation that demands emotional numbing, questions are raised as to whether healthcare professionals are able to act as authentic healers or become obliged to act as custodians.

Each of these has implications for the well-being of the mental health workforce. Although the particularities of a high security hospital bring this into special relief, concerns raised by this study have wider implications. Through studying healthcare professionals' emotions in relation to their practice, attempts can be made to understand how practitioners reconcile their personal values and professional roles. Institutional and emotion work theories encourage questions to be asked of the organisational expectations placed upon practitioners. Not only do they expose the detrimental effects of workers' suppressing their emotions, they also reveal paradoxes between the language of care and the practices of containment which are found throughout mental health services. Though presented as a 'healing' enterprise, much of psychiatry is obliged to respect social and institutional expectations of risk management. Fulfilling these obligations not uncommonly requires a more-or-less paternalistic if not custodial approach. This application of institutional and emotion work theories could be broadened to reveal how these seemingly irreconcilable ideologies might be more constructively brought together in the interests of both practitioners and clientele.

Similarly, this investigation of healthcare workers' experiences informs social theory by bridging two previously disparate areas of scholarship; institutional and emotion work. In doing so, it has exposed limitations of considering either of them alone, and the complementary strengths of each when combined. It would be irrational to study psychiatry without due considerations of individual feelings and emotions (Hochschild 1979, 1983). Likewise, feelings and actions cannot be considered without a given context (Hochschild 1979, 1983; Lawrence et al. 2009). Mental health services provide particularly vivid illustrations of the interactions between institutional work and emotional self-management, and wide range of opportunities to explore them.

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7

Community Mental Health Teams: Interacting Groups of Citizen-Agent?

Hugh Middleton

Service Setting: Community Mental Health Teams

Community mental health teams are organised around the needs of clients living within a geographically defined area. In the UK, every such area will have several teams, each one charged with providing for a particular set of clients. Sets of clients deemed to be the responsibility of distinct teams are differentiated on the basis of age, perceived risk, chronicity of difficulties and psychiatric diagnosis. Thus, broadly, in the UK a geographically defined population of some 300,000 will be provided for by a child and adolescent mental health service (CAMHS) team serving the under 18s, a mental health service for older people (MHSOP) team serving the over 65s, an early interventions for psychosis (EIP) team serv-

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H. Middleton (✉)
School of Sociology and Social Policy, University of Nottingham,
Nottingham, UK
e-mail: hugh.middleton@nottingham.ac.uk

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ing younger adults with incipient psychosis, an assertive outreach (AO) team providing for people of working age who have proved both a source of continuing concern and reluctant to accept assistance, a crisis resolution and home treatment (CRHT) team providing intense, short-term care for those in acute difficulty, a rehabilitation and recovery (R&R) team offering support and rehabilitation to stable but persistently disabled adults, a drug and alcohol team focusing upon the particular needs of the chemically dependent, and a primary care team providing liaison with general practitioners and short-term therapeutic interventions when these are considered to be most appropriate. Teams range in size from 3 to 4 to 20+ whole time equivalent practitioners. Configurations vary depending upon geography, demographics and choices made by service providers and commissioners. Nevertheless, in the UK this configuration continues to largely respect Department of Health guidelines issued in 2001 (Department of Health 2001).

Encounters between practitioners and their clientele occur in differing locations and at differing frequencies. Most are in clients' homes but they may take place in public spaces such as a coffee shop or a market, they may take place in a healthcare facility such as a general practice surgery or a room at the team base. Contacts can be as frequent as several times a day in the case of someone in acute crisis and as infrequent as once a month in the case of someone who is in a stable but persistently dependent condition. As their needs change, clients' provision may move from the caseload of one team to that of another, as might happen with someone who has been supported during an acute crisis and no longer needs the intense support provided by a CRHT, but continues to need the support of an R&R team or a short-term psychosocial treatment provided by a primary care team. Teams are multidisciplinary, predominantly made up of community mental health nurses (CPNs) but also including occupational therapists (OTs), social workers (SWs), psychologists, medically qualified psychiatrists and professionally unqualified healthcare assistants (HCAs) or support workers. The result is a comprehensive but complex set of activities. Furthermore, for reasons of financial accounting, risk management, quality assurance and professional governance, the activities of this workforce have to be recorded, overseen and kept under review. Individual practitioners are governed by their professional codes of conduct but whether working for the NHS, or another provider organisation in another jurisdiction, they are each, formally, an employee obliged to play their part in providing the service their employer has been contracted to fulfil. In the UK NHS, those services are largely specified by NHS England which oversees Clinical Commissioning Groups, which themselves contract to purchase services from provider organisations on behalf of the NHS. In other jurisdictions, service specifications are determined by negotiation between insuring organisations and state bodies.

Community mental health team working began as large asylums were wound down, in England from the 1960s onwards. Initially, CPNs were employed to “keep an eye” on those discharged from hospital and not uncommonly to administer depot neuroleptic medication. As psychotherapeutic interventions became more popular, and the range of conditions considered to be the remit of specialised mental health services was broadened to include depression, anxiety and personality difficulties, community mental health teams grew in size and their membership embraced these more varied tasks. The *fin de siècle* community mental health team was a group of individuals co-occupying a base (usually symbolically away from the hospital) from where they would each service a personal caseload. Their interventions would vary according to clients’ needs and an individual practitioner might, for instance, call in for a cup of tea and a chat whilst administering a depot injection with one, attempt exposure therapy in the form of a visit to the local shop with another and give benefits advice to a third, but all three and more besides would constitute their personal caseload, where a considerable degree of latitude and idiosyncratic practice was possible. There was one instance, in 1994, of an NHS CPN pursuing sexual relationships with several of his alcohol-dependent female clients at the same time.[1]

Not only did personal caseloads expose practitioners to such risks, but the arrangement was inflexible in that it was confined to working hours. As clients were considered exclusively the responsibility of individual practitioners, they could only be seen when their practitioner was at work. The UK NHS 2001 Policy Implementation Guide (Department

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[1] This situation confronted the author when he took up an NHS consultant psychiatrist post in 1994. The nurse in question was disciplined and lost their registration.

of Health 2001) was a response to these shortcomings and a rationale for considerably strengthening the community mental health workforce. Varying types of need were delineated and identified as the responsibility of differing “specialised” teams. Working hours were extended; a typical CRHT team will provide round-the-clock cover, an AO team might provide 12 hours cover six days a week, whilst a primary care team and a R&R team might continue to keep conventional working hours. A direct effect of extending working hours beyond the conventional is the need for shift working and as a result shared caseloads. Thus, an individual client comes to be seen as a team responsibility, or perhaps the responsibility of a small number of practitioners, so that informed action can be taken by whoever happens to be on duty at the time. This development has heightened the importance of how well the team functions *as a team.*

Practitioners in a *fin de siècle* community mental health team provided a variety of individualised functions defined by the particular needs of their individual clients. With the introduction of “specialised” teams, their tasks have become identified with the ethos of this, that or another team. However, it remains unclear whether or not these different ethos genuinely reflect different technologies of care, or whether they simply reflect contextually differentiated applications of a more generic set of activities which can still be understood as ”community mental health care.” This is important if such activities are to be refined, and if they are to be understood in a wider social context.

“Specialised” Community Mental Health Teams: The Evidence

A CRHT team will be identified with the task of containing an individual client’s distress within the home setting, with the aim of preventing admission to hospital. CRHT has now been evaluated as a package on numerous occasions. A recent review identified 24 qualitative studies, 16 clinical trials comparing CRHT with treatment as usual, 5 clinical trials comparing 2 models of CRHT, 4 national and regional surveys and 20 government/expert reports (Wheeler et al. 2015). Despite this considerable literature, the authors were unable to draw confident conclusions about the critical components for effectiveness amongst such teams. They did find limited evidence from the quantitative studies that CRHT teams can provide alternatives to hospital admissions; their primary *raison d'être*, but they also acknowledge that the activity is a complex one presenting considerable methodological challenges to the search for an understanding of critical components.

An AO team will be concerned with maintaining engagement with clients who are primarily reluctant to identify themselves as one with a mental health difficulty, and needing to alter their ways if they are to survive safely and comfortably. "AO" is a British term introduced in the course of importing an American approach otherwise known as assertive community treatment (ACT). In 1980, Stein and Test reported positive results from Madison, Wisconsin. The need for hospital readmission was reduced when clients were provided with an intensified programme of community support (Stein and Test 1980). A review of accumulated data in 1998 supported the view that this was superior to prior forms of mental health team activity amongst those prone to frequent hospital admissions (Marshall and Lockwood 1998). Subsequent reflection upon these findings has suggested that differences between ACT (or AO) and other forms of community mental health team activity are more accurately attributable to differences in context; longer periods in hospital and less comprehensive "control" conditions in Europe than in the US (Burns et al. 2002). Despite this, AO teams have become an integral part of UK NHS mental health service provision, perhaps reflecting an intuitive interest in responding energetically to clients with a reputation for troublesome behaviour and disruption, rather than scientific evidence. One attempt to clarify what the ingredients of AO might be, that do result in reduced hospital admission and other forms of clinical improvement, found significant associations between reduced hospital admission and small caseloads, frequent visits at home and the proportion of contacts that were domiciliary (Burns et al. 2006). The authors conclude, however, "Complex services need to be deconstructed before we can draw conclusions about their effectiveness" (p. 35).

The rationale supporting EIP is evidence of a relationship between the duration of untreated psychosis and longer-term outcome (Marshall et al. 2005). However, models of implementation vary (McGorry et al. 2010), there is little clarity about whether benefits that are observed are due to the early introduction of antipsychotic medication or other components of the intervention (Stafford et al. 2015), recovery trajectories vary quite considerably and it is unclear how these might be influenced by process variables such as engagement with services, the way in which individuals understand and cope with their psychotic episode, and their adherence to treatment (Hodgekins et al. 2015). Finally, there is continuing debate about how the effects of mental health service intervention upon young people might be measured (Kwan and Rickwood 2015).

An R&R team will be primarily concerned with enabling their clientele to move beyond the identity of one with a mental health difficulty into a life of greater autonomy and self-reliance. This is an expression of widespread interest in realising promises of the notion of "recovery," as articulated by Patricia Deegan in 1988 (Deegan 1988). "Recovery" is more a philosophic, existential or even spiritual concept than a term which refers to a specific form of treatment or service provision. Nevertheless, it has become a goal for all involved with mental health services (South London and Maudsley NHS Foundation Trust and St. George's Mental Health Trust 2010).

Primary care teams provide more explicitly psychotherapeutic interventions such as anxiety management, group-based cognitive behaviour therapy, distress tolerance or mindfulness training. In the UK NHS context, these activities are effectively indistinguishable from those of NHS counselling services introduced in recent years under the name of Improving Access to Psychological Therapies (IAPTs), which serve to provide short-term psychological interventions where appropriate without the need for clientele to become overtly associated with mental health services.

Services for clients at the beginning and later in life: CAMHS and MHSOP embrace the range of needs they encounter, with a particular focus upon dementia amongst the latter and family work amongst the former.

These teams might differ from one another in terms of clients' age or perceived level of risk, staff/client ratio or in terms of their hours of opening, but there are few pointers to distinct technologies of care. Distinctions between them provide a bureaucratically convenient way of rationalising the community mental health workforce but they leave a lot unsaid about what actually happens on the ground or in the home. All are likely to provide for some amongst whom the primary focus of treatment will be the maintenance of a medication regime, some for whom the prime focus is benefits advice, some for whom it is a programme of low-intensity cognitive behaviour therapy, and many for whom it is a much less well defined activity. All of these are interactions between mental health practitioners and clients resident in the community who have been identified as individuals with a mental health difficulty. From a sociological perspective these are people whose defining characteristic is that they have been identified as deviant (Scheff 1999). In most instances, involvement of the mental health team will have been in response to unacceptable disruptions of social order in the form of troubling behaviour or in the form of distressing distress. Community mental health teams respond to these eventualities. Although they are presented as a family of interventions, their overriding remit is to contain and limit the consequences of deviance and distress. Beyond specifying the client groups differing teams address, the existing literature provides little insight into how this is achieved and what can be learned from studying it. The field is teeming with questions, and yet relatively unexplored.

The Work of Community Mental Health Teams

One source of insight into how community mental health teams function and what they do is a large, nationwide study which was funded by the UK National Institute for Health Research (NIHR) between 2009 and 2012 (West et al. 2012). NHS Research Ethics approval was obtained for all aspects of the study. It was primarily an investigation into the quality and determinants of team processes. Most resources were invested in a quantitative study but interviews were conducted with a total of 144 community mental health team practitioners drawn from a variety of teams. These were intended to inform the quantitative research but it has been possible to review them with the aim of exploring what informants divulged about their work and the context within which it is conducted. Conduct and findings of the quantitative analysis of community mental health team processes are summarised, followed by an analysis of how respondents viewed their work and its challenges.

Team Processes

Community mental health team processes were explored using the productivity measurement and enhancement system (ProMES) (Pritchard 1990; Pritchard et al. 2008). This approach has been applied to the investigation of team processes across a range of contexts. By one means or another, a measure is developed of how well the team fulfils its stated aims. Estimates of this are then regressed against established indicators of team functioning. In this instance, a measure of community mental health team effectiveness was developed in the course of ten workshops organised in three phases. Participants were 157 practitioners and managers of all grades and professions, and clients and their carers, all drawn from 13 mental health provider trusts across England. The first phase identified the outcomes of an effective mental health team, the second how these might be expressed as questionnaire items and the third was a validity check upon them when formulated as such. This process resulted in a 20-questionnaire items such as “My team helps service users to build positive aspects of their lives,” “Service users rarely receive care from the same members of my team (negatively scored)” and “In my team, relationships with service users are based upon openness.” Responses to this questionnaire were obtained from 1500 community mental health practitioners drawn from 135 teams across 11 NHS mental health trusts. The questionnaire demonstrated good psychometric properties which were identified as a single latent factor comprising seven dimensions. These were improved service user well-being, creative problem solving, continuous care, inter-team working, respect between professionals, engagement with carers and therapeutic relationships with clientele (El Ansari et al. 2015).

