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exploring active and passive approaches to recovery

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Abstract

The present study aimed to examine the extent to which mental health service providers' (SP) intention to empower their service users' (SU) is realised in their service proposals. The service proposals (i.e. care plans and risk assessments) of three different types of SPs were selected for a critical discourse analysis (CDA) of the interventions proposed and the opportunity they permitted the SU to exercise choice and control based on their level of active/passive engagement with the SU. 'Active' approaches conveyed coercive interactions, such as the use of instructions, rules or contracts, thereby restricting SU choice and control, whereas 'passive' approaches indicated more hands-off interactions such as guidance or recommendation, thereby permitting or facilitating greater SU choice and control. The materials and SPs consisted of two care plans and one risk assessment from a low security locked rehabilitation hospital (LSLRH), one care plan and risk assessment from a community mental health team (CMHT) and one care plan and two risk assessments from a private rehabilitation SP (RALE). The LSLRH was found to be the most active SP whereas RALE was perceived to be the most passive. The CMHT team was found to be passive, however by contrast to the other documents, it appeared to have less direct contact with SU and largely functioned as a referral agency. The analysis of the data for the LSLRH in particular suggested little may have changed in acute contexts over the last decade since many opportunities for SU choice and control remained limited – an observation also made in previous research in similar contexts (Perkins, 2001; SEU, 2004; Masterson and Owen, 2006; Campbell, 2005: 80-81; Cutcliffe and Happell, 2009; Bentall, 2010; DoH, 2011; Leader 2012). Nevertheless, the results found for RALE offered some optimism in the context of community care. Finally, the present study's non-invasive approach to evaluating mental health services offered a new method of critically examining service provision and revealing contradictions between rhetoric and reality.

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1. Introduction

Living with mental disorder can be an incredibly disempowering existence. Individuals, who perhaps at one point in their lives had an established routine, autonomy over their environment and a defined identity, often lose this as a consequence. Having most probably observed altered behaviour first-hand, loved ones' and colleagues' perceptions of the affected individual change, by extension altering their social position, image and influence too. Upon accessing support services, becoming service users (SU), they may then be denied much of the access they once had to the community and must suddenly rely on others. Some might have suffered mental disorder and relied on others so early in their adult lives, they might not have ever developed an identity outside of support services at all. As the following chapters will demonstrate, individuals in support services appear to be struggling to reintegrate with communities, where they may find purpose and meaningful relationships outside the hospital discourse (SEU, 2004; IC, 2014). That being the case, services could take care and pay attention to not further disempower SUs in the very systems designed to support them into recovery – a state where one can both operate with self-determination and agency, and most importantly, of course, be happy.

During my role supporting mental health SUs I frequently observed the above story unfold accompanied by great conflict between patients and their practitioners. These conflicts usually resulted in SUs being readmitted or having some other freedoms removed from them in other ways. Having read more on the subject of SU empowerment, it appeared that there existed a fundamental dissemblance between what practitioners wanted to achieve compared to what their SUs seemed to truly have on their minds. It occurred to me then, that perhaps care plans would be more easily, and realistically, achieved had both parties been honest with each other from the outset. I began to observe interactions in a much more generalised view – rather than trying to understand what specific treatment was working, I instead questioned how it was being delivered and by whom. Soon after, it became apparent to me that there

were fundamentally two approaches toward recovery: active and passive. This notion was an epiphanic moment of realisation. The very essence of what makes us individuals, and masters of our environment, was being denied to SUs by their practitioners and in doing so robbed them of any opportunity to exercise this let alone demonstrate their capacity in the first place. A paradoxical existence became evident – Practitioners attempting to rehabilitate adults back into society while denying them their right to define, or at times even express, their identities. As someone who fully embraces experiential learning – particularly what we choose to savour and endure - since it is the meaning we take from experience that fashion us into individuals, such an existence strikes me as none other than devastating. I fear therefore that much of life's meaning and purpose may be stripped away using the current approach.

In his book, *Doctoring the mind: Why Psychiatric Treatments Fail, (2010)* Dr Richard Bentall discusses the various difficulties that have been faced over the years by both SUs and their service providers (SP) in delivering adequate support toward such recovery. Bentall's work has become a primary reference within this thesis given its diachronic account of the mental health system. This therefore proved particularly useful for identifying the overall discourses that we see in modern services and shaping the hypothesis in this thesis. Other research has suggested that while there is a strong awareness of SU disempowerment, there is also a great willingness to overcome it (Leader, 2012; Masterson and Owen, 2006; Hannigan and Cutcliffe, 2002). Yet, realising this has remained questionable, given the evidence suggesting SUs still complain about the services they receive and that they are not listened to (Campbell, 2005: 80-81; Cutcliffe and Happell, 2009; Bentall, 2010; Leader 2012). Further to this, even government initiatives have been mobilised recognising this and our subsequent failure to reintegrate SUs back into society effectively (Perkins, 2001; SEU, 2004; Masterson and Owen, 2006; Campbell, 2005: 80-81; Cutcliffe and Happell, 2009; Bentall, 2010; DoH, 2011; Leader 2012). This study therefore sought to critically examine the language used by SPs to reveal what realities and social paradigms are (re)created and the opportunities for SU to exercise choice and control.

The care plans and risk assessments of three different types of SPs were selected to examine interventions proposed and the opportunity they permitted the SU to exercise choice. As many observational studies in this field are quite outdated, this was a unique opportunity to gain some insight into current practice. This study is a small-scale detailed analysis of practice documentation which can reveal an insight into the multiple layers of oppression that can be present despite the espousal of the principles of SU empowerment – it asks: what disjuncture exists between SPs intention to empower SUs on their road to recovery and the recovery plan that is actually proposed, and what might be some of the barriers to realising this intention. Although service delivery agencies and professionals state that they are committed to empowerment, SU disempowerment is still evident within the discourse. Though this study makes no claim to generalisability, or reliability across different service locations, it will reveal a layer of complexity within three specific organisations. Finally, this thesis suggests avenues for further research into *how* we deliver our interventions rather than *what* we propose to do to solve SU problems.

The following literature review will offer the reader an overview of the scale of mental healthcare services, followed by the perceived problems faced by practitioners and SUs alike, as well as the development of discourses around mental health care and SU (dis)empowerment. The purpose of this is to offer sufficient background information on the subject of discourse and power within the context of mental health services in the UK, so that the reader can fully understand the project and the discussions later in this paper.

2. Literature Review

In recent years Mental Health Trusts (MHT) have been facing a challenging task of continuing safe and effective management of individuals experiencing mental disorder, while the economic climate required cost reductions (Social Exclusion Unit Report, 2004; Department of Health, 2011; Department of Health 2014). Figures suggested that NHS mental health hospitals and community care services were increasingly used to care for and contain people who pose a risk to themselves or others (HSCIC 2011). The Health & Social Care Information Centre's (HSIC) Mental Health Bulletin report released in 2011, demonstrated that despite a continual fall in the number of people who spent time in hospital since 2003/04, an increase was observed in the number of people using mental health services overall (HSCIC 2011). Three years later, the HSCIC annual report suggested this trend had continued, with the number of people spending time in an NHS hospital reaching its lowest record, however those in contact with specialist mental health services had increased from just under 1.3 million in 2011 to nearly 1.6 million (HSCIC 2013). This suggested that individuals accessing mental healthcare were not necessarily recovering, but instead that services have merely enabled SU to receive treatment in different ways, such as in the community. What was particularly concerning was that the majority of SUs in mental health hospitals were within the working age group with few opportunities to reintegrate into communities let alone develop careers (SEU, 2004). Unsurprisingly, Mental Health Trusts have a marked interest in finding more sustainable, outcome focused and cost-effective treatment methods.

Since the 1970s, one of the mechanisms mental health recovery services have relied on to address some of these problems has been to empower patients. However, their therapeutic engagement to achieve this has generally only gone as far as increasing a patient's skills, knowledge and self-confidence whilst overlooking additionally necessary aspects of empowerment such as one's availability of options and confidence in one's ability to make

decisions (Masterson and Owen, 2006). What has become increasingly noted in recent literature is maladaptive behaviour resulting from coercion and power relationships between healthcare practitioners and SUs' (Cutcliffe and Happell, 2009; Materson and Owen, 2006; Walsh et al., 2008; Hannigan and Cutcliffe, 2002; Bracken and Thomas, 2001). There has been an over reliance on practitioners to solve problems and manage the behaviour of their SUs, thus simultaneously thwarting the process of empowerment and delaying discharge from services (Fraher and Limpinnian; cited in Materson and Owen, 2009). As such, the support methods presently implemented are not sustainable often leading to years and, at times, a life-time of treatment when it may not be warranted (Bentall, 2010, Leader 2012). Of particular interest to this thesis, therefore, are the opportunities available for SU autonomy and how SU empowerment is displaced by the various ways SPs attempt to enhance security and compliance.

In recent decades, there has been increasing support toward SU empowerment, using client-centred and recovery-orientated approaches as a means of re-engaging SUs with their communities to become active, participating members of society (Bentall, 2010; Masterson and Owen, 2006; Hannigan and Cutcliffe, 2002). However, it has also been suggested that the use of the term SU empowerment has become merely lip-service since little research has been invested in the concept of power and its manifestation within the mental healthcare context (Cutclilffe and Happell, 2009). The current literature is largely theoretical and only explores outcomes resulting from top-down applications of power (i.e. practitioner over patient) within the mental healthcare system (Masterson and Owen, 2006; Walsh et al., 2008; Hannigan and Cutcliffe, 2002; Bracken and Thomas, 2001). There is little consideration of other forms of power, such as that which is inherent to certain social groups – e.g. social class, ethnicity, age, etc. - as well as latent and situational power (Lukes, 2005), such as the power and influence a patient may possess by playing the sick-role – being exempt from normal responsibilities and unaccountable for any behaviour that can be perceived as a consequence of the diagnosis

(Parsons, 1951; cited in Frank, 2013). Though largely unaccounted for this has been alluded to in theories of power and qualitative research in mental healthcare (Cutcliffe and Happell, 2009; Materson and Owen, 2009). Although some of the little literature available has cited examples of SUs attempting to adjust or escape the extraordinary nature of mental healthcare contexts (Cutcliffe and Happell, 2009; Goffman 1991) - suggesting some application of control and thus possession of power – this has not been explored further. There is apparently limited research around the various possible manifestations of power in current mental healthcare practice, particularly since Michael Foucault and Erving Goffman's work, despite literature frequently suggesting SUs are disempowered or disadvantaged (Gilburt et al., 2014; Leader, 2012; Bentall 2010; Cutcliffe and Happell, 2009; Walsh et al., 2008; Masterson and Owen, 2006; Campbell, 2005: 79-81; Hannigan and Cutcliffe, 2002; Bracken and Thomas, 2001; Buchanan-Barker, 2011; Goffman 1991). How can research make any commentary on the disempowerment of SUs without first understanding the concept and manifestation of power?