Measures of team functioning were obtained using the Aston Team Performance Inventory (ATPI) (West et al. 2005). This is a validated and psychometrically stable set of 100 items: 34 concern team inputs, such as “Every team member puts in sufficient effort to get the job done” or “This organisation only gives people the minimum training needed to work in a team (negatively scored)"; 28 concern team processes, such as "This team often reviews its objectives" or "Team members sometimes have unpleasant or heated conflicts with each other (negatively scored)"; 17 concern leadership, such as "(Leader) encourages the team to look at problems from a different perspective" or "(Leader) is available to team members to discuss a problem or particular issue"; and 21 concern generic team outputs such as "Managers often praise the quality of our work" or "I am satisfied with the amount of responsibility I am given in the team". In this way, the ATPI provides quantitative insights into individual team's performance and data that can be aggregated to explore interactions between team inputs, processes and outputs. Obtaining these data in parallel with an estimate of how respondents rated their team's ability to fulfil its specific aims provided measures of association between variables reflecting community mental health teams' performance, as a team, and their success in meeting relevant objectives (West et al. 2012). In summary, these are as follows.

Overall EIP, AO and MHSOP teams were shown to be performing well *as teams*, whereas teams continuing to address the full range of mental health difficulties as exemplified by a *fin de siècle* community mental team were not. Differences were most striking in relation to task design, and team effort and skills. MHSOP team members were more pleased with the levels of organisational support and resources they experienced. EIP and CRHT teams rated their team processes relatively highly and were particularly keen to report high levels of creativity. EIP teams also performed well in terms of leadership and the quality of teams' generic outcomes, such as team member satisfaction, attachment and innovation.

In terms of specific, mental health team effectiveness, EIP and MHSOP teams did better than other types of team. Team inputs associated with greater effectiveness were effort and skills, organisational support, resources and task design. The team process that most strongly predicted effectiveness across all types of team was creativity, and task focus and participation were important inputs. Unsurprisingly but exerting a measurable effect, team conflict impaired team effectiveness.

The ATPI approach also enables path analysis, in which strengths of association between team inputs, team processes and team outputs can be explored in search of ways in which the effects of team inputs upon team outputs or effectiveness may be mediated by identifiable aspects of team process. For the main community mental health team effectiveness score, there were indirect effects of task design, and team effort and skills. Teams that were more effective included members who rated the team as one which was clear about what it was expected to do and who felt they had the right degree of motivation and skills to achieve it. The team process that appeared to mediate these relationships was creativity. Similar associations emerged in relation to team outputs. Task design had a moderate effect upon team member satisfaction that was mediated by team member participation, and team effort and skills had a measurable effect upon team member satisfaction that was mediated by both team member participation and creativity.

These analyses provide a clear indication that the two most important team inputs—task design, and team effort and skills—make a positive contribution to generic team effectiveness and practitioner well-being because they enable greater participation and support creativity. More focused task design and more clearly identifiable and relevant team motivation and skills were also associated with higher levels of specific effectiveness, in this case as a community mental health team. These characteristics were more clearly apparent amongst EIP, AO and MHSOP teams. Details of the numeric bases for these conclusions can be found in the full report (West et al. 2012).

Community Mental Health Practitioners' Reflections on Their Work

In the course of an interview primarily intended to explore these team processes further, respondents were asked to comment upon and probed about a number of issues that reflected how they felt about their activities. These included ways in which their team improves service user well-being, therapeutic relationships with service users, problem solving, continuity of care, inter-team working and other aspects of their organisational context. Extracts coded by this framework have been reviewed in search of what they reveal about practitioners' feelings about their work.

There were very few references to the use of specific therapeutic techniques such as cognitive behaviour therapy or anxiety management. Instead, practitioners referred to their roles in much more general terms; to the support of the socially isolated and to a need for flexibility of approach in order to achieve that and, conversely, the need to maintain relational boundaries necessary to avoid such relationships becoming anything other than professional. Much was said about the value of team membership: how team working supported and enhanced what they were able to do for individual clients. There were some references to their responsibilities for managing risk and there were references to their team's working relationships with other community mental health teams covering the same population.

Respondents were very much aware of their status as employees governed by an organisational hierarchy. Several were lower-level managers; team leaders, and many of these individuals shared a sense of divided loyalty between their identity as "one of the troops" and that of institutional enforcer. This was particularly apparent in relation to corporate demands for records of activity and relationships with more senior managers. Respondents were also aware of a hierarchic relationship between medical and non-medical staff which was not always conducive to ideal practice.

Practitioner Roles

Practitioners communicated a sense of being there for those who had been rejected by others and needed assistance with the mundane things of life in order to acquire or resume autonomy and citizenship.

> The clients think, you know, this is someone that's the support that I see other people have in the community with their families, and support at college and support at different things. R&R team leader

One CPN somewhat movingly recounted:

> The other day when I was driving through one of the local towns, I was driving through and I saw somebody, one of my ex-service users and who was as disabled anybody could be with schizophrenia and he was walking

> through town chatting to somebody and that gave me an incredible amount of satisfaction. AO CPN

Flexibility

There was a strong sense of practitioners creatively engineering situations and opportunities in which support and a helping relationship could flourish.

> … when they're sat next to me in the car they're happy chatting so you take a long drive somewhere without them realising they're comfortable and they've talked. R&R CPN

Even if doing so involves going to quite extraordinary lengths:

> We've had to have freezers locked in cupboards and plugs moved so that the freezer doesn't get accidently turned off and food delivered on a certain day so that somebody can be there to put it away in the cupboard. We have had to be quite creative. MHSOP OT

Boundaries

Practitioners respected the need to contain relationships with clients in two ways: to ensure they didn't extend into their personal life and to minimise unhelpful dependency.

> In my attempts to get somebody au fait with a computer system, they wanted to be on Facebook in order to communicate with family and friends, she ended up a friend on my Facebook, … I won't do that again. MHSOP CPN

> It's about expectations as well in negotiating expectations, and I think the team are fairly clear on what it is that we can and can't offer, so that a person isn't left with a lot of expectations that can't be kind of fulfilled. R&R Psychiatrist

Team Membership

Respondents invariably spoke warmly about their colleagues, about the support they enjoyed, about the value of being able to bounce questions and about being able to share responsibilities:

> We work very well together. We support each other. We know what the stressful things are. We know we can, because we work so closely with each other, we can see when the other person is starting to stress and to get anxious about things. R&R Team Leader

> And they always discuss patients together, so we get a different angle on things, people have seen them maybe last time they were ill and like some people have been here a while, so they know them quite a while. AO CPN

> I think we're lucky that we can react very quickly if something goes wrong, because of the team approach. We're not waiting say if someone's off, we're not waiting for them to come back, we can deal with it. AO HCA

Risk

There was a sense of pride in being able to provide for challenging clients in a least restrictive way, and also respect for the precautions necessary to do that safely:

> I mean a lot of our clients are probably more unwell all the time than several, a large percentage that you'd find on the inpatient unit because we come to recognise that there isn't always a point in putting people in hospital and then discharging them. AO CPN

> We have to follow the lone worker policy and we do here, we're quite stringent, we have a folder, lone worker folder. We fill in where we're going, who we're seeing what time. We have our mobile phones with us. MHSOP SW

Other Teams

There was widespread stereotyping of other teams that expressed itself in references to grievance, misunderstanding and difficulties communicating:

> They [another team] don't actually physically see us joint working and doing our home visits and doing our assessments. They don't see that. They just see us when we're at base frantically typing things up …. CRHT CPN

> I think people get set in their teams, the way they work and then find it hard to accept what other teams do. I think that's perhaps where some individuals find it hard. AO CPN

Some of these frustrations reflected what were seen to be arbitrary distinctions of client suitability:

> People don't go and fit into boxes, people don't fit into boxes. I think they're clear about our remits but it's people, it's service users. Service users don't fit into boxes. […] that's when you get into your separate team silos and everybody starts arguing. R&R Team Leader

Though the overriding importance of clients' needs was clearly the deal breaker when arguments do develop:

> … if you're prepared to listen and talk and if somebody's cross you don't get cross back […] I have had tension with one person in one other team on one occasion, but I think the most important thing if you feel that tension is that that doesn't affect the care that your patient is receiving and I don't think it ever has. MHSOP OT

Manager Speaking

Team Leader or Team Coordinator is a role that combines a reduced clinical load with the responsibilities of coordinating the team and providing a link between practitioners and clinically inactive managers. These posts are commonly held by experienced clinicians and not uncommonly the practitioners they oversee are colleagues they also work with on the front line. The position is often one of being caught between two ideologies:

> And it's very difficult as the team leader because you're kind of stuck between the two places. One is I can understand why a lot of the paperwork is there and what it's for, but another one is if I could start from scratch I think I could do a better job, let alone a committee of people, I think I could do a slightly better job. And they've got themselves all caught up their own ar**s because our assessment form is an assessment form but it's also an audit tool. Primary Care Team Leader

Responsibility for others was experienced both in terms of pastoral support and in terms of wishing to improve the operational quality of the team:

> So the management role would include supervising the band seven nurses, so then looking operationally in their week what's going on, well or not in their week. AO Team Leader

> I've achieved putting in some systems that weren't in place when I came here. It was kind of chaotic when I came here and systems needed to be put in very quickly to make sure that patients were back up there on the priority list of what we do. CRHT Team Leader

Paperwork

All grades of staff complained about the teams' administrative burden. In particular, they referred to conflict between bureaucratic expectations and clients' expectations of intimacy and confidentiality, prioritising demands and the rigidity of IT systems.

In relation to care plans:

> I know there was one service user who just adamantly refused to sign it, which is their choice, but I mean I've spent several visits, couple of hours with her really saying but what is that you don't like, because we can talk about it? And she said no I agree with it all, just don't want to sign it. R&R CPN

In relation to competing demands:

> I went on a Management for Change course a little while ago, a few weeks ago, and one of the questions there asked what's the most stressful aspect of your job, and virtually without exception people put paperwork. And considering the patients that we work with, and how difficult their illnesses can be, you would have thought that that might be number one. But no, paperwork, too much of it by a massive amount. R&R Team Leader

In relation to the rigidity of IT:

> I think they're Key Performance Indicators, that have to be ethnicity, marital status that sort of thing. […] and you've got a very ill person you can't ask them all these questions, are you married, it could be that they've split up with someone which has caused all the problem anyway. […] we've got this wonderful computer system they have an informatics department. And so all these KPIs have boxes have to be ticked … as a Trust it feels that we don't really care about patients as long as everything, the boxes are ticked. AO CPN

Corporate Pressures

This experience of operating in an environment controlled by others was expressed as anger directed in a variety of directions.

Senior management was stereotyped as incompetent:

> Which is the trust all over really. They seem to run hot and cold on things. One week this is really important and this is what we need to be doing, and then a few weeks down the line it's, they've either backtracked or changed their mind, or it's something else that's important. R&R CPN

Change and uncertainty generated by financial pressures were unsettling:

> I'd say unsettled because no one knows, you know, what jobs are going to go. I mean, people say it's the hierarchy, it's bands 7s, 8s and above but it's that, you know, it could be, so I think until people know, you know, people have been unsettled and it's the not knowing. I think until somebody turns

> round and says you know, we all say nobody's job is safe so until we've got it in black and white and we know exactly what we're having people are unsettled. CRHT HCA

Many practitioners expressed frustration with a commercially driven ideology that seems to be at odds with their understanding of the task:

> It's okay to have a business ethic, but you can't necessarily apply business principles to a national organisation that's for everybody. It's understandable, I've worked in middle management for a little bit as well, so I understand that there's got to be checks and balances and audits and all these kind of things, but it just seems as if it's becoming too resource orientated. And that's not for the patient's benefit, it's covered up as if it's a benefit for the patient, it's just called re-engineering services to make them better. It doesn't make them better, it just makes them less and more cost efficient. But you know, I think a lot of people in the NHS are becoming more cynical. Primary Care CPN

Doctors and Others

By far the largest proportion of team members and interview respondents were nurses. There were several revealing references to working relationships between medical psychiatrists and others that reflect wider and longer-standing configurations of the nurse/doctor relationship which is possibly less applicable in this particular healthcare context:

> I think the care coordinators will often attend the CPA review with one agenda but the consultant psychiatrist may have a different one and I think there is that element of the consultant is always God isn't it, tends to be, so I'm sure that will still be the case here. R&R HCA

> I think I mean you've still got the medical model versus the model that's a sort of more humanistic model we try to use as nurses, but you have to try and marry the two and I often have to tread a fairly fine line between keeping the psychiatrist happy, but also making sure the patient's needs are met and that the team are happy with the input from the psychiatrist, so it is a fine line and sometimes it involves having to stroke egos a little bit, but I'm happy to do that if it keeps people happy. MHSPO Team Leader

> I would argue, maybe I do give guidance and I do lead the team when necessary, when appropriate. I mean I have overall, overarching responsibility for patients care as provided by the CPN I am the responsible clinician for all the clients under our care. So the overriding medical responsibility is still with me and eventually it's me who is accountable if something goes wrong. R&R Consultant Psychiatrist

Clients' or Service Users' Experiences

An account of community mental health teams' activities would be ill-informed and incomplete without clients' perspectives. There is a considerable literature documenting clients' experiences of mental health services and much of it has been collated as a set of recommendations for improvement (National Collaborating Centre for Mental Health 2012). Understandably, this focuses upon shortcomings and structural problems such as waiting times, attitudes of staff and flexibility, rather than "what works." Community mental health team clients have varying perspectives on their care. A particularly insightful group are those who have had experience of acute crisis, have been provided for by a CRHT and have recovered. They are in a position to reflect upon the experience and recall what was and what was not helpful. A 2010 review of published clients' experiences of CRHT identified 13 papers, 1 RCT review and 2 reports (Winness et al. 2010). Disappointingly, these provided few in-depth details. Characteristics of the experience that were valued included ready access and availability, being understood as a "normal" human being and readiness to deal with crises in an everyday life context. A later investigation (Shaw and Stapleton 2010; Middleton et al. 2011) adds to this literature and sheds further light on what CRHT service users do or do not find helpful.

Accounts of such experiences are usually obtained by a clinician or a professional researcher but this introduces a particular perspective which can distort them (Charon 2004; Godin et al. 2007). To minimise this effect (Mishler 1986; Clark et al. 1999; Lester et al. 2006; Rose et al. 2006), and in support of their ambition to conduct a piece of mental health research, a group of service users were enabled to interview subjects who had recently had the experience of being provided for by a CRHT team. NHS Research Ethics approval was obtained. Thirty-six interviews were conducted, all by individuals who had been or who were currently in receipt of mental health services. The interviewed sample comprised 13 males with a mean age of 42.9 years and 23 females with a mean age of 44.3 years. Transcripts were analysed by two processes conducted in parallel and blind to one another. One was conducted by a group drawn from the service user interviewers and supported by a research consultant and the other by a postdoctoral career social scientist with formal qualitative research training. This person had had no prior contact with the primary data or involvement in running the study. A broadly defined grounded theory (avoiding a priori assumptions) approach to identifying the phenomenology (subjective experiences) of interviewees' interactions with the team was adopted by both. The service user researchers chose to consider the transcripts stage by stage, as the interview proceeded through the respondent's recollections of their "journey," and then aggregated these into an overall view of "What helps recovery?" and "What hinders recovery?". The academic sought answers to "What was helpful?" and "What was unhelpful?" from the transcripts as a whole. She found little consistency amongst them at the level of specific actions or inactions, and sought common themes at a higher or more abstract level.

The service user researchers' analysis summarised the influences aiding recovery as:

- *Reassurance:* Knowing that there was someone who understood what was happening and was available either in person or by phone.
- *Positive relationships:* The experience of non-judgemental consistency, acceptance and understanding.
- *Involvement in the process:* An experience of control, making their own decisions and having choice in what was done to or for them.
- *Practical support:* Assistance with household tasks, shopping, cleaning, gardening and childcare, which relieved pressure.
- *Access and flexibility:* Feeling that support was available from professional services, family or friends when it was needed and in an appropriate form.

Influences hindering recovery were:

- *Unhelpful attitudes and behaviour:* Anything, particularly relational factors that interfered with any of the above, helpful relational issues.
- *Unmet expectations:* Disappointed, unrealistically high expectations as a result of misleading information.
- *Lack of continuity:* Where this was experienced, it hindered development of an effective supporting relationship with the team.
- *Lack of appropriate or sufficiently well-organised follow-up:* A common experience was poor availability of follow-up provision such as psychological therapy or other services. The experience was an unhelpful one when involvement with CRHT had to end before another indicated provision could become available.

The academic was less drawn to the mechanics of service provision and more to the subjective experiences different activities and contacts evoked. Her analysis distilled the transcripts to central roles for whether or not contact with the team or informal carers had resulted in a sense of feeling safe, accepted and understood.

> Just knowing somebody was there for you was nice. And that's what the CRHT team did when they got involved. They were a constant reassurance … the fact that they understood or seemed to understand what I was going through was really reassuring, and the fact that I could contact them at any time was also helpful. Although I didn't do it, I knew I could if I needed to … and also to know that other people were like that as well. Because they would say, 'This is what other people have told me', and you think … 'You're not just on your own with it'. Female, 53 years old

Safe

This was a reflection of knowing that the team was there or available, a sense of consistency in what they were providing and an experience of being in safe hands. "Knowing that they are there" was facilitated by consistency and stability in the team's availability. This included both a routine of visits and phone calls and the experience of sensing that the team was always available to them. Critically, availability reflected the trust and confidence the service user had in the team's ability to catch them should they fall:

> Knowing that they were always at the end of the phone, knowing that it was 24 hours available to me. If I was going through a difficult time I could ring them up and talk to them over the phone. … I didn't really use that service but I knew it was available to me, and it was there if I wanted it. That was obviously beneficial for me, knowing they were there 24/7. Male, 24 years old.

When the experience felt unsafe, the outcome was less satisfactory:

> I found they weren't there when I needed them. I'd got nobody else, I've told you that, and I'd been promised they'd be there, day, night, any time I needed to speak, to talk to them, they would be there for me, to express I suppose what I was going through. My grief, I suppose, weren't it? And they weren't. And because they weren't, I just went back on the booze. Female, 53 years old

Accepted

Experiences were considered helpful when the interviewee felt absolved from judgement and not responsible for events leading up to the crisis. When this was violated the experience was unsatisfactory and unhelpful:

> Her answer to me feeling suicidal was, 'Would you like to go swimming?' [Laughter]…. 'I can see you if you'd like to go swimming'. [Laughter] So she could see me more often than 3 weeks if I went swimming. And there's no way I could face going swimming, not how I was feeling, no way. Female, 37 years old

Many expected to feel judged and responsible for their own difficulties, and found the development of a relationship that did not carry those demands was therapeutic in its own right:

> It was very difficult to start off with. I can remember I couldn't even look at them, and I had this terrible paranoia that they were going to section me, and they went to great lengths to explain that they look at risk from a positive point of view and they do everything they can to keep me in my home. The more I realised how non-judgmental they were and how they really wanted to work with me and not to me, sort of thing, not directive, the more I think I started to relax. Female, 44 years old

Understood

This referred to experiences enabling the client to feel that the team could empathise with their experiences. These included appreciation of the service user's need for practical support and of how the service user understood and experienced their particular difficulties. The experience of being listened to by others who seemed to understand their difficulties was often reported as particularly helpful:

> Yes. I did [feel understood] because two of them had gone through similar problems and although they didn't go into their problems, they said they'd experienced similar types of feelings. Female, 45 years old

Feeling understood was related to the team's sensitivity to the interviewee's social context, including the potential stigma of being identified as a mental health patient:

> One experience with them that actually set me back quite a bit: it was quite near the beginning and two came that didn't really know me. They came to the door, one of them was carrying their diary, you know I'm paranoid about people thinking, you know because if you're not used to having people coming to your door and the neighbours, you know, curtains do twitch, and you've got this diary, and looking all sort of official, and they came in and they quite clearly knew nothing about me. Female, 44 years old

Although the two independent analyses of interview transcripts were conducted in different ways and from different perspectives, their conclusions were consistent and "triangulated" upon an important (though not necessarily surprising) conclusion. Contact with the CRHT team was considered helpful if it resulted in the experience of a supportive, understanding and unconditionally accepting relationship. It was considered unhelpful if this experience was undermined in any way.

Discussion

These reflections upon research investigating the activities of CMHTs can be considered from micro-, meso- and macro perspectives. At a micro level, they inform what is known and understood about the interactions between practitioners and their clients, and what the latter find helpful and otherwise. At a meso level, they inform what is known and understood about practitioners' everyday working lives, their relationships with colleagues and the conditions they work under. At a macro level, they provide some insight into how these teams are embedded in larger organisational structures and how they relate to one another. All of these offer contributions to the therapeutic literature and the development of social theory, and inevitably all point to opportunities for further research.

Relationship, Relationship, Relationship

Strikingly and consistently practitioners and their clients both draw attention to the central importance of the relationship between them. To the former this is the *sine qua non* of their work. They will go to great lengths to develop, nourish and maintain it. Doing so often requires creativity and a readiness to take personal risks. At the same time, they also respect and guard against those risks, whether they are of violence or of untoward emotional contact, thus making the exercise a realistic one. They will challenge and disrespect institutional pressures that threaten what they see to be appropriate levels of practitioner/client intimacy and confidentiality. Clients identify qualities of their relationships with practitioners as the defining features of a successful (or otherwise) series of encounters, and it is striking that the relational qualities valued by them and associated with therapeutic success are very much the same that have been reported in other contexts (Rogers et al. 1993, Rose 2001, Priebe et al. 2009). It is now generally accepted that it is the quality of relationship that most strongly determines clinical outcome in more explicitly psychotherapeutic contexts (Budd and Hughes 2009; Norcross and Wampold 2011). Community mental health practitioners appear to recognise this and respect it as a guiding principle. Similarly, their clients value and benefit from qualities of relationship that resonate with those identified with a successful, generic psychotherapeutic encounter (Rogers 1957) or wider considerations of what constitutes a helping relationship (Trivers 1971). Practitioners' reports of their face-to-face encounters with clients overwhelmingly referred to "engagement" or "relationship."

There is a wide sweep of conceptual and methodological approaches, from Martin Buber onwards, that concerns the nature and development of helping relationships (Cissna and Anderson 2002). It can do much to inform mental health practice, and it could be richly informed by the operational imperatives of mental health practitioners as they seek to "engage" clientele who by definition have lost or have been deprived of otherwise mundane but nourishing social interaction (Priebe et al. 2014).

The In-group and the Out-group

In describing their work, practitioners make much of the benefits they enjoy as members of a team made up of mutually supportive colleagues. Their work is emotionally challenging. It often involves relating quite intimately with individuals whose characteristics have made them unattractive to others. Mutual support is more than simply sharing the material burdens of visiting and paperwork; it is clear that it also embraces emotional support, and this plays a direct part in facilitating individual practitioners' ability to weather the emotional work involved in relating to difficult clients. Interestingly, better-quality team processes, which most probably underpin this, were found in some but not all types of team. Those that performed best in this respect were also those that felt they had clearer "task design": EIP, AO and MHSOP. These are teams whose clientele are clearly defined by external reference: in the case of EIP, by age and the early onset of psychotic symptoms; in the case of

AO, by wider consent that they are "challenging"; and in the case of MHSOP, by age. These external reference points could be considered validation of the team's distinct role and identity, offering it a focus of cohesion. It is widely recognised that the more clearly a group perceives its identity, the more cohesive and intra-supportive it will be (Raven and Riettsma 1957; Kerr and Tindale 2004). It is also widely recognised that as groups become more cohesive and intra-supportive, they also become more prone to stereotyping and conflict in relation to others (Brewer and Kramer 1985; Hewstone et al. 2002), and that inter-group conflict can be ameliorated by the recognition of superordinate goals (Sherif 1958). These intra- and inter-group processes are clearly observable amongst the different types of CMHT, and it is salutary to note that client welfare emerges as the superordinate goal capable of defusing inter-group conflict. It is clear that a sufficiently high level of group or team cohesion is necessary in order for each team to function well *as a team,* and thus provide members with much-needed emotional support, but it is equally clear that this has to be balanced by wide recognition of an acceptable superordinate goal. CMHTs offer a particularly valuable opportunity to research this balance. Although they are differentiated, this is much more on the basis of client group than it is on the basis of the task they are charged with, which is, across all types of team, essentially, to form and maintain relationships. As a result, reasons for differentiation are relatively distinct from differences in activity, and intra-and inter-team processes reveal themselves more clearly. How these are understood and optimised also, evidently, has a direct effect upon clients' welfare.

Institutional Setting

Some of the more vivid reflections on their work came from practitioners as they talked about change and about "management." At best, this was grudging acknowledgement, but more widely it was anger and frustration. Those charged with managerial responsibilities found themselves torn between group loyalties and hierarchic expectations. This is not confined to CMHTs (NHS Institute for Innovation and Improvement 2016) but the accounts considered here reiterate those tensions. Front-line practitioners appear to have very little direct contact with more senior managerial staff who appear to conduct themselves from a faceless distance. This suggests that Lipsky's notion of a street-level bureaucrat might provide an appropriate conceptual framework. Lipsky's original formulation of the street-level bureaucrat was of ways in which explicit policy initiatives were modified by the activities of front-line practitioners as they conducted their work in real-life settings. Expediency, self-interest, moral judgement and philanthropy all played their parts in this understanding of the process (Lipsky 1980). Street-level bureaucracy has been used as a framework to consider tensions between practitioners, and policy-makers and administrators across a range of healthcare settings including stroke nursing (Allen et al. 2004), community health centres (Walker and Gilson 2004), general practice (Checkland 2004), community nursing (Bergen and While 2005), learning disability (Brandon 2005a), palliative care (Walshe et al. 2008), midwifery (Finlay and Sandall 2009), children's services (Wastell et al. 2010) and acute general hospital nursing (Drinkwater et al. 2013). Inevitably, these disparate settings and interpretations of findings result in a variety of theoretical conclusions but they all identify tensions between the demands of bureaucratic order and predictability, and the realities of healthcare. One interpretation of Lipsky's notion has been that of the self-interested practitioner cutting corners in order to lighten their load, or at least to rationalise challenges between overwhelming demand and limited resources (Brandon 2005b). Another is that it is a complex field in which "street level bureaucracy" represents a variety of forms of practitioner discretion (Ellis 2011).

Although CMHT practitioners may have admitted to varying practices, what came across more strongly was a sense of them going out of their way to fulfil something that was not and could not be defined and embraced by a set of policies and procedures. They saw their primary task to be that of developing and maintaining a supportive relationship with each client, and the legitimacy of this is supported by clinical evidence. It is a good-quality therapeutic relationship that clients appreciate and which results in a satisfactory outcome. Although certain principles might apply, authentic relationship building and maintenance are bespoke and creative tasks that cannot be reduce to algorithm. As the team working research suggests, the context within which practitioners work does influence the success with which they are able to achieve this, but the relationship between institutional determinants of context, such as how teams are organised and relate to one another and how individual practitioners relate to their clients, is loose and certainly not directly causal. Amongst the intervening variables are a range of personal and social characteristics peculiar to the practitioner.