Many sociological theories, such as social learning (Bandura, 1977), strain (Durkheim, 1951; Cohen, 1955; Cloward and Ohlin, 1960; Cohen, 1965; Merton, 1968; Agnew, 1992) and action theory (Parsons, 1962) have also been largely unconsidered in the mental healthcare context, even though their operation can be observed in the literature. These theories could help explain some integral parts of co-dependent relationship forming and maladaptive behaviour patterns, which are counter-productive to treatment (Bentall, 2010). This was exemplified in Cutcliffe and Happell's (2009) research on power relationships in MH care. In their study, six forms of power and control were observed all of which resulted in SUs deliberately misleading practitioners to either escape or tolerate their mental healthcare contexts. Additionally, it was found that should a SU become frustrated and protest at the constraints placed upon them, their behaviour was deemed inappropriate, suggestive of a lack of insight and further evidence of mental disorder – a common fundamental attribution error observed in mental healthcare contexts (Bentall, 2010, Leader, 2012). At the very least, the

concern remains that if the seemingly disempowering nature of multi-occupancy facilities and mental healthcare service interactions reinforce challenging behaviour or a need to hide genuine mental disorder in order to cope, surely then this is only a further barrier to successful rehabilitation and reintegration into communities. We could argue that within the context of multi-occupancy facilities exists an opportunity for improvement.

In the following sections of the literature review, an introduction to these types of issues will be considered to offer some more insight into the consensus regarding what should be on the mental healthcare agenda. In order to understand the agenda, however, it is necessary to offer some context - an understanding of what the issues are and how they come to be - so that the unfamiliar reader may also follow any arguments throughout this thesis. The first section will provide a discussion of the main problems faced by mental healthcare SUs as identified in the social exclusion unit (SEU) report (2004a), which should offer the reader sufficient understanding of what issues are at a societal or global level. Throughout this section, I draw on additional literature to offer the reader a more detailed understanding of how some of the issues raised in the report develop and consider current services' shortfalls in attempting to rectify them.

2.1 The Social Exclusion Unit Report

Since the SEU report was meant to inform public healthcare services of how to improve the lives of adults experiencing mental disorder, it was felt this should offer a suitable introduction to new readers on the subject. The report outlines the "what" of the problem quite clearly, along with some useful statistics, thus providing a platform on which to build a more detailed understanding. There was little reflection in the report itself on how these issues might have developed and for that reason I have included some guidance from the literature. This too should help unfamiliar readers recognise the merits of any recommendations made and areas for further investigation.

Current Issues: Stigma, Vocational and Social Outcomes

The results of the SEU's investigations suggested stigma and discrimination were the leading issues identified since they were understood to contribute to secondary problems such as access to employment and developing families. It was posited that few employers would hire individuals with any disability, including those experiencing mental disorder. However, with mental healthcare SUs in particular, before even confronting the problem of finding work, it has been found that many patients encounter stigma *within* their hospital or SP (Bentall, 2010; Leader 2012). Professionals across sectors too often had low expectations of what mental healthcare SUs could achieve (Walsh et al., 2008). It would appear that despite the person-centred approaches offered, the doubt cast on SUs abilities to define their needs and problems was still prevalent[1] and suggested SUs were little more empowered in the community than they were in the institution. Moreover, their opportunity to engage and explore other social paradigms, such as employment, appeared limited. Despite work leading to a sense of purpose and better outcomes (Department of Health 2011; Department of Health 2014), this did not appear a realistic goal if most professionals did not genuinely believe their patients understood their own needs. By implication, any doubt a professional had in a SUs ability to look after himself left the extent to which he could identify - let alone meet - the needs of a professional environment questionable. How can one be expected to operate in a working environment, with duties and responsibilities on which his colleagues depend, if he is

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[1] In their article, Cutcliffe and Happell (2009) offer an illustration of this under the section 'deciding what will and will not be discussed and addressed.' Here clinicians were observed restricting what was on the agenda for discussion because, as the authors argued, it was not genuinely believed that a SU could understand their own recovery or well-being, have the ability to define their needs and problems, or that their contribution was to any extent pertinent. In one example, a SU who experienced a single psychotic episode was, unsurprisingly, shocked and had many questions regarding what happened to him, what medication he had been prescribed, and whether this would happen again...etc. This was a very unusual occurrence with distressing emotional consequences for the SU, and yet rather than taking the time to inform him, the psychiatrist marginalised and invalidated him by responding "let me ask the questions young man." In another example, a SU who had attempted to commit suicide found himself admitted in hospital. With little purpose in life, the only thing of value to him was his pet dog, who had not been walked or fed in two days. Despite asking about the welfare of his dog and what arrangements could be made during the SUs hospitalisation, he was ignored. The psychiatrist instead stated that he was very busy and concerned only with completing the assessment.

perceived to be unable to take care of himself? The best that had been hoped for was usually just a reduction in symptoms using medication (Bentall, 2010; Leader, 2012). Unfortunately this in itself brings its own problems including, though not limited to, the side effects of the medication prescribed, which imposed their own debilitating effects potentially causing a further barrier to discharge and community reintegration.

The SEU report also highlighted a problem of responsibility for promoting vocational and social outcomes for individuals suffering from mental disorders. This was particularly concerning since the present lack of on-going support to enable SUs to go back to work already significantly narrows the opportunity for social engagement. The report goes on to state that despite a generous £140m a year being spent on vocational and day services for SUs, these had done little to promote social inclusion. Whilst access to vocational services may have been excellent, SUs had nowhere to apply the skills they learned at these services. Instead, they remained in vocational and day services to occupy their time with the prospect of achievement, but never actually gaining any trajectory in life. Though it is commendable that there are vocational services available to develop skills, until the problem of stigma is resolved SUs may not easily return to work where they may apply them anyway. A similar effect may be observed in SUs returning to school or college, since gaining an education and specialising in any knowledge area is meaningless unless it serves a purpose (e.g. improving qualifications for a particular job). In this respect, both college and vocational services can become an end rather than a means. In some cases, SUs may choose to engage in vocational services and return to college in the hopes they may find meaningful relationships that are outside the hospital discourse and do not have a "health" agenda. Sadly, because so many SUs have the same limited avenues made available for reintegration, and only a selection of colleges' and services are specialised to manage their needs, SUs inevitably end up meeting other SUs and developing the same relationships that would have been available to them in an institutional environment (Gilburt et al., 2014).

SUs also appear to face a similar paradigm when trying to access some extracurricular activities, particularly sports. There appear few networks available for SUs to pursue such interests since the majority of individuals they have access to and identify with are others experiencing mental disorder (SEU, 2004), perpetuating the cycle of exclusion from those who do not. Given enough time, it may become too difficult to identify with those outside the mental health discourse[2]. While the report emphasised services not working well enough together to improve these outcomes, other literature has pointed toward the importance of SUs taking responsibility for participating in their recovery (mental health foundation, 1997). Take for example, research supporting patient outcomes significantly improving where carers and professionals function as facilitators, as opposed to active participants in the recovery process (Noordsy et al., 2002; Barker and Buchanan-Barker, 2011). During this research, the view held was that if a SU did not take responsibility for any decisions, while this would protect them from being held accountable for any downfalls, it also prevented any pride and ownership being taken for any improvement.

Proposed Recommendations

Over the years, the means proposed to tackle the problems highlighted in the SEU report were largely by campaign, policy and legislation, some of which have made a considerable impact, such as the Disability Discrimination Act (DDA) 1995 and the Disability Rights Commission 2000. Charitable organisations such as Rethink and Mind have helped to increase public awareness of mental disorders and to ease the public's wariness of mental

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2 Such an observation was made in my own experience with a SU who had tried to join a local football group. The first challenge presented in being the new face of an established group. However, additional factors contributed to increased feelings of rejection and her final decision to abandon this activity. She had been involved in mental healthcare services all her life and as such did not identify with a lot of the other girls on the local football team she had joined. Most of the existing team were raised in stable households and had a basic level education (i.e. at least GCSE level). She expressed that these factors alone made her feel alienated and inadequate. Adding to this separation was the side effects of her medication and heavy smoking behaviour, which meant that she was quite overweight, had acne scarring and very low stamina. Unable to keep up and not looking as physically fit as the other girls, it was not surprising that the benefits of attending this activity (however much she may enjoy the game itself and the health improvements it could bring), for her these did not sufficiently outweigh the costs. This experience was humiliating and, in her own words she felt "stupid."

diagnoses, whereas programmes such as Improving Access to Psychological Therapies (IAPT) endeavour to facilitate access to alternative therapies, albeit still accompanied by clinical treatments and medication. The Social Care Institute for Excellence, like the Royal College of Nursing (RCN), was established to promote excellence in practice, shaping health policies and offer courses for professionals in the field. Finally, the independent regulator for UK communications industries, Ofcom, established a committee to manage issues of portrayal of disabled people in broadcast media and used viewer research to maintain vigilant of any negative emerging trends. Nevertheless, according to the government's 2011 mental health outcomes strategy, titled "no health without mental health," the issues presented in the SEU (2004) report were still seemingly at large 7 years later. Despite inpatient population steadily falling from approximately 150,000 in the 1950s to circa 60,000 by the 1990s, this was not subsequent to any medical advances but rather due to social and legislative changes, which meant western culture was embracing open-door policies that allowed more patients to be treated in the community (Leader, 2012; Bentall, 2010). In fact, the increase in individuals accessing specialist mental healthcare services mentioned earlier in this literature review suggests occurrences of mental illness are apparently increasing (HSCIC, 2013).

This shortfall does not appear due to any situational changes that have occurred, such as our withdrawal from the very bricks and mortar of the asylum, but perhaps in the attitudes and interactions that have accompanied SUs (Campbell, 2005: 80). Michel Foucault's (1995) observation and analysis of the prison system and Erving Goffman's (1991) observational work in asylums, offers an insight into how the powerlessness experienced by SUs in the institution may have simply moved into the community. Foucault (1995) described the prison as an instrument of both observation and examination, whereby all behaviour and emotional or mental state was recorded and assessed, with the intention to reform one's character. One important assertion he made was that these mechanisms did not solely take place within the confines of a prison, but in fact extended into the wider justice system by way of dictating the

parameters of norm and delinquency which, by extension, defined the thresholds for intervention. A similar mechanism could be observed with managing mental disorders - only asylums no longer exist in England and have instead been replaced with hospital mental health wards, intensive care psychiatric units and community care. Although new treatment has also emerged to replace cruder and less effective interventions used during the asylum era, it is the approach or the way in which treatment is being applied that suggests a further but more subtle extension of the asylum that is of emphasis in this study. This can be exemplified by an analysis of Erving Goffman's (1991) concept of the total institution which he defined 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 (Goffman 1991: 11).

Members of modern society have a tendency to work, play and sleep in different places, under different authorities. Moreover, these activities are not necessarily carried out with any overall rational plan. As per Goffman's definition the total institution is, by contrast, a space where individuals conduct all three elements in the same place, under the same authority with a particular strategy. Following the decline of the asylum and movement toward community care, while the element of location has somewhat changed, the authority and level of strategy involved remains the same. Moreover, even the change in location has been limited in that SUs are merely sleeping in different places, but all gather at the same venues for work, treatment and leisure, as exemplified by the same avenues being available to college and vocational services mentioned earlier. Even the treatment itself, has also apparently not changed - SUs have complained that they are not listened to, taken seriously, or informed enough about the medication they are on; in addition there is contradiction, and perhaps some misconception, that living in the community offers more freedoms when Community Treatment Orders (CTOs) and the Mental Health Act (2007) (MHA) grant practitioners legal

powers to detain SUs, apply compulsory treatment and even enforce basic routines (Campbell, 2005: 80-81; Cutcliffe and Happell, 2009; Bentall, 2010; Leader 2012).