In their consideration of street-level bureaucracy drawn from observations of police men and women, rehabilitation officers and teachers Maynard-Moody and Musheno suggest a similarly more holistic formulation. They frame the practitioner as a citizen-agent prepared to extend themselves and make normative choices based upon their own values and cultural heritage (Maynard-Moody and Musheno 2000). Their use of the term “citizen-agent” resonates with Meyer and Jepperson’s emphasis on the degree to which social actors, particularly those engaged in public work are not disembodied “autochthonous and natural entities” (Meyer and Jepperson 2000, p. 100) but socially embedded phenomena sensitive to and determined by their direct and historic cultural context. Healthcare as a whole has very deep and influential social roots. CMHT practitioners in particular see themselves as conducting socially balancing work as they reach out to and support those who have become isolated and rejected by others. From this point of view, their work might more accurately be seen as acts of enabled citizenship than as acts of policy implementation, modified or otherwise. This is very much at odds with expressed NHS and medical insurance organisation policies, which are to purchase packages of evidence-based treatment. Careful consideration of what community mental health services actually do might present a challenge to this way of framing what they are, and they certainly offer an opportunity to explore its legitimacy.

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8

Handling Role Boundaries: A Basic Social Process Underpinning Decision-Making in Mental Health Teams

Melanie Narayanasamy

Background

Single Point of Access (SPA) meetings have been developed to provide a forum in which to discuss written referrals made by general practitioners (GPs), regarding clients who are thought to have mental health problems (Narayanasamy 2016). These referrals are formulated as letters, addressed to the appropriate community mental health team (CMHT), and undergo pre-meeting checks and triaging by a CMHT duty worker. If considered appropriate, these letters are processed to be discussed at the next SPA meeting, and clients' case notes may also be requested. Weekly SPA meetings at several sites, each providing for a different geographic area, are considered. Duration of meetings is variable, but they have regular attendance by CMHT members (e.g. nurses, psychiatrists, social workers, occupational therapists) and representatives from more specialist mental health services, which target specific mental health-related needs. Such

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M. Narayanasamy (✉)
School of Health Sciences, University of Nottingham, Nottingham, UK
e-mail: Melanie.Narayanasamy@nottingham.ac.uk

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specialist services include early intervention in psychosis (EIP), assertive outreach (AO), improving access to psychological therapies (IAPT) and the crisis resolution home treatment (CRHT) team. There is a common structure to all meetings, which sees an administrative staff member attend and distribute the referral letters and record proceedings. Letters are read out loud by members, and then discussion ensues. If deemed appropriate, reference to case notes may be made to support these discussions. The goal of all meetings is to make a recordable decision for each client before the meeting closes, and this is later processed on the organisation's information system. These decisions dictate the future mental health service trajectory of the client, which ultimately revolves around whether they become entrained into specialised services or not.

The organisation and dynamics inherent within SPA meetings have evolved to align with the changing context and perspectives that prevail in wider society. One particular sociological lens suggests that mental health problems are a label assigned to people whose behaviours have been judged as departing or deviating from accepted social "norms" of society (Giddens 2009; Eaton 2001; Erikson 1966; Becker 1963). Subscribing to this view, SPA meetings, in their capacity as a gateway to mental health services, can be seen as a method for dealing with the diverse behaviours that are now accepted by many as "mental health problems". In addition, there is now a family of services and teams in existence that have developed from different organisational backgrounds and philosophies. These need to be accommodated within the SPA meeting environment, along with an acceptance of multidisciplinary team working. Moreover, the SPA meeting must operate to deal with the reported difficulties that GPs struggle with in their management of mental health problems (Lucas et al. 2005; Read 2005), and support the risk assessment practice that is now expected of mental health services (Hewitt 2008; Turner and Colombo 2008; Rogers and Pilgrim 2005; Beck 1992).

Why Conceptualisation Is Important in this Area

Conceptualisation in this area is important, because the actual decision made within meetings influences the client's subsequent trajectory and interaction with mental health services. The meeting and business that occurs within it represent a critical juncture in the client's life. Understanding the social process behind this procedure is therefore important in order to not only convey the actual components of decision-making but also to offer a way of identifying which aspects of decision-making can be improved.

There are several reasons why the SPA meeting environment was an ideal milieu for the social scientist to conduct a comprehensive investigation which would unpack an underlying social process. Firstly, the SPA meeting has a clear but pivotal rationale, which is to allow attendees to work together to allocate clients to appropriate services and/or interventions. This rationale naturally invited a logical, focused level of sociological inquiry, which was to learn more about how attendees of the meeting operated to allow such decisions to be made. Indeed, this rationale was later confirmed to be the key motivator (known as the "main concern"—please see "GT Methodology") for behaviour observed in the SPA meetings. Therefore, a study was designed specifically around this milieu, to allow insight into the nature and conduct of business within the meetings. Secondly, the meetings bear host to attendees from diverse mental health professional backgrounds. This presented an opportunity to observe multidisciplinary liaising in action and possibly understand how this collaboration contributed to decision-making. Multidisciplinary working is already dominating the UK mental health service landscape and is predicted to continue (Bailey 2012). It is endorsed as a way of facilitating open exchange of expertise and perspectives to efficiently deal with clients' problems (Bailey 2012; Colombo et al. 2002). Therefore, SPA meetings, in playing host to diverse professionalisms and lenses, were seen as an appropriate substantive area that could allow understanding into this type of working and collaboration in pivotal decision-making.

Thirdly, and using a researcher's lens, this particular environment was very amenable to the Grounded Theory (GT) approach used to conduct this form of sociological enquiry. Before entering the field, from the author's perspective, there was very little known about the milieu, beyond the rationale for setting them up in the first place and some insight into who generally attended. This allowed a very broad research question to be structured, preceding data collection. This also meant that an open level of enquiry could easily be pursued, thus alleviating the risk of preconceptions reaching a level that would disrupt genuine conceptual emergence. Fourthly, as an environment that was essentially concerned with the passing of time (i.e. as a meeting with clear start and end points), this meant that the business within SPA meeting was likely to have an underlying Basic Social Process that would emerge through the methodological approach to be used (Artinian 2009; Glaser 1996). According to Artinian (2009), a Basic Social Process can be pursued when the enquiry focuses on participants moving through a situation. For attendees in the SPA meetings, this is reflected in them attending and getting through the meeting.

Finally, using Grounded Theory Methodology to conceptualise in an area leads to integrated concepts which can be easier to understand than descriptive analysis. Knowledge presented as a theoretical product can be enlightening, since it enables experiences to be captured in a way that has not been done before (Artinian and West 2009; Artinian 1998). In the context of this study, there is potential for the GT product to enable SPA meeting attendees to identify which aspect of their decision-making can be improved. This could then impact on the experiences of the clients receiving the services that these meetings allocate.

Grounded Theory Methodology

For all of these reasons, Glaserian GT methodology was used to investigate the SPA meetings, drawing upon the directives and guidance of Glaser and proponents (Artinian and West 2009; Glaser 1978). Data collection techniques included observation and semi-structured interviews. GT has an explicit methodological aim, which is to discover the main nature of participants' problems, and explain how they resolve these problems (Artinian 2009; Glaser 1998). With this in mind, and preceding discovery of this problem, a broad research question was pursued:

> What is the nature of business and interactions around decision-making within SPA meetings?

This research question served to guide the overall study, but it was also clear that the emerging theory, set around discovering participants' problems, needed to be prioritised. These problems and solutions cannot be known before entering the field, which is why a broad, guiding, research question was needed to provide some initial direction.

According to the GT lexicon, the process of identifying participants' problems is referred to as discovering their "main concern" (Cone and Artinian 2009; Giske and Artinian 2009; Glaser 1978; Glaser and Strauss 1967), which is the variable that motivates participants' behaviour. Behaviours shown by participants are their strategies for resolving this main concern. "Behaviours" can incorporate both verbal and non-verbal action, since it is understood to encompass ways of acting and conducting oneself (Oxford Dictionaries).

In GT research, participants must reveal their main concern themselves, and the opportunity is often provided through data collection methods. In this study, observations and interviews allowed the researcher to discover that participants were motivated by the need to work together to make decisions about clients within the meeting. This discovery was achieved by observing the explicit agenda and routine, which were made apparent in the meetings. The same basic structure occurred in all of them. It revolved around a list of clients being presented to the team through letters and case notes, subsequent discussions, and finally a decision being reached for each client. Furthermore, disclosures made during interviews confirmed that participants regarded SPA meetings as a forum for decision-making, and an appropriate system to deal with referrals:

> *As a system, of dealing with incoming referrals, quite effectively, I think it works…we will discuss and decide what needs to be done and hopefully come to a consensus on that.* (Consultant psychiatrist, male, Area 6)
>
> *So we conduct this, you know what can be seen as a triage or a sorting process.* (Consultant psychiatrist, male, Area 1)
>
> *Ideally the Single Point of Access meeting is the first forum through which referrals to the CMHT are discussed … the process is to just find the best pathway for each individual referral.* (Team lead, male, Area 3)
>
> *We've kind of built that system up over the years since we started and I think it works pretty well.* (Nurse, female, Area 4).

Constant comparative analysis was used, comparing data line by line and incident by incident. In the context of GT, an "incident" accounts for an occurrence in the field. Data is coded with categories that are seen to summarise ideas about the data. The eventual theory is constructed with categories integrated together (Artinian 2009). Categories can be seen as key words garnered from field notes, which relate to prominent ideas, themes and phenomena within the data. This process eventually revealed the theory explaining how SPA meetings work together to complete decision-making about clients within the meetings.

Categories can be of different levels, and the highest level one is known as the core category, which conveys the highest-level concept of the theory, and must relate to the other categories (Giske and Artinian 2009). The core category accounts for how participants resolve their main concern, and the categories which closely relate to this are promoted to concepts of the theory. Therefore, the final theory can be seen as a set of grounded concepts, organised around a core category and integrated as a parsimonious theory (Glaser 1978).

In this study, the core category of Handling Role Boundaries can also be seen as a Basic Social Process (BSP), because the meetings represent a point where participants are moving through a situation (Glaser 1996; Artinian 2009). This revolves around a period of decision-making that starts from hearing about a client and ends with making a decision about the client.

Another key GT strategy that was employed in this study was theoretical sampling, which involves using the data to direct the researcher as to which avenues of data collection should be further pursued (Giske and Artinian 2009; Glaser 1978; Glaser and Strauss 1967). This procedure enables category development to be achieved, by helping to strengthen current categories and/or discard ones that are no longer relevant (Bryant and Charmaz 2010). Theoretical sampling guided the decision around when to suspend observations and pursue interviews instead. The endeavour of the grounded theorist is to reach data saturation, which signals the point at which the data is not found to be revealing anything new and categories are sufficiently developed (Glaser 1978). This point was achieved following 24 meeting observations and 8 in-depth interviews with SPA meeting attendees.

Findings

Handling Role Boundaries takes into account the diversity of roles within SPA meetings, which might initially appear to be based on different professional expertise. Whilst this is certainly relevant, the BSP also considers the multiple roles that exist within one person, that is, their group identity that originates from membership of a CMHT, aspects of personality, as well as the meeting-specific role of being a chairperson. All roles have boundaries, which are informed by strengths, capabilities, limitations, role "norms", expectations, traditions, and tendencies. Therefore, individuals attending SPA meetings find themselves developing strategies that will enable them to handle the different roles and related boundaries that are present, in order to ensure that decisions for clients can be made within the meeting.

Figure 8.1 presents the theory Handling Role Boundaries in diagrammatic form and displays the four key variables that it encompasses. These variables are understood to be phases which have emerged through the concept-indicator model (Holton 2010) and, as such, have overt links to empirical incidents. Adherence to the concept-indicator model provides the assurance that concepts in the final product have earned their way into the theory. In addition, each phase accommodates sub-phases for clarity.

The phases within Handling Role Boundaries all occur systematically and consecutively (Narayanasamy 2016). Each cannot happen without the occurrence of the preceding phase. Table 8.1 conveys the main elements of the theory with key quotations for each sub-phase.

Discussion

Handling Role Boundaries

Recognising is the first and pivotal phase of the theory and allows attendees to develop an awareness of themselves and colleagues, as well as the whole group and the SPA meeting. It is within this phase that under-

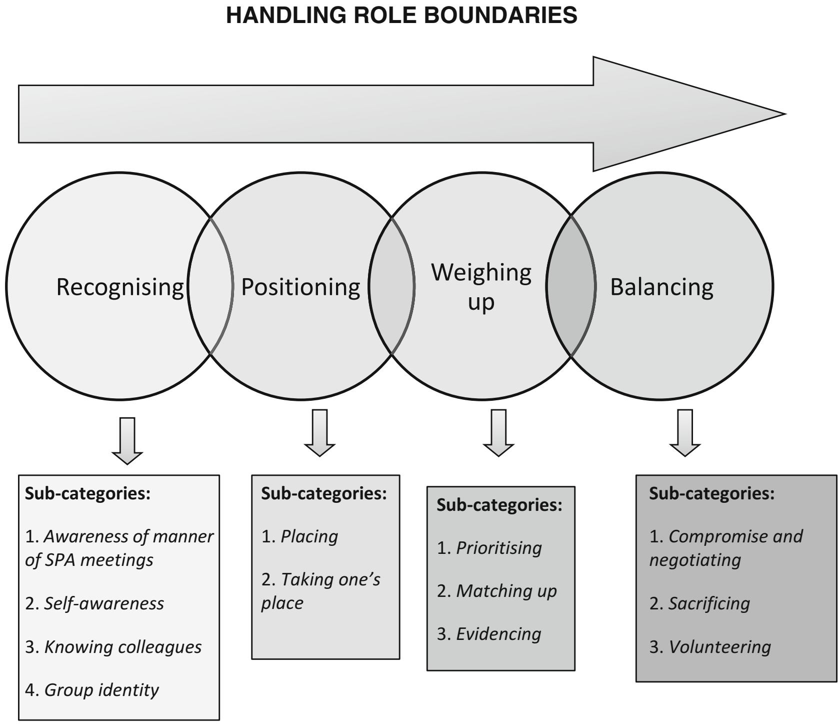

Fig. 8.1 *Diagrammatic representation of Handling Role Boundaries*. Main concern: Working together within the meeting environment to find a place for the client

standings around relevant roles and related boundaries are built. It provides a platform upon which expectations can be formed, as captured in the Positioning phase. For example, within the Recognising phase, one might learn that the SPA meeting operates with all attendees taking it in turns to read a GP letter. This then allows the attendee to enter the Positioning phase prepared to meet the expectation upon them to read the letter. This demonstrates how the Recognising phase informs the Positioning phase and why they occur consecutively.