Since the problem of escaping the 'modern' total institution will not be immediately changed, the recommendation here is to pay less attention to overt applications of power, and understand the subtler points of influence that determine where and how power resides – that is, our motives, attitudes, and what shapes them. These are aspects of power that all individuals possess and, however difficult customs may be to break, have the ability to change at any time. In the next section we consider what has been on the mental healthcare agenda and the dominant discourses to offer the reader an insight into the existing conflicts of interest that may be inimical to recovery, followed by an outline of our motivations and justifications for the current approach to treatment.

2.2 The Agenda

An overview of the literature on practitioner and SU aims has indicated that mental healthcare professionals ultimately require efficient means of achieving results, which at present is partly offered by medication. While in the long-run it can have debilitating side effects, the short term usually provides immediate stabilisation of symptoms and thus more manageable behaviour (Williams and Scott, 2002; Rogers and Pilgrim, 2003; Ritzer 2007; Bentall, 2010; Leader, 2012). SUs on the other hand value choice and control on their journey to recovery, whether it is access to suitable housing, ways to manage finances, sustain social networks or physical health (Perkins, 2001; Goldman, 2005). The issue that becomes immediately evident here is that the desired outcome is discordant between these two key stakeholders and it would appear therefore that from the very moment treatment begins, patients and practitioners are already disagreeing on what they wish to achieve (Perkins, 2001). Moreover, clinicians' attempts to seize their medical outcomes - securing their own agenda – often come at the cost of the SUs interests and, by extension, happiness and

wellbeing. Even CTOs and the MHA (2007) offer a further safety net to practitioners for any shortfalls with the care prescribed to patients– whereby if a SU has not agreed or adhered to the terms of his care while in the community, the practitioner has the legal power to detain him within the confines of the hospital unit for re-assessment over a period of time decided at the practitioner's discretion (Bentall, 2010). SUs therefore appear to have disproportionately fewer opportunities to exercise self-determination, since any protest or disagreement with the terms of care presented could result in favour of the practitioner's ultimatum, which in the case of a CTO would be immediate readmission into the hospital. Having forfeited their autonomy, SUs are perhaps left with little incentive to return to community living since it would in fact be more work to look after themselves as an end in itself, while carrying out dictated routines against their will, rather than simply being cared for inside the unit where this is administered anyway.

The process of SUs becoming 'dis-incentivised' is perhaps comparable to Goffman's (1991) civil death - the process of withdrawing adult-like autonomy or control over one's fate and identity through therapeutic justifications and clinical requirements. When first admitted to the asylum, patients would normally have what Goffman (1991) described as a 'presenting culture' - their own identity and sense of self, derived from various social arrangements that existed in their place in society and the lessons learned from their interactions here. Upon entering what was then the asylum however, they would be re-socialised in order to adhere to the various routines, practices and lifestyle therein (i.e. clinical requirements and therapeutic recommendations). According to Goffman's (1991) observations, this was achieved by a number of processes and changes to their reality - for example, the physical walls of the institution caused the patient to experience the first separation from his self as being a part of the wider world, blocking visitations and freedom to roam, becoming a member or inmate of the asylum. In addition, his role as an inmate lasted around the clock, since he would be unable to leave to go to a place of work or leisure as would be the case in the wider world.

Similarly, nowadays a SU is a role in itself, and while not necessarily within the physical walls of an asylum, their therapeutic care plan and CTO dictates their daily rounds and permissible activities, stipulating precisely within what timeframes, where and how frequently they may take place. Any social identity developed before admission to treatment may be subsequently deconstructed by this exercise. Bearing this in mind, there is a danger that services are merely replicating old issues in new settings – overcoming these issues will not be achieved by changing locations without reforming the service delivery itself (Gilburt et al., 2014). It is not unreasonable at this point to consider the possibility that perhaps the modern mental healthcare patient has simply been relabelled 'SU' but experiences civil death, or institutionalisation, all the same only among their own community through the daily rounds and routines enforced by CTOs.

Mental healthcare services have received a lot of criticism in the past for being overly resource-driven. However, in trying to rectify this by using a one-size-fits-all approach this quickly led to SUs specific needs being overlooked (Gilburt et al., 2014). To rectify this, the Care Programme Approach (CPA) was introduced in 1991 to place more emphasis on SU-led care programmes (e.g. person centred approaches and recovery models), which focused on SUs' choice of treatment types and permitted small but positive risk-taking (Onyett, 2005: 92; Bentall, 2010). Person-centred and recovery-oriented principles offered a consumerist attitude to mental healthcare and posited that SUs should be treated as clients and recognised, to some extent, as experts on their needs. Nevertheless, despite the theoretical strength of person-centred, self-reflective and recovery-oriented approaches, which are increasingly in implementation and offer some balance between clinical outcomes and SU needs, it is difficult to say whether this has had a significant impact on recovery. It has been argued that while the CPA was well integrated in policy guidance, it did not appear well executed in SPs' actual care plans (Onyett, 2005: 93). The literature has suggested that the same lip-service given to the concept of 'SU empowerment' has now extended to 'person-centeredness,' 'self-reflection'

and 'recovery approach' (Masterson and Owen, 2006; Lakeman, 2007). These may be no more than perfunctory exercises in current practice, aimed simply to demonstrate that SUs have taken their granted opportunity to express their views, which may be seen to be considered because they are documented under agreed formats.

On the other hand, the health paradigm can be an empowering idealisation as this absolves the player of the sick-role of any responsibility (Parsons, 1951; cited in Frank, 2013). Similarly to the emergence of deviant behaviour defined by strain theory, mental disorder can present an alternative lifestyle for those who have less access to comfortable, if not profitable, livelihoods. It would not be unreasonable to suppose hospitalisation becomes an option especially for individuals raised in family units that are already supported by this system. If indeed emerging from a family unit already supported by mental health services, this is perhaps a natural transition in life rather than a deliberate decision. This may also not necessarily be a means to achieve a comfortable lifestyle, but one in which an individual can wield a certain amount of power that he would not otherwise possess in an ordinary context, namely outside an institution. Arthur Frank's (2013) article uses Talcott Parsons' conceptualisation of social roles to demonstrate how the sick-role may be applied in such a way in mental healthcare asserting that the role of being ill entitles individuals to be relieved of normal responsibilities, and obligated only to comply with medical aid. Moreover, the doctor legitimises the patient's sickness and entitles permissive aspects of the sick role (Frank, 2013). With mental disorder in particular, studies have demonstrated that the current process for identifying genuine mental 'illness' can be highly unreliable (Slater, 2004; Rosenhan, 1973). With a number of participants, Rosenhan and later Slater demonstrated that by performing symptomatic behaviour they were all admitted for treatment. As such, patients can potentially force a practitioner to sustain a given treatment and continue to provide 'sanctuary' from the harsh existence that accompanies independent living within society. Within the institutionalised context a SU can legitimately command attention, participate in drug abuse,

be fed and sheltered. Admittedly, psychiatric institutions do not appear to offer a particularly safe or comfortable environment but may nevertheless be an option that still presents the lesser of two evils since a co-dependent relationship may be easily developed here (Marstolf et al., 1991). Consider an individual who emerged from an unstable family unit, with few positive social role models and poor educational background. With little praise given for his Intellectual potential and the abuse or neglect that may have presented in the household, the care and attention offered by doctors and nurses becomes an inviting scenario. Every crisis is reinforced by the attention it elicits from professionals. As evidenced by research into co-dependency from the 1970s onwards, the term was later defined as:

> …learned behaviour, expressed by dependencies on people and things outside the self; …dependencies include neglecting and diminishing of one's own identity. The false self that emerges is often expressed through compulsive habits, additions, and other disorders that further increase alienation for the person's true identity… (Whitfield, 1991: 10)

What emerges is a very subtle token economy - whereby inappropriate behaviour, considered to be outside the patients control, is in fact rewarded because he is made to feel special for having complex needs. Such behaviour may be a powerful tool to call the attention of his newfound 'guardians' and set the terms of his care. It could be argued that the danger here is that the more co-dependent the SU becomes with his SP, the fewer opportunities he will recognise, and seize, to develop his own identity which would permit the individual to exercise true control, self-determination and agency.

A similar extension of SU disempowerment has been observed even in most research conducted around SUs, ironically, around the quality of services (Beresford, 2013; Beresford, 2012; Boxall, Dowson and Beresford, 2009; Beresford, 2006). In his various studies Beresford argues that, surely, in order to improve the quality of services we should invest in researching the views of the SUs themselves, since they are ultimately the recipients of what is on offer.

Despite quality becoming a political priority in health and social care, predominantly around developing a 'choice agenda', little attention has been given to those who use and experience services even though this could guide our approach. The current view, as a consequence of the 'choice agenda', is that improved quality must come from having a choice of service, supplier or clinician (Beresford, 2006), however, having a choice over one service, supplier or clinician over another does not address the significant issue of disempowerment experienced by SUs if the only options available offer equally disempowering circumstances.

His observations suggest two models to quality that have guided research. The first is a managerialist model that adopts industrial and business-driven approaches and, secondly, a professional model rooted in the concerns of logic and professions operating in the field – embracing positivist approaches (Beresford, 2012). Although there are certain merits in adopting positivist approaches, particularly for the purposes of quantifying outcomes, such managerialist and professional models that embrace this sustain an inherent vulnerability to 'bureaucratise' quality, subsequently inhibiting flexibility, responsiveness and innovation (Beresford, 2006). The most pertinent issue presented by adopting positivist approaches with regards to disempowerment, is that one who experiences problems such as disability or oppression is considered to be too 'close to the problem' and by extension cannot be objective about it (Beresford, 2013). Such research values also promote the assumption that knowledge from first-hand experience therefore must have less legitimacy and, ironically, the views and understandings of those who are already oppressed are seen as less reliable and, worse, invalid. In addition, by attempting to standardise measures many of the multifaceted views of the very users of the service may go unheard, which could potentially uncover additional outcomes going undetected in current measures. This last point is almost certainly the case since previous research has demonstrated over time that what policy makers and SPs value and consider 'good quality' has not coincided with what SUs want (Harding and Beresford, 1996; Evers et al., 1997; Beresford, 2003). If this trend continues there is a danger that policy

makers and SPs fail to assess the value and purpose of services and merely provide placements for SUs rather than outcomes that are meaningful and thereby also constructive (Beresford, 2006).

Despite SUs needs having fallen outside of what health and social care can provide, and a strong view held among SUs about key issues relating to involvement, respect and equality as well as empowerment and choice (Harding and Beresford, 1996; Evers et al., 1997; Beresford, 2003; Beresford, 2006), during a 2 year national development project undertaken by Shaping Our Lives (a national user-controlled organisation and network) much resistance was still observed from agencies to an approach to quality improvement based on user-defined outcomes (Shaping Our Lives National User Network et al., 2003). Surely, by using SU knowledge to guide what is on the agenda to influence mainstream discussions, wider thinking, policy and practice, the system would also be offering an instrumental avenue of empowerment to SUs. Not doing so implicitly suggests SU experiences are a less reliable source of knowledge here too, further extending their social exclusion by not permitting their collective voice to join the political discussion arena to which other social groups are given invitation. Moreover, this must add such insult to injury since not lending credence invalidates the experiences of those who are already heavily disadvantaged.

It is telling that individuals currently accessing mental healthcare services in Britain are struggling to recover from mental illness since recovery has been argued to be greater in countries during economic recession rather than economic boom (Whitaker, 2005; Hegarty et al., 1994; Warner, 1985; WHO, 1979; WHO, 1973). And while we have vastly improved our knowledge in social psychology and possess an array of treatment options that has certainly widened the criteria for suitable candidates, the continued growing number of individuals accessing services would suggest this has potentially had little influence on recovery. In the next section therefore we consider how treatments are being delivered to examine how SU-

led we truly are, where opportunities for improvement exist and what old errors we continue to make. Since the concern in particular is with our attitudes toward the mental health paradigm - how this disempowers SUs into remaining connected to services, rather than becoming relieved of them - a diachronic understanding of current mental healthcare discourses will be presented over the final sections, answering why we have implemented the approaches we have today, how our beliefs and attitudes have constructed our conceptual perception of mental 'health' and what wider implications may be associated with these attitudes. The first of these final sections begins by offering a brief introduction to discourse, to provide the unfamiliar reader a platform on which to understand all subsequent sections.

2.3 Discourse Practice and Ideology: Text, Talk, Power and Reality

Language may be understood as a social practice, since all text and talk attempts to accomplish something (Edwards and Potter, 1992), both interpersonally and collectively, and it does so through knowledge. Knowledge applies meaning and significance to text and talk, making it constitutive. By assigning meanings to reality we also bring realities into existence, not only by simple labelling of tangible matter, but also by way of interpreting or understanding reality (Wodak and Meyer, 2009). For example, when we learn the term 'chair' we not only associate a visual interpretation of the object, but simultaneously learn what that object is good for – i.e. the social practice associated with said object. We are therefore quite actively re-creating reality in this way, not only by (re)defining the physical objects around us, but even abstract objects, or ideas.

An example of an ideological object that is solely constitutive of language is the law. This may be abstract, yet can still be understood as a 'tool' for regulating behaviour. Social practices, such as the law, in any present society will have come into being following various ideologies struggling for dominance. In law and politics, each party that has been in power will have made its etching in policy, legislation and, by extension, the epistemology of the

community which it serves too (Jäger and Maier, 2009:34). Similarly, the common practice found in mental healthcare today will have its foundations rooted in the various treatment approaches that preceded it. What has prevailed can be described as an amalgamation of the treatments that have succeeded in their struggle for dominance.

The actions which we associate to different circumstances, which prove to be 'dominant' in our lives, are supported by our ideologies. Essentially, every subject's way of thinking and behaving will have been reinforced by the circumstances, choices and consequences presented in their life (Van Dijk, 2009:62). However, circumstance and consequence not only dictates whether a way of thinking and behaving would be repeated by one subject, but potentially adopted by others thereby becoming a collective ideology, which may even be passed down generations becoming diachronically embedded into a culture (Van Dijk, 1998). Some of the products of ideologies are social objects and paradigms which, over time, (re)create the same social contexts that reinforce an institutionalised way of thinking and behaving, thereby becoming a discourse (Van Dijk, 2007; Van Dijk 2008a). It is by this process in particular, I propose that the schools of thought in the branches of Psychiatry and indeed Psychology have formed ideologies and become discourses in their own right.

Discourse, in its simplest form may be defined as ways of communicating meaning, however, discourse and discourse practice in this thesis refers to its multidimensional socio-phenomenological definition (Van Dijk, 2009:62) - the means by which things are constituted and (re)create realities. Certain words, terms of reference, phrases, metaphors, rhetorical styles, systematisations of knowledge, so on and so forth, help create social phenomenon. Take for example, the terms "patient" or "service user" ; these are not entirely different to "client" or "customer", yet do not constitute the same social significance. We could breakdown the term SU to define an individual who uses a service, however, this is not the meaning attached to this term in the context or, more specifically, the communicative

situation of mental healthcare. In the specific context of mental healthcare this may be defined as a patient accessing services outside a hospital setting. It is the communicative situation under which subjects apply such terms (e.g. community mental health care) and the actions with which we associate them (e.g. using mental health services) that vastly separate one social object, and the discourse from which it stems, from the other. Subjects' (re)application of these social objects create, reconstruct and reinforce such distinctions, normalising this knowledge and associated behaviour, eventually becoming a known practice, taken–for-granted-knowledge, common-sense and, particularly in this case, intellectual tradition (Van Dijk, 2009). Discourses may therefore be profoundly influential, and exert great power since they provide the means to institutionalise ways of talking - the very means by which we describe and interpret the (physical and social) world, reinforce actions, and in turn (re)create reality (Link 1982; cited in Jäger and Maier, 2009).

From this perspective, what is asked of a SU, and of the staff who support them, can also be equally influential in shaping a particular reality and social paradigm. Service proposals in particular, may appear to offer a number of opportunities to empower SUs but, equally, demonstrate various instances of some counterproductive approaches being used in favour of more pressing agendas. The question that may be asked, that is the specific consequence of this study and may be answered by studying current mental healthcare discourses, is what realities are SPs creating for their SUs – what is the proposed strategy to recovery, with which discourses does the strategy align and what social paradigm does this intend for SUs. In the next section we explore the various discourses that exist in mental healthcare, as well as their merits and shortfalls, to offer the reader an awareness of the various risks and possibilities that may present, and we can perhaps expect.

2.4 Discourses in Mental Health Services

Until the 1970s, two broad schools of thought could be distinguished within the mental healthcare arena that have shaped treatment methods and, by extension, current discourse (Bentall 2010); biomedical (or bio-psychiatric) and socio-psychological. The biomedical discourse attempts to explain mental phenomena in pathological terms. Since health and illness implies a physical pathology it is the ideology to which the term mental 'health' lends itself. Before the 1940s, the most widely adopted biomedical approaches to managing mental disorder, particularly the psychoses, were: Insulin coma therapy (ICT), prefrontal leucotomies and electroconvulsive therapy (ECT) (Cerletti, 1956; Fink, 1999; Doroshow, 2006; Shorter and Healy, 2007; Bentall, 2010; Steck, 2010; Ellenbroek, 2012). These were the accepted medical approaches - or ideologies – for treating what was then understood as 'madness'. The medical research at the time was largely based on natural observation, since there was no technology available to forgo this and ultimately the change in behaviour observed appeared highly effective. Walter Freeman, a famous American neurosurgeon commented on the widely perceived merits of these procedures, asserting that patients who were previously aggressive and disorderly became immediately docile and admissible, making patients symptoms more tolerable, following these interventions (Whitaker, 2002) thereby endorsing their use as well as the biomedical perspective.

Eventually the lobotomy and leucotomy procedures alike came to receive a lot of criticism due to the high risk of fatality posed as well as harm to patients it involved. What was most revealing of the on-going biomedical position was the uncritical adoption of the drug thorazine (chlorpromazine), which produced precisely the same effects but without the risks associated with the surgery – the product in fact being marketed as the chemical lobotomy (Yawar, 2009). This simply demonstrated how different means were being explored to achieve the same ends, with the emphasis being on producing more 'manageable' patients with

immediate effect. Whether patients became any more effective, healthy or happy human beings was another end entirely, seemingly overlooked[3] in this model, but recognised in later discourses.

Medical research has largely failed to find direct causes of mental disorders in genetics (Rose, Kamin and Lewontin, 1985; Tienari et al., 2003; Joseph, 2003; Elkin , Kalidini and McGuffin, 2004; Bentall, 2010). The current biological explanation has relied on neurochemistry, which has been used to endorse neuroleptic medication. However, even this justification is flawed as may be illustrated following a brief outline of how neurochemistry works. Neurobiology has demonstrated that the brain consists of about one hundred billion neurons – comprising of dendrites, a body and axons - which are the means by which the brain communicates the sensory information that sustains our thoughts, feelings and behaviour. Neurotransmitters are secreted at the axon of a preceding neuron, and then bind to the receptors on the dendrites of the next. This causes the next (post-synaptic) neuron to become electrically excited, with a potential to fire its own neurotransmitter onto the next neuron. It is the over or under production of certain neurotransmitters that has been shown to relate to different mental disorders. The over production of the neurotransmitter dopamine, for example, is the most well-known neurobiological explanation for schizophrenia. Neurochemical behaviour of the brain therefore offers a biological explanation of mental phenomena and, by extension, has offered justification for the biomedical treatment of mental 'illness.' A potential criticism of the neurochemical perspective, however, is that it does not necessarily explain the cause but rather illustrates the manifestation of mental phenomena, since neurochemical activity may be triggered by external events (i.e. environmental stimuli)

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[3] Clinical psychologists of the anti-psychiatric position recognised neuroleptics, lobotomies and other treatments designed to subdue patients, as powerful suppressants which resulted in individuals dissociated from their environment and even their very self (Yawar, 2009; Bentall, 2010). Patients were quite acceptably transformed into inoperable beings, incapable of acting with self-determination or agency, and far from being healthy, were at higher risk of heart attacks, obesity, diabetes and strokes (Yawar, 2009).

rather than be subsequent to an inherent imbalance. Take for example the fight-flight response - when danger is perceived this spikes the production of the hormone adrenaline, which in turn causes heart rate and blood pressure to elevate in preparation to fight or flight from the danger stimulus. This being the case, chronic anxiety or psychotic episodes may just as easily be explained by unfavourable environmental circumstances triggering the neurochemical reactions that produce these experiences, rather than existing neurochemical imbalances causing the subject to make poor decisions thereby creating the unfavourable circumstances in which they live. This notion has been a source of great challenge to the pharmacological industry and fuelled much argument between the biomedicalists and psychologists around the ethics and merits of prescribing life-long, and often debilitating, medication to SUs since their emotional distress or mental disorder could potentially be resolved by simply correcting the unfavourable aspects of their lifestyle. What becomes evident here are the kinds of struggles these ideologies face in a competition for dominance in mental healthcare discourse.

By contrast to the bio-psychiatric community, the second school of thought, largely supported by clinical psychologists, maintains that environmental factors, and life events, in addition to cognition and biological predispositions can also explain much mental disorder. This may instead, or just as easily, therefore result from various stressors that are present in the world. In principle, making changes to the immediate environment should suffice to minimise impact to emotional vulnerabilities. A lot of research has supported this perspective, demonstrating psychosis as largely resulting from higher exposure to sudden trauma, supporting the assertion that mental disorder can result from environmental influences (Mednick et al, 1987; Myhrman et al, 1996; Neria et al., 2002; Morgan et al., 2007). Unsurprisingly, this second perspective has become the second, nevertheless equally dominant, discourse in mental healthcare.