The Positioning phase then takes place and considers knowledge around role boundaries that have been acquired from the previous Recognising phase. It provides direction for the attendees because it is here that they

Table 8.1 Description of Handling Role Boundaries

Phase	Description	Relation quotations
Recognising	Attendees recognise the different role boundaries present in the meeting—their own role boundaries and those of their fellow attendees	*Awareness of the manner of SPA meetings* "Yeah, I think it's, it's a good make up of a good good spectrum of people there, good broad, broad span of skills and er you know it's it's good, it's good we have, you know medics, social workers, specialists, psychologist, CBT, IAPT, the Eating Disorders, i-it's, it's a really sort of good mix really".(Team lead, male, Area 3) *Self-awareness* "I don't like reading because as a bloke I can only single task and if I read, I can't actually concentrate on what the letter's saying". (Consultant psychiatrist, male, Area 6). *Knowing one's colleagues* "By working closely… kind of know where we're all coming from… from my point of aspect, it's actually very helpful because you do get a sense of where the team are at, as well in terms of how many people they can see… You also get an understanding of the social care assessment process, which is a mystery to most medics I have to say…'. (Consultant psychiatrist, male, Area 6) *Group identity* '…we're really sort of at the higher end of people with mental illness with you know moderate to severe depression and psychosis. We're not really for the worried, we're not really for the people with, you know with social problems which can be addressed elsewhere so I mean it's you know it's think there are people out there with genuine worries, concerns, anxieties but they don't need us, they need they need something else sometimes". (Team lead, male, Area 3)

(*continued*)

Table 8.1 (continued)

Phase	Description	Relation quotations
Positioning	This involves attendees making expectations of themselves and their fellow attendees based on the role boundaries that they have recognised. They also take their place by behaving in certain ways in the meeting	Placing "…looking at the individual or the individuals one by one, through the lens, through the clinical lens, erm, and so attempting to elaborate a perspective of the individual based upon the information that's provided, through the particular lens or from the particular position that each of us is sitting in…". (Consultant psychiatrist, male, Area 1) Taking one's place "…there's a place for my opinion, my subjective opinion, but not for that to be the basis of the decision. Decision making needs to be across the board…". (Consultant psychiatrist, female, Area 5)
Weighing Up	There is a consideration of contributions and conceptions that have emerged as a result of the previous phases	Prioritising, matching up, and evidencing "…it's a question of actually taking it on face value and actually saying 'Well yeah, it's been referred to Dr ******* but it's more appropriate to go to IAPT because that's the nature of the issue that's in the letter… some, some come through to er the the medical lead I mean the the the local consultant either Doctor **** or Doctor ****or sometimes Doctor ****, some come through to erm… CPNs who've seen the person in the past, but it, they all get sort of erm the same sort of er, same discussion and the same thought put to them'". (Team lead, male, Area 3)

(*continued*)

Table 8.1 (continued)

Phase	Description	Relation quotations
Balancing	A balance is negotiated that takes into account all the role boundaries that are present in the meeting	Compromising and negotiating I'm sure you've heard me say it, when somebody's said "well I'll take, I'm not sure but I'll take it", then I always say "that's fine, thank you very much, assess and bring back if there's any issues or you feel it's, it's not for your service… and I think that helps and I think it works well because people then don't go away worried or resentful, "well I've been lumbered with this, no matter what I've got to see it". (Service team lead, female, Area 2) Sacrificing "So even if I thought to myself 'Well I actually think I could see that person.' I think medically you keep away because it would cause problems. I'd bow down to her (colleague), if she had a really strong view about that, there's no question. Even if I had quite a strong view, I would kind of go with her". (Consultant psychiatrist, male, Area 6) Volunteering "I think it's cos I volunteer, I think it's a fault on my part in the sense that sometimes I'd rather take the responsibility myself than delegate it. Because I feel that I delegate enough other things that, you know I'm often putting on staff and I think sometimes well that's and that's, probably sometimes it does need a manager to do it, sometimes. I think it holds a bit more resonance so…". (Team lead, male, Area 7)

form expectations upon themselves and each other. This is highly significant in a multidisciplinary arena, since there cannot be reliance on one single person; skills and capabilities of all the group need to be taken into account. Positioning also enables the person to consider the expectations that have been made upon themselves, and plan how they may respond. It gives attendees direction around their conduct within the meeting. In addition, this phase also progresses the discussion element of the meeting by allowing space for conceptions of clients to develop and be put forward. This then creates an opportunity for Weighing Up, the third phase of Handling Role Boundaries, to manifest.

Weighing Up encompasses the main discussions that occur within SPA meetings, and provides insight into verbal contributions and motivations behind these. The three sub-phases often occur closely together and explain key aspects of the SPA meeting discussions, such as justifying why a particular intervention is ideal for the client. They also often lead to a narrowing-down process, in which the number of potential services/interventions is reduced, to allow a more manageable amount of options to be considered. This process supports the time restrictions inherent in each meeting. As with previous phases, what occurs within Weighing Up sets the pace for the subsequent phase (in this case, Balancing) to occur. In some situations, Weighing Up allows the attendees' main concern to be resolved, since it might conclude with a client being designated to a service/intervention and/or another decision that can be recorded. However, when client cases are more complex, and Weighing Up has not successfully resulted in a decision being made for the client, attendees enter the Balancing phase.

The Balancing phase is particularly relevant when clients have complex problems and cannot be easily allocated to a service or intervention. The processes that go on in Balancing through the three sub-phases are helpful in assisting attendees to resolve their main concern. These processes represent the last strategies that attendees use to complete decision-making within the meeting's timeframe and consider all the role boundaries and contributions that have emerged from previous phases. Essentially, this phase enables attendees to balance the role boundaries through negotiation-based strategies and finalise joint decision-making around where to place the client.

Once a Grounded Theory has been developed, the researcher is advised to embark on a focused literature review that hones in on the core and related categories of the theory (Artinian and West 2009; Glaser 2007; Heath 2006; Glaser 1978). For the purposes of Handling Role Boundaries, this has led to selected literature around identity, self, interaction and roles to be consulted.

Identity, Self, Interaction and Role Theory

Handling Role Boundaries brings attention to personality traits and professional identity, which need to be considered alongside the larger sociological concepts of self, interaction and roles. Stets and Burke's (2005) review of sociological understandings into self and identity is useful in this context. They consider Stryker's (1980) structural symbolic interactionist approach to understanding society and individuals, which diverges from Mead's traditional situational symbolic interactionist perspective (Mead 1934). Stryker does not subscribe to the notion that individuals have freedom in defining situations; rather, they must do so within established structures which host patterned "norms". These "norms" have been established through human action over time and therefore self and society are reciprocal (Stryker 1980; Stets and Burke 2005).

> *Individuals act, but those actions exist within the context of the full set of patterns of action, interaction, and resource transfers among all persons all of which constitute the structure of society…*(Stets and Burke 2005: 129)

Thus, there is a place for human agency, since it contributes to prevailing social structures, but individual actions should be considered within the social structures in which they are taking place (Stets and Burke 2005). Handling Role Boundaries finds resonance with the structural symbolic interactionism thesis, particularly with regards to the Balancing phase. Returning to the SPA meeting context, the choices open to attendees exist within a strict meeting agenda that obliges them to engage in joint decision-making to ideally find an appropriate place for each client. In this respect, observed individual action within SPA meetings will always reflect the immediate and wider context within which they exist, that is, the immediate SPA meeting and wider NHS organisation.

It is also of interest to explore theoretical understandings into the term "role", since it is central to the BSP. Biddle (1986) suggests that role theory is useful despite early proponents' lack of agreement on its use. Biddle highlights its significance in understanding an important aspect of social life:

> *It explains roles by presuming that persons are members of social positions and hold expectations for their own behaviours and those of other persons…* (Biddle 1986: 67)

This is also supported by Stryker and Burke (2000) in their treatment of social roles, since they imply that in any relationship expectations are formed around the social positions that people assume. These understandings are endorsed by the Handling Role Boundaries theory, particularly as captured in the Recognising and Positioning phases (Narayanasamy 2016). The social roles present in SPA meetings were both formal professional roles and personality traits, but these did not necessarily exist separately or compete for prominence. Rather, they sometimes combined and co-existed to produce behaviour that contributed to decision-making. An example would be the Balancing phase in which strategies of negotiation were often proposed by the chairperson. The act of negotiating could have been carried out because this is seen as an appropriate and expected action of a chairperson. However, the way in which they negotiate may be linked to qualities of their personality. Indeed, the decision to appoint this person as chair in the first place may have been informed by their known knack for being a "peacemaker" and skills in effecting compromise.

Despite not competing for prominence, multiple role identities, as relevant for SPA meeting attendees, undergo an organisation procedure which can be described as a salience hierarchy (Stryker 1980; Stets and Burke 2005):

> *The salience hierarchy focuses on how an individual will likely behave in a situation. What one values may or may not be related to how one behaves in a situation although there is a significant relationship between the two.* (p. 12)

The salience hierarchy is advocated by Handling Role Boundaries, with this approach being evident largely in the Balancing phase. Some SPA meeting attendees disclosed during interviews that when complex cases arose, they took the decision to hold back particular views and personal beliefs so that decision-making could progress and conclude. This may demonstrate a conscious decision to sacrifice one's own agenda (which can be informed by both personality and professional role) to prioritise the collective interests of the group. There are sanctions and rewards that accompany the salience hierarchy, which contribute to decisions over which identity should be promoted (Stryker 1980; Stets and Burke 2005). In the context of SPA meetings, however, this all occurs against the backdrop of the main concern and an ardent endeavour to resolve it.

Role theory suggests that humans are socially aware actors who draw upon experience to form expectations and, in the same way, develop an awareness of the expectations upon them (Biddle 1986). Expectations are derived from three main sources: norms, beliefs and preferences, which then mean that behaviour is also informed by these modalities. Handling Role Boundaries embraces this understanding into the formation of expectations and shows how the three modalities influence which roles emerge. Reflecting the structural symbolic interactionist thesis, the "norms" inherent in SPA meetings have evolved, with actions becoming patterned regularities over time. In interviews with SPA meeting attendees, individuals also revealed how their behaviour could be influenced by the beliefs and preferences related to their immediate working role (such as social worker). These were not always compatible with their more general role as a CMHT member and lead to difficulties, or what is recognised as "role conflict".

Handling Role Boundaries overtly conveys the importance of personality roles in a work setting, but this is something that has not been addressed as widely in sociological and multidisciplinary literature (Ebbs and Timmons 2008). Peck (2003) contributes significant insights into CMHT organisations and professional role boundaries, suggesting that conflicts arise when multiple disciplines compete in one physical space. Such situations can produce barriers that lead to ineffective working. Peck elaborates on the origins of professional boundaries:

> *… boundaries come into being through differences in organisational structures and values…they are inculcated into individuals through training regimes and sustained patterns of socialisation…*(p. 72)

In accordance with how Peck describes the way in which professional role boundaries develop, Handling Role Boundaries also assumes that personality traits are instilled in individuals through sustained patterns of socialisation and regimes. Therefore, they are as prominent as professional roles and similarly have associated boundaries that need to be managed. In the face of conflicts that may result from role boundaries, the specific main concern for SPA meeting attendees has paved the way for strategies (such as that captured in the BSP), to emerge, to ensure that decision-making is not hindered. Attendees are driven to resolve their shared main concern (and therefore complete the decision-making process) through the Handling Role Boundary approach. Indeed, Peck (2003) concurs that effective working is supported and strengthened when teams operate under collective aims.

Goffman's sociological understandings of social beings, as captured in his work on impression management and the presentation of self in everyday life (1959), also offer some comparative areas for reflection. The SPA meeting accommodated both professional roles and personality traits, and this relates significantly to the theatrical analogy that Goffman (1959) adopts. Goffman depicts social life as encompassing both front regions and back regions. Front regions enable formal, professional roles to materialise, which can then be discarded in back regions in favour of more informal aspects of identity. The SPA meeting cannot easily be demarcated in this way, since arguably, it plays host to both front region and back region behaviour. For example, on first impressions, the meetings may be perceived as a "backstage" arena, since they are external to the face-to-face clinical encounters that mental health professionals have with clients. Informalities were observed, in terms of some lack of formal language, light-heartedness, levity and affable chat. On the other hand, the meetings also operate under a formal agenda, which was more purposively promoted at certain points, including when personality traits emerged in a way that would threaten the formal agenda and therefore needed to be handled. The endeavour to resolve the prominent main concern and adhere to the formal meeting agenda meant that it was often more appropriate for attendees to remain in their clinical roles. These examples demonstrate how SPA meetings also operate as a front region setting.

The complexities of SPA meetings are revealed in the fact that multiple aspects of identity can exist through both back region informalities and front region formal behaviour. This helps elucidate why Handling Role Boundaries is needed as a strategy in this particular forum of mental health decision-making, and why it devotes attention to both professional roles and personality traits.

The Implications of Handling Role Boundaries

Handling Role Boundaries brings insight into how professional roles *and* individual characteristics, such as personality traits, are all contributors to decision-making behaviour (Narayanasamy 2016). This is telling, considering that SPA meetings were developed to (a) promote specific professional lenses to understanding the client's mental health problem; (b) respond to the reported difficulties that GPs have in making decisions regarding services and interventions for clients with mental health problems; (c) accommodate a certain level of risk assessment in order to direct clients to services more appropriately. The SPA meeting is in fact one clinical space where holistic approaches to understanding the client are not encouraged by individuals; rather, each attendee is, on the face of it, expected to wear their "professional role cap" to offer insights into clients based on the former's expertise. For personality traits to be so prominent within these meetings, contributing to behaviours such as taking one's place and negotiating, we must delve a little more into the SPA meeting to consider why.

Firstly, the uncertainties that afflict the wider mental health landscape are transferred to SPA meetings, even though they were set up to resolve some of these uncertainties. For example, GPs' reportedly struggle to make decisions about mental health clients due to lack of training and time (Lucas et al. 2005; Read 2005). However, the clinical pictures that guide discussion during SPA meetings are not a raw presentation of the client; they are an interpretation created by the GP who is struggling to allocate the client to an appropriate service or intervention. Secondly, there is a public and professional expectation that mental health professionals engage in some form of risk assessment (Turner and Colombo 2008; Rogers and Pilgrim 2005; Beck 1992) to specify, for instance, whether the nature of the mental health problems in question warrants a crisis service that caters for more severe cases. This might be difficult to do on the basis of letters and case notes. These two issues exist against the backdrop of accountability, with media and regulatory bodies' scrutiny focused on the consequences of decisions made by mental health professionals (Manuel and Crowe 2014). This might foster a sense of defensive practice, which could involve avoiding taking on cases that convey uncertainty. In addition, as mentioned before, SPA meetings were conceived as a forum in which attendees promote their professional lenses, which could serve to exacerbate even further concerns about accountability and engender decisions that prioritise self-protection.

The role of personality and reliance on personality traits is likely to be a response to the milieu of uncertainty, the effects of concerns about accountability, and the fact that human beings are at the heart of decision-making practices in SPA meetings. Uncertainty about what to do with clients based on descriptions written in letters and case notes, and the pressures of limited time and resources, mean that expectations on oneself and others (as captured in the *Positioning* phase) are designed around personality traits as well as professional capabilities. This might include expecting the chairperson to have to hand strategies for speeding up decisions, such as bargaining tools. Other expectations may involve relying on someone to be a good timekeeper, or depending on someone in the group to be flexible and open to negotiation (with negotiation being a key part of the *Balancing* phase). In the midst of concerns around accountability, negotiation is a particularly pertinent characteristic that is relied upon in more complex cases. After the *Weighing up* phase, there was often a narrowed-down list of two or three potential services that were deemed as appropriate for that particular client. However, the prominent uncertainties still threatened the commitment to a decision around *who* should take on the case. This invited the role of *Balancing* and in particular the negotiating sub-phase, in which an attendee could suggest that one of the representatives from the narrowed-down services could provisionally take on the case. This would be done with the added reassurance that the representative could bring the case back to the SPA meeting, if they found that they could not offer the client anything. This shows how personality traits are in fact sometimes key to enabling decisions to be completed when there are factors contributing to uncertainty, such as time pressure, and concerns around accountability.

Conclusions

The chapter has considered a Grounded Theory-christened "Handling Role Boundaries"- which emerged in a field centred on the decision-making of mental health professionals. The four key phases of the theory have been discussed in relation to the sociological themes of identity, self, interaction and roles. The extension of constant comparative techniques with extant literature shows that Handling Role Boundaries finds resonance with existing sociological themes and ideas. These include structural symbolic interactionism and Biddle's (1986) interpretation of role theory, which were found to be cognate sociological tenets. Whilst highlighting that Handling Role Boundaries considers the prominence of personality traits as well as professional roles in decision-making, this chapter has also endeavoured to explain why this is the case in SPA meetings, by reviewing the uncertain elements inherent in the SPA meeting environment. It argues that in this context, at least, these uncertainties result in reliance on something other than professional expertise when it comes to pivotal the decision-making.

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9

Mental Health Uncertainty and Inevitability

Melanie Jordan

Chapter Overview

This concluding chapter considers the findings, analyses, and implications from across the book's internal chapters to construct an overarching commentary; it also debates the concepts of uncertainty and inevitability in relation to mental health. The studies in this tome represent mental health work in prisons, hospitals, therapeutic communities, care homes, and community settings in the UK and the US. Some of the mental healthcare analysed is NHS commissioned and provided and some is privately provided care. The chapters' analyses are based on empirical social science investigation with research methods including ethnographic work, quantitative data analysis, qualitative fieldwork, policy review, practice evaluation, and case study inquiry. Elements of formal healthcare

Melanie Jordan (✉)
Assistant Professor in Criminology, School of Sociology and Social Policy,
University of Nottingham, UK
e-mail: melanie.jordan@nottingham.ac.uk

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provision are evaluated (e.g., resource constraints and structural barriers) but so too are informal and unplanned routes to therapeutic change (e.g., social interactions and collegial cultures).

This book is intentionally multidisciplinary. Evidence and theory is included from social science, social theory, psychiatry, psychology, and nursing. Hugh Middleton and I have worked with the book's contributors in this regard and have required authors to make links between social science and clinical psychiatry/frontline mental health work—specially, how these theoretical and practical disciplines might reconnect and develop each other. The intention has been to further marry these fields to (a) develop legitimacy regarding, and freedom within, the relationship and (b) to create timely, apt, and worthy implications for mental health policy and practice plus future research and development.

In terms of structure, this concluding chapter explores mental health uncertainty and inevitability via four themes: inevitability of the social, uncertainty of social agent action, inevitability of identity work, uncertainty of illness experience.

Uncertainty and Inevitability

To briefly introduce the two concepts of uncertainty and inevitability Middleton, an academic and a psychiatrist, argues in the opening chapter to this book that (a) social disruptions are an *inevitable* element of organised societies and that (b) there is growing *uncertainty* about how these so-labelled mental health difficulties might best be conceptualised and addressed within society. Mental health broadly defined, to include for example mental healthcare provision, encapsulates myriad elements—two of which are uncertainty and inevitability. Synonyms here include ambiguity and doubt and then inescapability and innateness. Marrying these elements is, albeit daunting, exciting as it offers the opportunity for innovative research, thought, and development in the field of mental health—if uncertainty and inevitability are embraced as facilitators, and not obstacles, to consideration and change. Nowotny (2016) claims 'uncertainty is inextricably enmeshed with human existence' (p. viii).

This eloquently combines the themes of uncertainty, inevitability, and social life—very apt for this book. These themes are discussed further below, with the added inclusion of mental health and fieldwork evidence from this book's internal chapters.

Inevitability of the Social

Jordan's chapter highlights the will and skill of NHS staff who work in a prison with patients experiencing mental illness; however, this is contrasted with difficulties experienced in the custodial setting regarding care provision, which are narrated as establishment-, resource- and structure related. Significance is attached to this research endeavour by the staff, as they argue that the experiences of those who are incarcerated are not routinely considered and thus their interview narratives act as a vehicle of change for patient benefit. Staff in the prison argue mental healthcare is an important topic for continual research and development attention particularly because the voices of institutionalised persons are not easily or often heard. Experiences and voices of patients are thus crucial. Some patients, quite literally, cannot appeal for change due to mental ill health, lack of knowledge regarding the system, lack of access to comments and complaints procedures, and so on.

Overall, Jordan's chapter could be understood as forging an inevitable link between positive mental healthcare provision and positive teamwork. Refer to the chapter itself for full details. What is salient here is that mental ill health might be argued to require an inherently collaborative response from members of society (psychiatrists, psychologists, frontline daily carers, healthcare assistants, community psychiatric nurses, registered general nurses, and family/friends/carers). Stepping beyond this specific study, perhaps mental health is *inevitably*, therefore, a multiparty social endeavour. In a sense, this claim is somewhat common sense and redundant as arguably to be human is to be social and thus involved in multiparty social endeavour. (For further reading regarding the innate sociality of the human condition, see Goffman (1959) *The Presentation of Self in Everyday Life*.) However, perhaps the aforementioned assertion has an additional, more sonorous, claim: Mental health is the *responsibility* of the multitude and not of the individual.

To continue this theme of society and inevitability, Clarke emphasises the influential impact of the everyday in therapeutic settings. Clarke demonstrates how informal social encounters can act as health-giving mechanisms in mental healthcare environments—specifically therapeutic communities in this fieldwork. Clarke's work articulates the formal and informal healthcare boundary and appeals for additional consideration of the informal aspects to beneficial mental health change. Clarke's chapter argues that social encounters are instrumental in (a) sense of self-construction and (b) learning to belong to our host community—both individual and societal ramifications. Evidence from Clarke's study highlights how time outside of structured therapy is important for generating therapeutic change. Thus, it follows that these periods of non-directed social interaction warrant further academic analysis.

An appeal to devote increased research and development funds to mental health studies with micro-sociological and tacit foci seems a fitting recommendation here. (See Livingston (2008) for a fascinating read regarding tacit knowledge, local midenic practices, and human reasoning which is not related to mental health.) However, during our current era of welfare state austerity and during a time when the importance of being able to clearly articulate tangible research outcomes at funding application stage is crucial, this is somewhat problematic. Perhaps the contemporary prioritisation of research themes such as demonstrable research impact and measureable clinical effectiveness fail to wholly embrace the importance and the *inevitability* of the social in mental health research and development.

Everyday encounters contain complex social mechanisms that significantly impact upon individuals, according to Clarke's work. In addition to the above application, this principle could be applied to healthcare service *organisation* too. Indeed, Ballatt and Campling (2011), in a Royal College of Psychiatrists' publication, develop the notion of Intelligent Kindness within their debate concerning the culture of healthcare provision. Ballatt and Campling (2011) tackle the politics of kindness and the edges of kinship in their narrative (with overt reference to the NHS). The authors elaborate on their model of Intelligent Kindness for healthcare set-up and prioritise kindness and kinship in healthcare services due to their creative and motivating powers within healing relationships (see Chap. 12 of their book for full details regarding this philosophy for care). Further, in the Foreword for this book, Dartington states, 'The NHS is itself an expression of community, of reciprocity of need' (p. vi). Healthcare *is* social. We ignore this at our peril.

To return to mental healthcare specifically, Martin (2006)—in a book for an Oxford University Press series regarding practical and professional ethics—discusses morality, mental health, and the idea of virtue and vice in therapeutic culture. Crucially, any dichotomy or divide drawn between therapeutic attitudes and moral attitudes is considered a fallacy and thus rejected—furthering the theme of this section (i.e., the inevitability of the social). Martin (2006) argues, 'Moral virtues overlap and interweave with the criteria for positive mental health' (p. vii). A sense of moral accountability within society for mental health is presented. Therefore, Martin's (2006) expounded approach to mental health 'links self-fulfilment with responsibilities to others, as well as to oneself' (p. 71). According to Martin (2006), moral values are *inevitability* embedded in our conceptions of mental health and link to our *common* pursuit of a meaningful social life. Thus, morality leads *to* mental health (and all the implications for conceptualisation and care therein). However, this therapeutic trend in ethics, as depicted by Martin (2006), has the potential for both negative and positive outcomes (see Part II of his book). As an example, in an engaging and unorthodox manner Martin (2006) utilises the television drama "The Sopranos" to debate contemporary clinical criticism regarding therapy, therapists, non-judgemental clinical practice, relativism, subjectivity, and individual life preferences (p. 62 onwards). The roles and responsibilities of the clinician in the realm of mental healthcare in our current era are deliberated, which appropriately links this section with the next as it takes mental health service workers and their frontline work as its foci.

Uncertainty of Social Agent Action

The chapters by Middleton and Hui examine employees in the field of mental health and the nature of frontline mental health work—in community and forensic settings, respectively. Their chapters can be utilised to debate the uncertainty of social agent action in this realm. Hui demonstrates that work in psychiatry includes myriad often contentious (e.g., containment and care) professional roles and that the personal values of staff are often overlooked. Reconciling professional and personal conflicts and the emotions of workers are thus discussed. Action in mental health work impacts those who receive care; therefore, as Hui argues, workers' feelings and experiences in relation to organisational expectations warrant investigation. In summary, Hui's chapter evidences a relationship between workplace as institution, worker emotion, and worker action. Fieldwork data demonstrate a rhetoric *versus* reality divide; further, a formal and informal work distinction is highlighted between both policy and practice plus training and reality. Crucially, individual worker interpretations of institutional values were exposed—herein lies the uncertainty of social agent action.

Similarities exist in the Middleton chapter, where the informal and non-audited elements of community mental health teamwork are deliberated. Tensions between recognised and bureaucratic work *versus* intuitive and humanitarian work are analysed. Middleton uses Lipsky's theory regarding street-level bureaucracy to frame these discussions. Importantly, creativity in the mental health workplace is praised and linked to practitioner well-being; creativity invites an innovative, yet *uncertain*, element to mental healthcare. However, creativity is, according to Middleton, constrained by the governance of an organisational hierarchy and the requirement, of practitioners, to perform as institutional enforcers in the workplace. Practitioners' working lives involve negotiation, and it is within these arbitrations that uncertainty lies. Social agent action at the frontline is, in some ways, uncertain—for example, the creativity and emotive action demonstrated by Middleton and Hui.

Inevitability of Identity Work

Roe's chapter explores the themes of spoiled identity, stigmatisation, and socially constructed identities. These are analysed via the relationship between mental health service user and mental health service professional. Roe debates the interactions amongst clients and practitioners of an assertive outreach mental health team. The power and control of the medical model in mental healthcare—especially in settings where this approach is not intended to dominate but still does—is critiqued. Roe highlights that, even in this community mental health service, practitioners' institutional setting powerfully influences their constructions of clients' identities. Traditional organisational norms and values from clinical psychiatry remain persuasive and these conceptualisations constrain the assertive outreach team. Members of this community-based clinical team construct meanings for various aspects of the team's activities, which are then modified, reinforced, and replicated amongst colleagues over time. Such activities include team purpose, daily routines, workplace responsibilities, and engagement pursuits with clients. Constructed meanings fashioned by practitioners are also derived from perceived characteristics and traits of individual service users, plus patients' social and material objects.