One example of how environment and context can impact psychological well-being and behaviour is clearly demonstrated by the Stanford Prison Experiment conducted by Haney, Banks and Zimbardo (1973). This study simulated a prison environment by turning the basement of the psychology department at Stanford University into a prison ward. The participants were students who were randomly assigned to the role of guard or prisoner for a planned duration of two weeks. In summary, the guards quickly became sadistic with their fellow colleagues in the prisoner role, while the prisoners became depressed and began to show signs of severe anxiety; one in particular even developed a psychosomatic rash. Despite having been told this was only an experiment and that they could withdraw at any time, participants playing the prisoner did not leave since some began to believe they were truly imprisoned and others feared they may be heckled by their fellow colleagues for being too 'soft.' Most alarmingly, the lead researcher admitted having fallen into a prison warden role, briefly losing touch with his research aims. These escalations were quickly breaching the ethical boundaries of the study and so the experiment was ended prematurely just six days in. What Zimbardo's (1973) experiment successfully aimed to demonstrated was how easily such contexts caused deindividuation – the process whereby individuals lose their sense of self and act according to the group role. Psychiatric hospitals, and indeed community treatment orders, are comparable in that they are highly routinized operations and potentially susceptible to recreating these contexts. What is of particular significance to this study, and relates to the present thesis therefore, is not only how quickly even healthy individuals can become psychologically perturbed by these contexts, but also the deindivduation that can potentially befall care-takers.

When further research, similar to that conducted by Zimbardo (1973), demonstrated that disorders could also be managed with the right environmental stimulus' it was understood that by rewarding and punishing desirable and unwanted behaviour respectively, therapists could mould their patients' habits quite reliably, which presented new opportunities. Firstly,

from a functionalist perspective, behaviour could not only be corrected without surgery or by its extension, medication administration, but large groups of patients could also be more easily and cost-effectively managed by a small number of practitioners using a privilege system – the token economy (Liberman and Corrigan, 1994). In addition, since patients' lucidity and health did not have to be compromised, as would be the case where neuroleptic medication had been prescribed, there might have been opportunities for patients and SUs to make decisions about their lifestyles and improve their skills. Unfortunately, since behaviourism by and large rejected the consideration of mental events, practitioners of this doctrine have not generally cared much for patients' feelings or aspirations anyway and mental healthcare patients' treatment subsequently invarably been accompanied by medication ever since its discovery (Bentall, 2010). Any opportunities to surpass the shortfalls of the biomedical model therefore appear to have been squandered and only the functionalist aspects of the new model reserved (Watson, 1924; Bentall 2010).

Since therapists were essentially able and permitted to shape their patients behaviour in whichever way, the second perspective's approach still called into question the patient or SU's right to define his own identity. Even the socio-psychological approach therefore, was not immune to the mental healthcare system's underlying discourse which (re)created the social circumstances that did not permit SUs to assert themselves. Without the patients' feelings or aspirations to guide the treatment, SUs were once again stripped of their power to act with self-determination and agency. Rather than attempting to cater for the SUs personal needs, the reward-punishment system would validate only the behaviour that was perceived to be conducive to the purposes of the treatment and the agenda of the therapist. Such problems have been identified even in Goffman's (1991) observation of asylums, of which the functionalist institutional privilege system still manifests in today's mental healthcare systems. Firstly, the institutional privilege system sustains an adult-child paradigm, as evidenced by the setting of 'house rules,' instructional support and the immediate punishment-reward model,

which would usually only be reserved for interactions between parents and their children or even pets and their owners, whereas adults in society on the other hand generally experience indirect consequences for their actions and decisions. In addition, the institutional privilege system does not reflect the same indulgences or prerequisites available to the adult in society and instead offers an absence of deprivations. Surely, such a privilege system is poor preparation for independent living therefore, since it does not reflect the same interactions and responses that are present in civilian life.

The patient does nevertheless appear to have come into possession of some control and thus power in the above social contexts. Firstly, the patient possesses the pseudo-power to make choices and actions dependent on the practitioner's appraisal of his request or within the boundaries of permissibility under the institution's or mental healthcare SP's 'house rules.' In addition, latent-power may also be available in the behaviours associated with his diagnoses since these may be used as a means to achieving satisfactions – certain sick, 'bad' or inappropriate behaviour may not necessarily be punished if attributed to the patient's diagnosis and thus perceived to be beyond his control (Pearce and Pickard, 2010). The patient under such circumstances could therefore act out any resentment he held against staff or other inmates without appropriate consequence, and indeed even remain sectioned without having to admit to his inmates or staff that he did not wish to leave (Goffman, 1991). If the patient had become accustomed enough following his civil death, he would unlikely be able to operate outside of this context without reassembling his self once more to suit another social context. Such a discourse is very counterproductive both from the perspective of the SU as well as the therapist therefore.

All the invasive medical procedures mentioned in the beginning of this section, with the exception of ECT and medication, have been abolished and are now understood as rather crude interventions largely involving brain damage (Bentall, 2010). Biomedical and socio-

psychology communities have also reconciled many of their differences, now offering

biopsychosocial approaches to mental care. Psychiatrists provide quick remedies for risk prone

behaviour, while psychologists assess psychological limitations and social needs on which to

base their prescribed-lifestyles. One remaining criticism of this model is that it is still in danger

of making fundamental attribution errors; a tendency to attribute behaviour to a trait, while

overlooking circumstances and the extent to which they may have contributed[4]. This is not to

say that traits do not play a part, since they may offer predispositions to certain strengths and

vulnerabilities under different contexts. The difficulty lies in knowing precisely where the

enduring trait ends and environmental factor begins. Throughout the evolution of these

therapies however, the discourse appears to have remained the same – to subdue, reassemble

or funnel SUs into complying with a rather narrow set of lifestyles or, in the least, leading a

tolerable existence. Perhaps the only distinction that can be made between biomedical and

socio-psychology approaches, is that the former could subjugate an individual entirely,

whereas its successor would instead attempt to merely manipulate him. Only during the SU

movement in the 60s and 70s did a new discourse emerged that attempted to understand SUs

as more than bearers of symptoms that should be quarantined, but as individuals with

consumer rights and preferences (Lakeman, 2007).

The 'SU movement' of the 1960s saw the beginnings of the SU empowerment discourse,

which has been finding its place between its competitor discourses since (Lakeman, McGowen

and Walsh, 2007). During this time philosophers and sociologists, Michel Foucault and Erving

Goffman, challenged institutional operations and mind-sets; even psychiatrists themselves,

such as Thomas Szasz, David Cooper and Ronald Laing, criticized the methods adopted,

offering further trajectory to what was then also recognised as the anti-psychiatry movement.

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[4] This is similar to the actor-observer bias, whereby the actor attributes the behaviour of others to their traits, but recognises his own behaviour as resulting from circumstance, e.g. you are difficult because you are an argumentative person, whereas I am only being difficult because I am having a hard time right now.

The general feeling was that psychiatrists prescribed debilitating medication, ran prison-like wards and failed to acknowledged patients' interpretation of their experience. Whilst psychologists compensated for some of these shortfalls by spending more time attempting to understand their SUs, treatment and lifestyles were still being prescribed, which is a similar extension of psychiatrists' powers since they also appropriated SU decision-making authority. Moreover, the MHA (2007), whilst originally designed to protect SUs, still bestowed much power among mental healthcare services to section SUs. Whilst this is not the same as – nor should be confused with - the Mental Capacity Act (2005) , which labels one as unable to make decisions, these are often referred to interchangeably since a patient who did not volunteer admittance for treatment may be understood as unfit for decision making if his assessment suggested otherwise. The SUs prospects are somewhat ironic - while understood as a 'patient', the social object 'SU' has not been permitted the same social etiquettes that are afforded mainstream medical patients.

The (dis)empowerment discourse within the mental healthcare arena stemmed largely from the revolt over the harm observed in long-term asylum incarceration (Lakeman, McGowen and Walsh, 2007). Even when the breakdown of the asylum began however, a need to recognise SUs as individuals emerged, since many of the services in communities were simply extensions of the institution (Gilburt et al., 2014). The empowerment model supported the idea that decision-making power should be held by the SU, since it had been demonstrated that recovery from a state of institutionalisation could be achieved by simply having sufficient choice and control over the environment (Ritzer, 2007; Goffman 1991). By handing back decision-making power to the SU, we may overcome many of the problems associated with institutionalisation since it would reduce the SU's dependency on a system to find solutions to perceived SU problems in the first place. It was these values that shaped the practice and principles of social inclusion, recovery and reflective practice, and person-centred skills (Lakeman, McGowan and Walsh, 2007) all of which maintain the consensus that the SU should

be at the steering wheel of the recovery vehicle they have chosen while SPs remain only facilitators in sustaining this vehicle.

To date, the biomedical, socio-psychologist, and now, empowerment ideologies have been the most prevalent, struggling for dominance and shaping the discourse of contemporary mental healthcare. We would therefore expect aspects of these ideologies to become apparent in all the text and talk produced by services under the mental healthcare umbrella. In addition, given the demand expressed, and need present, across the literature for SUs to become more empowered on route to recovery, the present research aims to examine the extent to which this is evident, or even possible, across three different SPs. It could be asked what opportunities have we permitted, or indeed over-looked, for SUs to exercise self-determination and agency so that they may retain or develop their own identity and sense of purpose.

One key distinction can be made however between the SU empowerment discourse and its predecessors which is discussed in the next section. This assisted in separating one approach or style from the other for the purposes of the analysis used in this study. In this section I introduce the concept of active and passive approaches, developed by my perspective on the matter of mental healthcare. This will assist the reader in understanding the analysis applied, but also offer insight into my own position, which is of course a product of discursive processes too.

2.5 SU Empowerment for the Writer: Introducing Active and Passive Rehabilitation

During my role supporting mental health SUs, most of whom were still readjusting to community-living and often following recent discharge from hospital, I frequently observed conflict unfold due to the fundamental disjuncture discussed earlier; between what practitioners wanted to achieve compared to what their SUs appeared to truly have on their

minds. Practitioners would often make recommendations and patients would quite complacently nod and agree with these, but then outside the office would behave in ways that were unconducive to their recent agreements. The SPs privilege system would then come into play and, depending on the severity of the conflict, SUs would either be readmitted or have some other freedoms removed from them in other ways. What struck me was that the whole process was contrived and cumbersome. Surely, all of this would have been much easier if both patient and practitioner had been honest with each other from the outset. Perhaps, rather than the practitioner making the recommendations - that the SU would undoubtedly agree with on face value but in truth opposed or cared little about, since years of being in hospital will have taught and reinforced compliance as a gateway to attaining some freedoms – had he instead asked his SU what he really wanted, and then worked toward recommendations for accommodating his preference, maybe then he would actually have the SUs buy-in. I began to observe interactions, in a much more generalised view – rather than trying to understand what specific treatment was working, I instead questioned how it was being delivered and by whom. Soon after, it became apparent to me that there were fundamentally two approaches toward recovery; active and passive.

In most cases, SPs were the 'active' agent, pushing and persuading SUs to undergo a given treatment or receive particular support, while SUs remained observers and passive recipients of everything done unto them, occasionally protesting but in most cases accepting their prescription. On occasion however, some practitioners had candid conversations with patients about what they really wanted, and took time explain why some requests might be unrealistic and manage expectations. In this model SUs were engaging, guiding, and at times were even the executive of their recovery, while practitioners became merely facilitators and the passive observers. By contrast, this passive support offered a very different existence and reality to SUs, where they could assert themselves and moreover, could take full ownership for any improvement as well as any shortfall in their lives.