Whilst Roe's chapter does not follow this exact path, theory and evidence regarding the social distribution of treatment is relevant here. Rogers and Pilgrim (2005) are seminal scholars in the sociology of mental health and illness. Rogers and Pilgrim (2005) debate the paradox and problems of psychiatry and the inverse care law, which generally applies as intended to physical health. (See Chap. 8 of their book for a full discussion.) Rogers and Pilgrim (2005) state: 'In the light of the stigma attached to mental health services and the role of psychiatry, some of the time in the coercive control of socially disruptive behaviour, then it is little surprising that some social groups are more vulnerable to service receipt than others' (p. 157). Societies can then be analysed via service usage and, as examples, ethnicity, socio-economic group, gender, age, education, or military service.

Indeed, for Roe's research, elements of clients' histories, at point of arrival to the team, shape their future clinical *identities*; collective meanings amongst the team contribute to staff *expectations* regarding clients. Institutional imperatives rooted in medicalised paternalism strongly influence and direct therapeutic interactions, even in community teams explicitly contracted to embrace psychosocial interventions. Well-established systems of care in the mental health field are shown to exert constraining effects upon practitioners' constructions of clients' identities and their interactions with them as service users. Working environments can be governed by institutional rules, even when the setting is not physically boundaried, as they can be in traditional mental health hospitals. Institutionalisation theory thus becomes relevant. (See Jones and Fowles (1984) *Ideas on institutions*.) Indeed, renewed attention to the total institution work of Goffman (1961) today is fitting, as a recent mental healthcare study conducted by van Marle (2007) stresses Goffman's institutionalisation work remains relevant to contemporary prison (i.e., institutionalised) life and mental health work therein.

Even though the work refers to residential and not community settings, Jones's (1972) paper regarding the 24 steps of institutional admission also has salience here for mental health clinicians. Jones utilises Goffman's seminal thesis that the nature of admission to social institutions such as asylums, prisons, monasteries, and army camps instigates a process of role dispossession, alongside specific detailed cases of the author's own and concludes 'while the actual events differ, there is a central unity of process' (p. 405). Jones uses the term 'Ego' to refer to the person, and 'System' indicates the institution. According to Jones, institutions cause physical and psychological alterations to occur; it is considered inevitable: 'Once contact between Ego and the System has been established, it is only a matter of time' (p. 407). Poignantly, Jones highlights that 'whatever expectations Ego has, the System will have very clear ones' (p. 409). Indeed, Roe's evidence exemplifies this claim concerning the power and domination of the system over the ego—even in non-physically boundaried settings. Jones refers to the ego as 'an object to be transported and stored' (p. 409). Working in and/or for well-established institutions can have long-lasting ramifications for both body and mind. Interestingly, Jones does not limit scope to the presumed and traditional social and medical institutions, but also suggests that 'it may be possible to cast the net wide enough to include hotels, religious communities and boarding schools' (p. 406). Indeed. Roe's work persuasively extends these institutionalisation ideas further, into community settings.

To return to Roe's work, the fieldwork makes it evident that staff play a significant and influential role in patient identity work—and thus care provided; there is a relationship between mental health clinician and patient identity construction. This theme of identity is explored by another author in this book, Narayanasamy, but her work centres on staff identity not patient identity. The overall outcome, however, is the same (i.e., patient care is effected).

Narayanasamy's chapter focuses on a critical juncture within a client's pathway through local community mental health services—the Single Point of Access (SPA) meeting—where referrals from general practitioners are discussed and actioned. These meetings include nurses, psychiatrists, social workers, occupational therapists, and some specialist mental health service staff (e.g., assertive outreach). Decision-making in these meetings—which are typified as complex and multidisciplinary ventures—is Narayanasamy's focus for analysis. The options and choices in these meetings are important for patients, as decisions allocate clients to services and/or interventions. Fieldwork demonstrates that individual staff contributions to the decision-making process reflect something beyond their professional capacities. Narayanasamy stresses this is highly significant, given that the meetings were specifically intended to utilise professional lenses and perspectives. Complex meeting dynamics are documented which combine issues of identity, self, roles, and interactions. Narayanasamy fashions the term 'Handling Role Boundaries' in her work, which considers the range of roles present within SPA meetings. Handling Role Boundaries acts as an analysis tool to academically explore the client triaging process undertaken during these SPA meetings. A patient's mental health service trajectory is directed by the decision made in the SPA meeting amongst the mental health colleagues. This is perhaps, at first, an unassuming research finding; however, the frontline result is far-reaching for the patient and the decision-making process itself is far from simple, predictable, or objective—hence the salience of this Narayanasamy's chapter. Helman (2007) explores cross-cultural psychiatry and also discusses psychiatric knowledge and practice as cultural constructions; power is given to the subjective aspect of diagnosis and the influence of social, cultural, and political forces on the process of diagnosis—consistent with Narayanasamy's findings.

Narayanasamy highlights that both professional and *personality roles* are present in mental health service decision-making. Personal staff identity work is inherent, crucial, and influential to their wider professionalised mental health work. Thus, there is an *inevitable* link between the person and the workplace. Narayanasamy debates the role of personality and staff concerns regarding self-protection plus personal accountability and personal risk. Further, fieldwork evidences that SPA meeting members' expectations of themselves and others are constructed according to perceived personality traits of colleagues (as well as their professional capabilities). In addition, powers of negotiation are influential in decision-making, indicating that individuals' personalities can demonstrably impact team decision-making and thus patient care. Overall, Narayanasamy stresses the impact of staff personality traits on mental health services in a very tangible sense, with significant outcomes for patients.

Griffiths and Franks (2005), in a book analysing psychiatric and mental health nursing, prioritise the centrality of 'the need to tolerate not knowing and to reflect on self and others' (p. 74) in nursing mental health. This combines the topics of uncertainty (a theme for this concluding commentary) and the inevitability of self in mental health (a theme for this subsection). Self-reflection is seen as a crucial capacity and is, therefore, recognised in nursing curricula. Griffiths and Franks (2005) also stress that managing relationships with both colleagues and employing institutions is essential to the nursing task and, further, that the use of self in the mental health workplace is not a new phenomenon. (See their chapter for thought-provoking experiential knowledge regarding role confliction and role navigation.) However, Griffiths and Franks (2005) analyse the Tavistock Clinic specifically and seek to apply psychoanalytic theory. Perhaps, therefore, further linkage between this paradigm and wider mental health practice might prove fruitful, especially as Narayanasamy's study highlights that research work and theoretical understanding regarding *use of self* in the mental health workplace is not yet complete—albeit long standing as Griffiths and Franks (2005) emphasise.

Uncertainty of Illness Experience

Scales's chapter analyses institutional logics in long-term care homes to highlight how residents' experiences of dementia, regardless of diagnosis can be produced by particular logics and associated practices of the care setting. Scales's work challenges, with convincing empirical data, some of the assumed links between dementia diagnosis and dementia experience; findings demonstrate that differing institutional logics underpin care practices in discrete settings and that these logics, in turn, create divergent dementia experiences. The outcomes for patients are striking; one setting's set-up mobilised loss of independence and dignity, social exclusion, and inactivity, whereas the other setting's set-up facilitated independence and dignity, social inclusion, and meaningful activity. Dementia experiences are produced via contextual and relational processes in the care setting and the notion of personhood is important (not cognitive function concerns only). Scales considers dementia to be intersubjective and situated—not just pathological. Thus, there is the potential for person-centred care strategies to ameliorate certain distresses. This is clearly a positive finding. Refer to the chapter itself for full details. Crucially, for Scales, assuming disease pathology as the primary source of distress or stability fails to acknowledge the conditions and practices that may have produced these situated experiences. This highlights the influential role played in the field of health and illness by the care setting's social and structural elements.

Moving beyond Scales's work, what is certain is that our socially constructed institutions where mental healthcare takes place significantly and measurably affect patients. For seminal theory in this regard, see Jones and Fowles (1984), Barton (1976), and van Marle (2007), or the 'context is crucial' argument of Jordan (2010, 2011). Thus, incorporating patient narrative into service development is important for ensuring that social and structural conditions of care support rather than undermine health and well-being.

There are possible models of practice available in this regard. For example, Davies et al. (2013) explore the NHS and co-production of change between service providers and service users. Joint working is depicted as an ideal norm for healthcare. The patient voice is prioritised and patient-centred care is argued to represent quality. Commissioning culture and work should include, in a genuine sense, patient stories; patient experience can contribute to needs assessment, service specification, contract design, and evaluation. NHS commissioning teams are reminded of the importance of 'seeing care as patients do' (p. 43). (See Chap. 10 of Davies et al. (2013) for further details regarding experience-led commissioning.) However, experiences of engagement in healthcare governance are extensively critiqued in Section 3 of Davies et al. (2013), specifically Gilbert's chapter regarding the engagement industry and a failed engagement system.

What remains particularly uncertain is how the inherent *divergent* patient narratives, and how the subjectivity of mental illness experience more generally, can be most appropriately embraced—for the benefit of myriad stakeholders (patients, clinicians, commissioners, managers, etc.). To complicate this uncertainty, Nowotny (2016) argues that the outcomes of purposeful societal action (in this instance, perhaps altering a service for mental health service users at the frontline) are uncertain: 'Experience shows that what has been actually achieved usually differs substantially from what was intended. The cunning of uncertainty courts surprise and invites the unexpected' (p. *x*). This double uncertainty is somewhat exciting from a theoretical perspective, but less comforting for NHS patients and staff. Perhaps the lesson to learn here from Scales's work, therefore, is to (a) reject the assumed certainty of the diagnosis equals illness experience equation and (b) embrace, where possible, the uncertain nature of a mental illness' course.

Chapter Conclusion

To conclude, Nowotny (2016) eloquently states that 'the arrow of time continues to advance the tenuous balance between the punctuated, incomplete and biased knowledge of the past and the uncertainty of what the future will bring' (p. viii). Similarly, the core argument of this book is that mental health, broadly defined, is permeated with the somewhat competing notions of uncertainty and inevitability; the future of mental health, mental illness, and mental healthcare is indeed uncertain in myriad respects, but there are several inevitabilities in this field, and some of these have been elucidated earlier in this tome. Therefore, Nowotny's work could be utilised at this final stage in the book's narrative as a call for stakeholders involved in mental health to learn from past (and current) knowledge in this field in order to appropriately tackle uncertainty ahead.

However, Nowotny (2016) complicates this matter by highlighting that 'the more we know, the more we also realize what we do not know as yet' (p. vii), and it is with this appeal for epistemological maturity that this book ends. This epistemological entreaty is intended neither as a necessary evil to be surmounted nor as a constraining obligation regarding mental health research and development; rather, it is intended to act as (a) an exciting opportunity and research justification for *perpetual* mental health theory, policy, and practice advancement and (b) as a prompt to avoid any future complacency, as mental health knowledge will never be complete.

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Index

A
academic psychiatry, 3
accepted, 15, 25, 50, 111, 134, 140, 159, 186–8, 190, 200
access, 112, 125, 133, 172, 184, 185, 200, 223
accountability, 87, 216, 217, 225, 320
Alzheimer's disease (AD), 29, 74–6, 96
American Psychiatric Association, 4, 24
amicable collaborative endeavour, 107
anti-psychiatrist(s), 5
anti-psychiatry, v, 4, 10
anxiety, 28, 42, 50, 51, 60, 76, 78, 90, 109, 110, 112, 152, 153, 159, 169, 172, 177
anxiety management, 172, 177
assertive outreach (AO), vi, 21–43, 168, 170, 171, 175, 176, 178–82, 190, 191, 200, 227, 229
Aston Team Performance Inventory (ATPI), 174, 175
asylum(s), 5, 8, 22, 76, 141, 169, 228
attachment, 48, 175
attitudes, 131, 184, 186, 225
autonomy, 16, 21, 31, 36, 38, 77, 87, 91–3, 122, 123, 125, 133, 134, 144, 172, 177

Note: Page numbers followed by "n" denote footnotes.

H. Middleton, M. Jordan (eds.), *Mental Health Uncertainty and Inevitability*, DOI 10.1007/978-3-319-43970-9

B

barriers to healthcare provision, 2, 11, 15, 74, 106–8, 112, 117, 124, 171
Basic Social Process (BSP), 199–217
benefits advice, 169, 173
biomedical model, v, vi, vii
Blumer, H., 28, 30, 32
boundary, 53, 107, 117, 224
Bourdieu, Pierre, 82

C

care coordinators, 183
care home(s), vii, 73–99, 221, 230
caseloads, vii, 34, 92, 115, 168–71
certainty, v, vi, 1, 232
Charcot, Jean-Martin, 7, 8
Chicago School, 2
citizen agent, 167–93
client, vi, 14, 15, 27–9, 31–8, 40, 42, 48–53, 56–67, 121, 167–74, 177–81, 184–93, 199–5, 210, 211, 214–17, 226, 227, 229
Clinical Commissioning Group, 169
CMHT. *See* community mental health teams (CMHT)
coercion, 108
cognitive behaviour therapy, 172, 173, 177
cognitive impairment, 75, 77, 80, 90, 92, 96, 97
collaboration(s), 2–5, 81n2, 115, 201
Collins, Randall, 49, 50, 52–5, 66
communication with colleagues, 133
community-based services, vi
community mental health teams (CMHT), 28, 30, 37, 40, 167–93, 199, 203, 205, 213, 226
community psychiatric nurse (CPN), 40, 109, 168, 169, 177–84, 208, 223
confidentiality, 50, 57, 108, 181, 189
consistency, 115, 127, 185, 186
constructions of clients' identities, 227
constructivist, 3, 4, 6, 10, 12, 16, 22, 142, 148, 158
consultant, 169n1, 183–5, 203, 207–9
continuity, 99, 106, 176, 186
continuity of care, 106, 176
contradictory professional roles, 68, 99, 138
corporate pressure, 182–3
creativity, 175, 176, 189, 214, 226
creativity at the frontline, 226

D

decision-making process, vi, 214, 229
dementia, vii, 73–99, 172, 230, 231
Department of Health, 31, 119, 138, 141, 159, 168
depot neuroleptic medication, 169
depression, 24, 26, 29, 109, 110, 169, 207
desensitisation, 137–62
detachment, 137–62
deviance(s), 6, 173
deviant, 109, 140, 142, 173
Diagnostic and Statistical Manual of Mental Disorders (DSM), 4, 24, 76, 96