In my mind, the active/passive model to recovery was almost analogous to cellular membrane transport – the mechanism by which cells regulate the exchange of intra and extracellular solutes. This exchange can be executed in two broad ways: Active transport and passive transport. Active transport is the passing of material in and out of cells using endocytosis (chemical absorption) or exocytosis (chemical expulsion), both of which cost the cell energy to execute since it will absorb and expel materials against the concentration gradient (i.e. from low to high concentrations). Passive transport on the other hand is the means by which cells exchange molecules via processes such as osmosis, dialysis and facilitated diffusion. By contrast, this process does not require cellular energy since it uses the advantage of the concentration gradient. When first acquainted with the concept of SU empowerment, both in the literature and at work, membrane transport always came to mind. It appeared to me that SUs and traditional support services were frequently working against the grain; expending so much effort due to conflicting agendas. If, however, practitioners were to take a passive approach, supporting SUs only to achieve their goals, SUs could exercise and demonstrate self-determination and agency in more productive and healthy ways by making decisions about things that were truly important to them, and that would not necessarily have a health agenda at all, rather than doing so within the co-dependent relationship that often develops between the patient and practitioner. Recovery could become, to some extent, more organic, since the SU would be defining the cultural identity that he is most comfortable with and realistically reintegrate into following discharge.

The powers granted to the biopsychosocial models have led much decision-making power to be exercised by the SP and enforced upon the SU. Such treatment appears a very active approach to care and rehabilitation, since it involves imposing changes upon SUs, potentially against their will and contrary to what they may be naturally inclined to do – against their personal 'gradient.' Multi-occupancy facilities, such as hospitals and care homes, are invariably prone to this given their highly routinized nature, which is to some extent

required in order to regulate behaviour and facilitate the management of groups of individuals. This pervades into the treatment methods employed since lifestyles and choices will become restricted as a consequence for catering a large group of individuals.

As demonstrated earlier by Goffman's (1991) observations - such processes create parent-child social contexts, whereby the institution sets out the rules of social conduct, and outlines the immediate consequence for any disobedience or non-compliance, much like a parent disciplining his child. Even the enactment of the sick-role reflects a parent-child paradigm whereby the behaviour associated with the diagnosis is permitted much in the same way parents permit their children to behave like children of their age group. Moreover, as discussed earlier, this could be perceived as both an incentive and opportunity to remain sick; having no palpable indicator of recovery in mental healthcare, no scar tissue to observe and little pathology beyond chemical imbalances, means the sick-role may be exercised to the SUs advantage. The permissive aspects of the sick-role allow the SU to behave in ways, which would usually be deemed inappropriate, but in this context may achieve immediate gratifications. It is the mental healthcare context that lends currency to this behaviour – it offers the SU a means to becoming a highly empowered patient but not necessarily an empowered human being since the same outcomes may not be achieved outside this context. This is, once again, counterintuitive to the aims of treatment since SUs can work against the goal orientation of the SP anyway. Overall, the active approach to treatment appears to be fraught with opportunities for conflict.

In contrast, the empowerment approach suggests allowing room for decision-making to be held by the SU, which has created a need for SPs to adopt a more passive approach to delivering care and rehabilitation in that it would require the SP to work in accordance with, or around, the SU's requests. In this instance, the SU is the active player in his recovery, taking responsibility for any improvement as much as any shortfall. He may also maintain his identity

by defining his own lifestyle, including the home he wants to live in as well as the communities he wants to be a part of. By defining his life, he is also creating his own incentives in the community and toward recovery. This should resolve at least some of the resistance to adherence since any treatment will have been self-imposed, allowing SPs to become merely facilitators of the SUs personal gradient and natural inclination to treatment progression, recovery and well-being. By contrast to active rehabilitation, the passive approach also invites the patient-practitioner to hold an adult-adult dialogue, where both parties understand and openly communicate their needs and agendas, and while recognising each other's differences, identify and agree the mutual goals that should be worked towards.

As will be outlined in more detail in the following methods section and based on the evidence above, it is expected that any hospital based SP will be more inclined toward active methods, whereas community services be more passive. It is expected that results will still show many missed opportunities for SU empowerment, but it is hoped that this passive sentiment does emerge too given the research meriting this.

3. Methodology

Following the SU movement, SPs have been increasingly urged to empower patients to better equip them to become effective agents in society and socially included in their community. In the last section this study explores the merits of this recommendation by considering subtler applications of power, offering some examples of how discourse has shaped the agenda, and how practitioners' traditional agenda can erode the attachment between the individual receiving treatment and the wider world, even going as far as creating a dis-incentive to recovery. Given the counter-productive nature of these approaches and the long term social detriment caused to individuals subjected to this, there is a marked interest in moving away from this discourse and toward a more sustainable model. The recent development and roll-out of recovery-oriented approaches and SU-led treatment has offered such an opportunity, so that mental health SPs can move away from the oppressive discourse that preceded it. This study therefore investigates the extent to which this movement has in fact taken effect by examining the various social practices that are (re)produced in the texts generated by mental healthcare SPs and identify whether they are inherently active or passive. By examining service proposals – that is, care plans and risk assessments - we may identify both the opportunities and barriers being presented for SU empowerment, and understand better the division between our intention to empower patients and the disempowerment that commonly arises despite the best attempts to materialise these intentions.

3.1 Research Method

Double-blind randomised controlled trials (RCT) are considered the gold standard method of assessing treatment efficacy (maintaining internal validity), effectiveness (external validity) and value for money, sitting at the top two tiers of the evidence-based practice (EBP) hierarchy (Fisher and Happell, 2009). EBPs are adopted globally and are therefore immeasurably influential in the care delivered to all healthcare patients. However, in this

section, I would like to point out some of the problems that accompany reductionist and positivist understandings of mental disorder and its treatment compared to the merits of reflection and the holistic approach that has been embraced in this thesis.

RCTs involve randomly assigning a group of participants to a minimum of two conditions; one control condition and one or more treatment conditions. Random assignment should reduce outcomes simply reflecting differences in participants rather than their conditions. In addition, keeping the researcher and participants ignorant of the conditions participants have been assigned to for the duration of the experiment (double-blinding) reduces subjective biases such as placebo effects and observer/experimenter bias (a phenomenon whereby participant behaviour conforms to what is perceived to be the observer's expectation or to subtle cues communicated by the experimenter). RCTs are perhaps, particularly suited for assessing drug treatments since both dependent and independent variables can be easily observed and measured. However, whilst such approaches have been able to demonstrate causal relationships between environment and behaviour, it involved breaking down stimuli into their most fundamental components and observing them in isolation. Such an approach would take many other essential elements out of context if adopted for assessing behaviour therapies. We could argue that results from studies that break down therapies into component parts are somewhat artificial and perhaps at high risk of being misconstrued as a consequence.

The difficulty with assessing psychotherapeutic treatments using RCTs, or any other experimental approaches, comes down to both the inability to control confounding variables or subjective biases, and potentially an ideological or philosophical inappropriateness. An experiment on psychotherapies cannot be double-blinded, since the treatment cannot feasibly be concealed from either the participating therapist or patient (Harper and Thompson, 2012; Coolican, 2009). The most that can be hoped for is a single-blinded approach where only the

researcher carrying out an assessment of the outcomes is kept ignorant of the conditions, rather than the therapist or patient involved in the treatment. There is also a difficulty in controlling therapist variance, since having different therapists to deliver each treatment proves difficult in accounting for variances in skill, which perhaps may only be mitigated by having the therapist(s) deliver all treatments (Bentall, 2010). This way we can ensure personal differences will equally influence each treatment. Nevertheless, there remains a trade-off in this scenario, since every therapist may have an allegiance to a particular approach, which will influence how one treatment is being delivered in comparison to others.

Ideological difficulties associated with experimental designs for studying therapeutic and interpersonal relationships stem from the over-reliance on reductionist approaches to understanding knowledge rather than constructivist perspectives which are more frequently embraced by social therapists. Ultimately, what is perceived to be 'therapeutic' and central to psychotherapeutic treatments is open to much subjective interpretation since this is an experiential and largely unobservable phenomenon. It would seem appropriate at this point to consider the extent to which experimental designs can ever hold practical value for socio-psychotherapies and interpersonal relationships, since much of the experiential phenomena on which they depend – the very unique circumstances which influence context and behaviour through the (re)construction of knowledge - is stripped from examination and renders it, quite literally, meaningless.

By comparison, qualitative methods hold constructivist values, the fundamental assumption that everyone's perceptual constructions differ from one another and knowledge is therefore relative. For example, our own personal perception of what constitutes the social object 'service user' will differ slightly to others' perception of the same social object. This will be relative to our life story and experiences, which are unique from one individual to the next, thus the means by which we learn 'our' knowledge, which will justify our behaviour within

certain contexts. Bearing this in mind, it became immediately apparent that qualitative methods were, incontrovertibly, the most becoming approach for this study as it would allow the research to examine the very things that shape our attitudes.

Given the interpretive nature of socio-psychotherapies and interpersonal relationships it would be most fitting to examine treatments using a method that would tap into meaning and therefore epistemological perspectives, understanding who is affected and why, with a great level of detail and intensity. Moreover, this could be achieved in a variety of ways including, observation, interview, or simply examining text and talk. Since the thesis was interested in whether SPs were truly empowering their SUs, it was essentially concerned with what is being done and why, which evidently meant an examination of discourses. As discussed earlier, discourse understands language as a social practice since communicating with others is a means by which we achieve things. Making a promise, for example, may be understood as making a contract with ourselves or others (Wodak and Meyer, 2009). Similarly, giving instruction may be understood as being prescriptive and, based on the context, we may draw further conclusions about its meaning such as whether the speech act was didactic or coercive. Accordingly, we may establish whether SU empowerment has indeed pervaded into mental healthcare agendas as well as the various perceived merits of different treatment propositions, SPs' justification for selecting particular approaches within service proposals, and even expose contradictions between proposed means and perceived outcomes.

3.2 Design

A Critical Discourse Analysis (CDA) was the chosen method of investigation for this study as it would offer the richest and most diverse results, particularly given the materials used. Traditional forms of discourse analysis (DA) study are often applied on dialogues, media articles or other overtly 'positioned' material, since it is particularly suited to examining naturally occurring language (Wodak and Meyer, 2009). However, since the current study was

examining SPs' care plans and risk assessments, traditional applications would be unsuitable since these texts contained largely descriptive content. We would expect, for example, very few instances of collective symbols or typical illustrations. A critical approach to DA on the other hand, particularly using a combination of Foucault's and Van Dijk's sociocognitive approach to discourse theory, acknowledges a much wider spectrum of media as communicative, such as format and imagery in addition to text and talk, and therefore offers an opportunity for even more variegated results (Van Dijk, 2001: 352). Conclusions may be drawn not only through text and talk but also by visual illustration such as painting, decorating, organising, etc., since such exercises also have a function and, much in the same way as text and talk, are simply extensions of our preferences and ideologies. For example, why is it that our hospitals are seldom colourful, or schools group children of similar ages; why were these decisions made and what were their intended purpose; are there other approaches that may offer a different, even better outcome, perhaps that make hospitals less intimidating, and different children recognise they have more in common than just their age..