Did Not Attend, 110, 126–8, 134
differentiation, 191
distress, 6, 9, 15, 26, 41, 42, 48, 49, 56, 60, 68, 91, 96, 97, 129, 132, 170, 172, 173, 231
Durkheim, Émile, 48, 49, 52, 54, 56

E

early interventions psychosis (EIP), 167, 171, 175, 176, 190, 200
effectiveness, 47, 49, 64, 79, 87, 107, 114, 171, 174–6, 224
efficiency of clinician, v, vii, 108, 109, 111, 113, 114, 117, 121, 122, 131–3, 149, 180, 184, 225, 228, 232
emotional energy, 49, 50, 53–5, 65–7
emotional labour, 146
emotional reaction(s), 3
emotional support, 190, 191
emotions, 30, 49–51, 54, 56, 58, 60, 61, 63–7, 138, 142, 145–8, 150–3, 155–62, 226
emotion work, 137–62
employer, 169
enabled citizenship, 193
enacting NHS change in the prison setting, 110, 122–6
enjoyment at work, 107, 111, 112
epidemiology, 2
ethnography, 56, 83
ethnomethodology, 3
everyday interactions, 52, 65, 66, 146
evidence-based, 9, 11, 193
existential, 15, 172
expectation, 13, 15, 24, 25, 30, 33, 38, 41, 65, 67, 80, 138, 147, 149, 154, 156, 157, 159, 161, 178, 181, 186, 191, 205, 206, 208, 210, 212, 213, 216, 226–8, 230
experiences, vi, vii, 4, 15, 16, 26, 27n1, 28, 29, 42, 49, 56, 58, 63, 74, 78, 79, 81, 87, 92, 95–7, 99, 106–8, 112, 116, 120, 124, 132, 142, 149–51, 161, 162, 184–9

F

flexibility, 122, 128, 177, 178, 184, 185
follow-up, 186
forensic psychiatry, 137–62
Foucault, Michel, 3, 8
Freud, Sigmund, 7, 8

G

Goffman, Erving, 2, 5, 22, 23, 25, 26, 27n1, 28, 39, 49, 52, 53, 74, 80, 81, 146, 214, 223, 228
grounded theory, 142, 148, 185, 211, 217

H

Her Majesty's Prison Service (HMPS), 105, 108, 109, 113, 119, 124, 125, 128–33
hierarchic relationship, 177
high secure hospitals, 138, 140–2, 146
historical account(s), 1
hospital admission, 171
human brain, 14

humanitarian concern, 2, 226
human relationship(s), vi, 16

I

identity, vii, viii, 5, 6, 22, 23, 26, 28, 32, 37, 40, 41, 52, 79, 80, 92, 119, 139, 172, 177, 191, 205–7, 211–15, 217, 222, 226–30
identity construction, 229
illness discourse, v
implementation guide, 169
incarceration, 5, 105
inevitability, v, 17, 221–33
inevitability of identity work, 222, 226–30
inevitability of the social, 222–5
informal support, 57
informal time in therapy, 49, 57
innovation, 175, 191
In-reach team(s), 106, 109, 116, 117, 124, 132
institutional, vi, 2, 5, 6, 23, 28, 33–7, 41, 42, 73, 74, 79, 82–4, 86–7, 92, 97–9, 107, 108, 111, 122, 137–62, 177, 189, 226–8, 230, 231
institutional logics, 74, 82–4, 86–7, 92, 97, 99, 230, 231
institutional logics theory, 82, 97
institutional pluralism, 139, 160
institutional pressure, 189
institutional rules, 145, 228
institutional setting, 2, 146, 191–3, 227
institutional work, 111, 138, 144–7, 162
institutions, 17, 22, 26, 74, 80, 82, 86, 98, 138, 139, 142, 143, 145, 147, 148, 161, 228, 230, 231
interaction rituals, 47–68
interdisciplinary tie(s), 3
International Classification of Diseases (ICD), 4
inter-professional relation(s), 9
intersubjective workplace aphorisms, 107
inter-team working, 174, 176
interviews, 56, 57, 83, 108, 109, 133, 142, 148–51, 159, 160, 173, 185, 202–4, 213
intimacy, 58, 181, 189

J

Jones, Maxwell, 48, 67

K

Kitwood, Tom, 78, 81
knowledge translation, 81, 82

L

labelling theory, 6
labels, 24, 37, 39, 40, 121, 131
Laing, R.D., 4, 5
life world, 9
lunacy, 1, 141

M

madness, 1
manager, 89, 92, 119, 149, 174, 175, 177, 180–1, 209, 232

managerial responsibility, 191
medical approach, 1, 3, 5, 10, 12, 13, 25, 78
medical assistance, 14
medical model, vi, 27, 37, 38, 86, 183, 227
medication regime, 173
medicine(s), 1, 3, 4, 8, 10, 12–14, 16, 22, 139
meeting dynamics, 229
mental disorder(s), 1, 24, 76, 96
mental health, v, 1, 21–43, 47, 73, 105–34, 137, 167–93, 199–217, 221–33
mental health difficulty, vi, 4, 6, 28, 171–3
mental health practitioner(s), 9, 28, 37, 173, 174, 176–84, 190
mental health professionals, 12, 14, 24, 25, 29, 124, 201, 214, 216, 217
mental health responsibility, 1, 27, 139, 167, 169, 170, 175, 181, 184, 223
mental health service, vi, vii, viii, 6, 10, 15, 16, 22, 26–9, 31–3, 37–40, 42–3, 65, 106–8, 115, 131, 133–4, 137, 142, 146, 161, 162, 167, 169, 171, 172, 184, 185, 193, 199–201, 225–7, 229, 232, 320
mental health staff skills, 106, 108, 111, 113, 114, 133, 223
mental health staff willing, 106, 108, 109, 111, 113, 114, 143, 223
mental illness, 1, 2, 4, 5, 14, 17, 23, 25, 26, 29, 31, 42, 43, 80, 106, 108–10, 112, 113, 129, 131, 132, 149, 207, 223, 232
microsociology, 52
multi-disciplinary, 107, 115, 168, 200, 201, 210, 213, 222, 229
multidisciplinary teamwork, 107
multidisciplinary team working, 200
multiparty social endeavour, 223

N

narrative ethnography, 56
National Health Service (NHS) staff experiences, 106
National Institute for Health Research (NIHR), 81n2, 173
nurse/doctor relationship, 183
nursing home(s), 73n1, 80, 87, 91, 92, 95

O

objects, 30, 32, 33, 35, 37, 41, 43, 53, 54, 227
occupational therapist (OTs), 168, 199, 229
old guard *vs.* new guard, prison staff, 110, 129–32
organisational, vii, 38, 39, 41, 112, 118, 138, 144, 146–8, 156–9, 161, 175–7, 189, 200, 214, 226, 227
organisational context, 37, 176
organisational pressures, 38, 39
organisations, 42, 55, 116, 118, 124, 137, 140, 142–5, 147, 148, 169, 213

overarching workplace goals, 107
ownership of roles, 123, 133

P

paperwork, 126, 181–2, 190
participant observation, 39, 56, 57, 83
paternalism, 13, 227
penal healthcare, 107
personal change, 48, 49, 51, 52, 56, 63, 66, 67
personality, vii, 79, 169, 205, 211–17, 320
personality difficulties, 169
personality disorder, vii, 47, 109, 149
person-centred care, 79, 81–6, 92, 93, 98, 231
personhood, 74, 77–81, 84, 85, 89, 91–5, 97, 98, 231
phenomenology, 185
placebo effect, 14
policy, 5, 8, 9, 21, 23, 31, 38, 42, 79, 83, 98, 107, 113, 120, 124, 154, 179, 192, 193, 221, 222, 226, 233
positive teamwork, 223
positivist, 3, 5, 9, 12, 16, 22
possession, 1
practical support, 31, 185, 188
practice theory, 82, 96, 98
practitioner, 8–10, 14, 17, 28–33, 37, 42, 43, 82, 121, 137, 138, 155, 161, 162, 168–70, 173, 174, 176–84, 189–93, 199, 226, 227, 229
practitioner roles, 177–8
prescription, 14
pride in the workplace, 122
prison mental healthcare, 105–34
problem solving, 174, 176
process of diagnosis, 229
productivity measurement and enhancement system (ProMES), 174
professional, 8, 14, 21, 24, 27, 39, 43, 115, 117, 119, 121, 123, 124, 128, 130, 132, 138, 153, 157, 159–61, 168, 177, 184, 185, 201, 205, 211–17, 225, 226, 229, 230
professional and personal conflicts, 226
psychiatrist, 2, 4, 6, 14, 16, 23, 24, 39, 109, 168, 169, 178, 183, 184, 199, 207–9, 222, 223, 229
psychiatry, v, vi, 1–17, 22, 25, 41, 42, 76, 137–62, 222, 226, 227, 229
psychoanalysis, 2, 6–10
psychologist, 2, 63, 65, 78, 108, 109, 149, 168, 207, 223
psycho-pharmaceutical(s), 14
psychosocial care, 168
psychotherapy, 14

Q

qualitative research, 22, 185

R

reassurance, 185, 186, 217
recovery, vi, vii, 21, 30, 31, 42, 56, 137, 139, 168, 172, 185, 186
relational qualities, 189

relational vulnerability, 3
relational work, vii
relationship, vi, vii, 2, 5, 8, 9, 11, 12, 14–16, 21, 22, 26, 27, 29, 32, 36–9, 42, 47, 48, 53, 78–80, 82, 89, 92, 99, 108, 117, 120, 121, 123, 125, 133, 144, 145, 148, 152, 153, 159–62, 169, 171, 174, 176–8, 183, 185–7, 189–93, 212, 222, 224, 226, 228, 230
relationship building, 38, 86, 97, 192
restrictive practice(s), 156
risk, 77, 79, 94, 95, 138, 139, 141, 142, 150, 161, 167–9, 172, 177, 179, 188–9, 200, 202, 215–16, 230
risk assessment, 126, 200, 215, 216
role, vii, 13, 14, 23, 25, 27, 35, 36, 38–40, 43, 47–68, 80, 107, 120, 122, 138–40, 147, 150, 154, 155, 157, 180, 181, 191, 199–217, 227–31
role theory, 211–15, 217
Royal College of Psychiatrists, 4, 6, 16, 50, 224

S

safe, 48, 110, 111, 114, 137, 154, 156, 157, 183, 186–7
self, 23, 29, 30, 37, 40, 47–50, 57, 65, 67, 79, 82, 110, 111, 120, 129, 144, 147, 153, 157, 159, 162, 192, 206, 207, 211–17, 224, 225, 229, 230
self-acceptance, 16, 65
self-reliance, 172
service user, v, vi, vii, viii, 6, 21, 27, 28, 30, 32–4, 36–42, 48, 56, 108, 131, 174, 176, 180–1, 184–8, 226–8, 231, 232
service user perspective(s), vi
shift working, 170
sick role, 13
Single Point of Access (SPA), vi, 199–207, 210–17, 229, 230
social construction(s), vi, 14, 74
social constructivism, 3
social deprivation, 3
social disruption(s), 1, 222
social engagement, 15, 92
social geography, 3
social interaction(s), 8, 27n1, 28, 41, 49, 53, 65, 111, 114, 132, 190, 222, 224
social learning, 48, 67
socially isolated, 177
social order, 5, 97, 173
social science(s), v, vi, 1–17, 21, 22, 49, 64, 105, 138, 150, 160–2, 221, 222
social scientist, 1, 2, 4, 22, 67, 160, 185, 201
social structure(s), vi, 16, 53, 83, 143, 211
social theory, vii, 2, 16, 67, 68, 74, 98, 108, 160, 162, 189, 222
social worker (SWs), 2, 149, 168, 199, 207, 213, 229
sociologist(s), 2
solidarity, 49, 52–4, 59, 60, 63–7
SPA. *See* Single Point of Access (SPA)
spiritual, 172
spoiled identity, 6, 226
stability, 36, 53, 96, 119, 186, 231

staff values, 111, 121, 137, 138, 157, 160, 161, 226
stigma, v, 2, 5, 6, 21, 30, 47, 77, 188, 227
stigmatisation, 28, 226
street level bureaucracy, 192, 193, 226
street-level bureaucrat, 192
structural problems, 184
structural symbolic interactionism, 211, 217
supportive relationship, 12, 14, 192
symbolic, 3, 11, 14, 21–43, 55, 83, 211, 213, 217
symbolic interaction(s), 28–30, 32, 41, 42
symbolic interactionism, 3, 11, 17
symbolic meaning(s), 29, 33, 35, 37, 41–3
systems world, 9
Szasz, Thomas, 4, 5, 22, 25

T

task design, 175, 176, 190
team cohesion, 191
team effort, 115, 132, 175, 176
team membership, 177, 179
team primary task, 107, 118, 119, 133, 192
team process, 173–6
technologies of care, 170, 172
therapeutic communities, vii, 47–68, 221, 224
therapeutic relationship, 15, 174, 176, 192
therapeutic technique, 177
transcript, 83, 107–9, 111, 112, 114, 119, 120, 128, 149, 185, 186, 188
tribal distinctions, 2
troubling behaviour, 173

U

unacceptable-mental illness prevalence, 109
uncertainty, v, vi, 1, 182, 216, 217, 221–33
uncertainty of illness experience, 222, 230–2
uncertainty of social agent action, 222, 225–6
understood, 8–14, 29, 33, 37, 40, 48, 49, 64, 67, 74, 77, 78, 80, 92, 95, 96, 99, 107, 121, 124, 129, 170, 172, 184–6, 188–9, 191, 203, 205, 223
unhelpful attitude, 186
untreated psychosis, 171
use of self in the mental health workplace, 230

W

wellbeing, 15, 16, 36, 42, 80, 94, 95, 132, 161, 174, 176, 226, 231
worker interpretations, 226
working with patients/prisoners, 110–13
World Health Organisation (WHO), 4