Foucauldian CDA acknowledges discourses as (re)emerging systemically, and considers three planes of analysis and discussion. The first descriptive level offers a characterisation of the material, considering when it was said or written, who by and who for. In the first section of the results, I address this by describing both the SPs and the documents selected. The SPs were described based on observations of their respective websites, whereas all the documents' individual page formats, layouts, topics and any other overall observations were described. The aim on this level was to establish what discourses the text and talk was seemingly aligned to, and where possible draw conclusions about any perceived intentions. For example, a process-driven writing style might be suggestive of a very mechanical and instructional SU treatment, aligning to active discourses, whereas narrative writing styles align with self-reflection associated with passive discourses. The description of the materials also assisted in identifying any emerging themes, by considering the topics covered across all

documents. For clarity, it is worth noting at this point the distinction between topics and themes; the term topic used in this thesis refers to the specific information a SP has chosen to highlight in a given SU's document. This therefore might represent a theme about the SU but might not necessarily be emerging in other documents sufficiently, or at all, to be suggestive of an overall theme representing the SP's agenda, intentions or discourse alignment.

A second functional level, (covered by both the structural analysis and discourse strands sections) considers the content found within the format, layout and topics identified in the preceding level. This offers another layer of understanding about each SP's agenda, either affirming or challenging overall initial observations. The structural analysis offers an opportunity to understand how information is being navigated or rationalised whereas the discourse strands represent the most prevalent discursive practices found across all texts. Both sections pay particular attention to different management styles and proposed patient-practitioner interactions, as well as any variances in the tightening and loosening of control over SU freedoms across services.

The third, and final, global level covered in the discussion section, considers the societal explanations for the functional and descriptive levels of analysis described above. We may draw upon the literature review offered to gain insight into how Western culture's mental health ideology has come to form the various institutional mind-sets and micro-communities that present across the types of SPs selected for this study – in this case a low security locked rehabilitation hospital (LSLRH), community mental health team (CMHT) and private specialist rehabilitation support service (RALE).

3.4 Ethics

The present study was submitted to the Coventry University online ethics procedure and, as it did not require any identifiable information to be used and there was no contact with participants, was therefore classified as low risk. In addition, the data required were already

captured within the materials used as part of the normal business processes operated by the selected mental healthcare SPs.

The only ethics-related uncertainty faced was around access permissions and consent for using materials. As the materials were written by different SPs, but stored and used by a new SP, it was not clear who had ownership and should take responsibility for providing gatekeeper permission. The Information Commissioner's Office (ICO) was consulted regarding DPA process, particularly around the proper handling of documents containing participant information. It was advised here that provided all identifiable information had been omitted and anonymised before handing over to the researcher, there would be no issue with regards to their distribution for use within the study. Consent and gatekeeper permission was therefore granted by the current SP on the basis that all patient identifiable information within the documents could be anonymised prior to handover to the researcher. In addition, while the identity of original SPs were known to the researcher, their identities (with the exception of RALE) were also redacted to ensure protection against any perceived threat to their image or reputation by the findings. Only RALE provided consent for their identity to be disclosed within this study.

What has been rather exciting about this study was the opportunity to examine current treatment methods without many of the ethical dilemmas often encountered with more traditional methods, which would also impose many limits on what could be observed and therefore discussed, but with an approach that was found to be unequivocally appropriate and becoming. There was no risk to anonymity, confidentiality, inappropriate (researcher-participant) behaviour or harm. As there was no direct contact with stakeholders, there would be no risk of clandestineness or contrived behaviour presenting and, by extension, contaminating results as could be expected in interviews or observational settings. Finally, and most genially, the non-intrusive nature of the approach permitted a gentle examining of the

events without inducement, provocation, resistance or challenge. A passive approach - like that endorsed in this paper - could also be taken to studying the materials. I have had the opportunity therefore to carry out my study and raise debate by the same fair and principled means with which we all long or expect to be treated.

Before the results chapter begins, I offer an overview of the SPs as the authors of their service proposals and the materials examined. As with any methods section, materials are described to offer the reader visibility and understanding of what is being examined. By 'author' I mean who – collectively - has been producing texts, and the epistemological position of this source, whether active or passive. This is considered by a brief and high level analysis of the SPs website, since text on this medium is designed for marketing purposes, and we may expect to see here the perceived public needs as well as the services' intentions to meet those needs.

3.5 Material

The materials and SPs chosen for the present study consisted of two care plans and one risk assessment from a low security locked rehabilitation hospital (LSLRH), one care plan and risk assessment from a community mental health team (CMHT) and one care plan and two risk assessments from a private rehabilitation SP (RALE). It appeared reasonable to rule out interview or observational research methods, firstly, because this would entail more work than would be required for the scope of the study. Secondly, these options posed various risks and ethical concerns. If an interview or observational approach were being planned for example, there would be several perceived risks to the researcher such as attack or verbal abuse, as well as around SU and practitioner data protection. Furthermore, observational methods would be difficult to examine in enough detail without the aid of a cam-recorder, which only raised more ethical concerns around securing the identity of participants. The validity of observational methods would also be difficult to protect, not just from subjective bias of the researcher, but

also from observer-bias - i.e. participants behaving differently because they are aware of being observed, rather than behaviour occurring naturally (Hróbjartsson et al., 2014). As such the lengths required to overcome these obstacles considered to be greatly disproportionate to the merits of carrying out pseudo-natural observations, and fell well outside the scope of the study.

SP documents - namely, care plans and risk assessments – were considered to be particularly suitable since these are the conventional means by which services acknowledge and communicate patients' assumed needs, as well as methods by which to best meet those needs, to those delivering their care. Since these are written materials, we could argue that any assumptions or guidance presented here are accepted on a wide enough scale, for example at a societal level, to be 'on record.' This therefore feels an appropriate place to explore what are perceived to be acceptable discourses.

Care plans detail how and what care is to be delivered to best meet the needs of a SU, whereas risk assessments assess and propose mitigation strategies to manage specific risks perceived to a SU, staff or others (e.g. community). What is particularly useful is that if a given SP delivered a care plan, therapy or treatment that proved very effective for a given SU this would not necessarily carry over to the new SP in the event of a service handover or SU discharge, unless mandated by the former consultant or care co-ordinator. This suggests that there exists room for judgement calls to be made between services, and we would therefore expect to see tightening or loosening of freedoms allowed to the SU between the various service proposals written by different SPs. Additionally, care plans and risk assessments vary greatly in their presentation and written content, which may provide some further insight into a service's choice of treatment, and will therefore also be taken into consideration throughout the characterisation of materials and structural analysis sections.

Documents were selected from SPs currently in operation (written between 2010 and 2012). The service proposals came from three SPs including a low security locked rehabilitation hospital (LSLRH), community mental health team (CMHT) and private community rehabilitation support service (NGHealthcare). A gradual movement away from active, 'rigid' and indoctrinated approaches offered by formal multi-occupancy facilities (such as LSLRH), toward more passive and flexible approaches that may be offered in community-operating services (i.e. NGHealthcare) was expected.

In the following results section, there are three broad aspects of the data presented. Firstly, a commentary on the content including who it was written by and what was covered in the documents; secondly, structure to consider how the information has been presented and is navigated; and, finally, an examination on the discursive significance of the content.

4. Results

The following results section begins with a characterisation of the SPs and the materials used. The first section of the characterisation section involved getting to know the SPs as 'authors' of their service plans by examining their websites in order to gain a sense of their intentions and strategies. The characterisation of the material, on the other hand, involves a straightforward description of the documents, including their intended use, appearance, immediately obvious information (such as the topics covered) or absence of information and other initial visual observations. This is not only to offer an illustration but also, perhaps, some insight into the upkeep of the document as well as its look and feel. This is followed by the structural analysis section which will offer a more detailed examination of the documents content, format and layout, to understand what information is being selected and how it is organised and navigated. The overall aim of the characterisation and structural sections is to

examine the SP's seeming epistemology and whether this is evident, or extends, into the structure as well as content of their documents.

Further to this are the results of a word frequency query conducted as a high-level check for any re-occurring statements which might have assisted with defining the discourse strands presented in the subsequent section. The word frequency offered a quick insight into whether there were any frequently occurring statements that were immediately obvious that could be grouped into themes. Upon reading the texts, similar statements were highlighted and grouped into their relevant categories. Four core discourse strands were identified and are presented with a brief description and examples under the Discourse Strand Summary subsection, followed by a breakdown of their prevalence across the texts under the Prevalence section.

4.1 Characterisation of Authors and Materials

This section will provide some consideration of each SP as the author of their respective service proposals by examination of their website and brochures, followed by a descriptive analysis of their internal documents. The characterisation of authors will involve picking out elements of the text and images that appear to either support or challenge SU empowerment in an active and passive capacity, in an attempt to understand each SP's orientation within the SU empowerment discourse. Extracts of public content are supplied in the appendices to offer the reader an opportunity to review this independently of any influence that may be present in this thesis. This section is then followed by a descriptive account of the internal documents themselves. Extracts of these materials will not be available for the reader's independent review due to confidentiality. As services can vary significantly, three particular providers were selected to represent three broad SP types or 'communities' for examination – a low security locked rehabilitation hospital (LSLRH) to represent the examination of a clinical environment, a

community mental health team (CMHT) to examine public community services and a private community support provider (RALE) representing specialised community support.

Following from the literature review and the assessment of the SPs' websites below, it was suspected that the clinical environment (i.e. LSLRH) would offer fewer opportunities for SU empowerment than the CMHT given, like many multi-occupancy facilities, it would be closely aligned to the approach of the total institution requiring a highly routinized approach to managing all its patients. The CMHT team was anticipated to have more opportunities compared to LSLRH, but still more restricted than RALE since it was perceived to be more closely aligned to the global discourse which, as suggested by the literature review, is still largely dominated by biomedical and psychosocial discourses, which SU empowerment is still pervading. It was anticipated that RALE would offer the most opportunities for SU empowerment since this was the main selling point of the company – specialised in SUs asserting their identity and defining their own lifestyles. In addition, RALE offered one-to-one support, which suggested the SU would have the opportunity to define the terms and direction of their support on a daily basis. Since all SPs have the same legal obligations, similar documents are produced, particularly care plans and risk assessments. These were therefore the chosen subject of investigation, since they may be comparable. Special attention was given to any (dis)similarities in the proposed approaches and both their justification and the practical consequence on SUs and their freedoms was questioned.

The Authors

LSLRH website and brochure

The main page of the LSLRH's website (see appendix 1.1) described the facility as a 24-bedded rehabilitation hospital for adult women (over 18 years of age), open to both informally admitted and detained SUs. To support SUs with various complex needs, they openly advertised taking a multi-disciplinary approach which, as per the description on the website,

included Psychiatrists, Psychologists, Educators, Nurses, Social Workers and Occupational

Therapists (OTs). As in all subsequent pages, there was a picture of a mansion-like building in

the header, which presumably were the hospital grounds. The level of specialism carried by

the multidisciplinary approach, coupled with the vivid imagery associated with the term used

to describe itself as a hospital, conveyed that this was a highly clinical environment.

The facilities page (appendix 1.2) listed the various other parts of the building available

to SUs. The relaxation/multi-faith room and occupational therapy arts and crafts room

conveyed the efforts made to accommodate different lifestyles and creative hobby choices. A

"service user kitchen" was also advertised, which struck as quite odd and socially excluding in

some respects, since it implied that this is not for staff and such a distinction has not been

made for the dining room or lounge. Finally, there was also a clinic and treatment room,

suggesting that therapy took place in a designated space, rendering the rest of the hospital a

contained accommodation rather than a place of recovery as a whole.

The treatment page (appendix 1.3) offered information about the type of services

available, and that these were "highly supportive gender-specific, individualised care

packages." I gained a strong sense of specialism again with the range of support being offered

such as in education, occupational therapy and psychology. Social inclusion was presented as a

therapy, which demonstrated acknowledgement of a need or demand for SUs to become

socially included. The SP also stated that SUs are "encouraged to be active in their own

recovery and engage with a range of therapeutic opportunities." This conveyed a sense that

the SP would be the active agent in treatment and recovery, since the very act of encouraging

a SU would be instigated and led by the SP. The assignment of designated spaces for different

activities as well as the term "gender-specific" struck as rather contradictory to the aims of

social inclusion however, since it implied some degree of separation. "Gender-specific"

suggests a social paradigm where men and women cannot undertake the same activities or

pursue the same interests. This is taken for granted knowledge that has defined, very precisely, the social object 'man' and 'women', perhaps restricting the social acceptability or flexibility to permit any deviation from these boundaries rather than embracing an endeavour to achieving equal access to and power over the world and its inherent opportunities.

The care team page (appendix 1.4) offered the opportunity to 'meet' some of the team members delivering treatment. Admittedly, this was also an opportunity for the SP to display their exemplary skill set. The gallery (appendix 1.5) offered an insider's view of the premises. The table in the Activities Room gave it an executive look at first glance however the colourful items on the walls and shelves, which appeared to be a collection of paintings, board games, and hand sculpted ornaments, presented a nursery-like feel similar to that in the paintings in the Game and Art Room. The success stories page (appendix 1.6), exemplified by two SU case studies within this section of the website, offered defence and justification for their treatment methods. The final website page denoted safety and SU welfare (appendix 1.7) placing a lot of emphasis on knowing what to do, and SU protection.

The brochure (appendix 1.8) offered some additional insight about the SP's epistemological orientation that was not present in the website. The document was split into five sections; an introduction, "experienced service and staff," "the service," "person-centred care" and "respect and dignity." The first section asserted that care was all evidence-based. Evidence-based practice (EBP), as discussed earlier in chapter 2.3, has been a source of some controversy and largely disqualifies theoretical and qualitative studies for consideration in practice since, by comparison to RCTs, they sit on the fifth and sixth tiers of the EBP hierarchy - just one above the lowest (Fisher and Happell, 2009).Given all research in SU empowerment has been based on theories of power and explored only in qualitative examinations, it would be unrealistic to expect a passive approach being adopted here therefore. EBP suggests a larger reliance on medical and cognitive behavioural approaches, since the strength of these

approaches will have been evidenced by RCTs. On the other hand, patient-centred care was

briefly mentioned in the SP's brochure, offering some emphasis on treating patients with

respect and dignity, asserting that patients' care is individualised and that they are supported

in the choices they make. The marketing text also asserts that every woman is "treated as an

individual," as a unique selling-point of the service even though this should be standard

procedure, since this is the baseline behaviour afforded other people. By stating this outright

however, the SP is also admitting, implicitly, that mental health patients, even now, are not

afforded the same social etiquettes, but here an effort is made to ensure this.

The second page of the brochure comprised of a further five sections as well as an image

of their step-down facility, which was not present on the website. In the "clinically led team"

section there was further emphasis on multidisciplinary teams (MDT) but also on social

inclusion, recovery focused and psychosocial models of care, which suggested that SU

empowerment was recognised at the facility and by extension presumably being adopted. In

keeping with their EBP approach, they also boasted the use of outcome measurement tools

such as the Recovery Star[5] and HoNOS[6]. Finally, a lot of emphasis was placed on having

dedicated teams to "support the client to achieve their individual goals and desires by

encouraging structured daily activities." While on face value, this attempted to convey an SU-

empowered approach by supporting patients toward achieving "their individual goals," this

has been contradicted by attempting to do so through "structured daily activities" which as

discussed in the literature review is an extension of the total institution and in fact highly

active.

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[5] *The Recovery Star is a 10-armed diagram (see example in appendix 4), measuring 10 key recovery domains, each of which are assessed on a scale 1-10 that represents an underlying ladder of change. 1-2 represents being stuck, 3-4 accepting help, 5-6 believing, 7-8 learning and 9-10 for self-reliance. Widening its use across all mental health care services is currently being considered by the department of health.*
[6] *HoNOS is the most widely used and recognised 12 item outcome measuring tool for mental illness, assessing behaviour, impairment, symptoms and social functioning. This is the currently recommended measuring tool by the English National Service Framework for Mental Health and Department of Health.*

Nevertheless, the facility was adamantly pro- recovery, albeit not necessarily by permitting the most power to SUs, as implied per the assertion made in the "assessment" section of their brochure that "the philosophy of the service is driven by the principles of rehabilitation and recovery, underpinned by social inclusion and robust risk management." The goal was ultimately focused on "supporting a pathway to a less supportive environment and community living." This suggested that the facility was merely the first stepping stone out of institutionalised care. It would therefore be quite active in its approaches, but did at least intend to support SUs out of institutionalised care toward greater responsibility and access to social empowerment.

Given the security measures, the LSLRH's purpose appeared to manage mental disorder that had too high a likelihood of relapse and/or severity to allow close proximity to the community. Being a locked facility with designated rooms for different social needs, and structured approaches to activities, emphasised close monitoring of any leaves or visitations as well as easy capture and control of any issues. Additionally the term 'hospital' coupled with the clinical teams and therapies offered implied a heavily biopsychosocial-driven institution and perhaps a seemingly superficial attendance to SU empowerment given the emphasis on the SP to encourage SU engagement. Nevertheless, there was a strong desire for patients to recover and move onto less supportive environments, thus the overall biomedical character merely suggested perhaps that passive approaches just could not be realistically embraced in this context.

CMHT website

The CMHT's consisted of several sub-pages within the local NHS trust's website (appendix 2). Since this was a public service it had to accommodate a wide range of needs and circumstances by having different centres across the county to support SUs in their local community. There were eight subsections to the CMHTs MH section of the website (appendix

2.1) including; "your IPU (Integrated Practice Unit) and you," "care clusters," "referrals,"

"acute care," "community care," "rehabilitation," "Improving access to psychological therapies

(IAPT)," and the "veterans project."

The CMHT described itself as a general MH support service offered to adults living in the

area. It was general in that there were no specific complex needs listed or exemplified that

they were restricted to, or specialised in catering for, in contrast to the LSLRH. Services could

fall into three groups – non-psychotic, psychotic and organic. The "our services" page

marketed the CMHT as a highly flexible organisation given the wide range of services to

accommodate the needs of children, adults and elderly, both with short or long-term needs, in

a variety of settings including the community, day clinics as well as hospitals (appendix 2.2).

This page in particular had very little information however, therefore other subpages had to be

accessed for a more details about specialised services. This included options for veterans

(appendix 2.3) to improve access to specialist services available for those returning from the

armed forces who often suffer from post-traumatic stress disorder (PTSD) and the IAPT

organisation (appendix 2.4) for those who suffer different degrees of anxiety or depression.

The main page conveyed an endeavour to offering individual care using what was referred to

as a "care cluster" – a group of people who have been identified as having similar mental

health needs (appendix 2.5). Individual needs were assessed via the IPU following referral by

the person accessing the services, a GP or an existing SP (appendix 2.6). Similarly to the LSLRH,

this approach appeared to still involve some degree of separation by way of organising

individuals into similar groups. Whether these groups would therefore be individualised

enough to suit the needs of individuals accessing these services could be questionable.

The community care page (appendix 2.7) asserted that community teams consist of

"social care professionals," which is quite ambiguous in terms of what specific professionals

would likely be involved with a SUs case. A reference was made to the Royal College of

Psychiatrists' website, which suggested clinical involvement. Upon accessing the website however, there was no explicit information on the what professional involvement would be available through the CMHT and it was therefore difficult to say to what extent clinical discourses and active approaches would generally be present from this text alone. The acute care page on the one hand (appendix 2.8) strongly suggested the use of clinical intervention and highly active approaches for those who struggled to cope with their mental health in the community and have severe symptoms. In addition, acute Day Services offer support for those when an acute crisis is being experienced and are available from purpose built facilities. This appears an extension of the hospital setting since it is, in essence, a unit where people go to receive emergency treatment much like A&E. The likelihood of a patient receiving clinical intervention during or following a crisis is therefore heightened rather than lowered demonstrating a heavy reliance on, or perhaps greater faith in, biopsychiatric approaches for managing critical events. Whilst their main page advertises an endeavour to respect SUs individuality, CMHT services in this instance appear to have many controls in place and opportunities for SUs to return to clinical intervention. Like the LSLRH, reference was made here to 'specialist services' being involved for those who needed treatment in a 'safe environment' – that is, in a hospitalised setting. The Crisis Home Treatment Team assessed the needs of SUs when an acute incident would take place and have three possible outcomes to choose from, presumably to reduce the need for hospital admission wherever possible. These included recommending care to the Community IPU, Acute Day Service IPU and Inpatient IPU Teams. Inpatient IPUs could include inpatient recovery services in step-down facilities, presumably wherever a SU's symptoms were believed to be manageable so they could return to the community. The rehabilitation page on the other hand stated that SUs were prepared for community living by empowering patients and supporting them to recognise their potential in a 'homely' environment (appendix 2.9). This suggested a strong endeavour, like the LSLRH, to reintegrate SUs back into communities, rather than remaining dependent on services.

The CMHT appeared to function as a form of gatekeeper in some respects as evidenced by their referral system (appendix 2.10). Following a referral by the SU, GP, carer or SP a 'parole' assessment would take place before allocating the appropriate services, which could indeed include admission into hospital where an acute case was found. Since this was a public service, SUs who cannot afford private care would likely be assessed and monitored by a CMHT throughout their recovery. In addition, as government funded public services are closely aligned to political demands, we would expect to see a lot of the global discourse emerging in texts produced by this service – that is, an endeavour toward SU empowerment, but with a strong reliance on biopsychiatric methods.

NG Healthcare RALE programme website and brochure

NGHealthcare was a community based one-to-one support and care service. Their website (appendix 3.1) described a range of specialist home care services which encompassed three basic pathways: The care pathway, which entailed traditional domiciliary care including housekeeping, medicine prompts, meal preparation, etc.; the enablement pathway that emphasised increasing a given SUs independence; and finally the specialist rehabilitation pathway, which was a time-bound programme that was person-centred and outcome-focused. The material used from NG Healthcare pertained to the specialist rehabilitation service called the Reconstructive Adult Learning Experience (RALE) programme.

Whilst the rehabilitation pathway described itself as specialist, it did so without reference to using clinical involvement, by comparison to LSLRH. There was nevertheless mention of some of the diagnoses they catered for, which included acquired brain injuries (ABI) and some mental illnesses in their service features. They offered an example of a case study SU to illustrate some of the outcomes achieved, serving a similar purpose to the LSLRH's "success stories" page, however outcomes were more centred on being independent, rather than symptom reduction. The community transition assessment centre (CTAC) model

illustrated further their emphasis on de-institutionalising SUs and preparing for independent living. Independent living trials (ILT) were for those who wanted to increase their independence which suggested this was optional and conveyed an openness just as much to those who perhaps did not wish to live independently to those who did.

Their first brochure (appendix 3.2) explicitly stated RALE was "time bound, person-centred and outcome focused" conveying a very goal oriented SP. There was a similar statement made by the LSLRH suggesting some active intervention, asserting their focus on "motivating the individual to achieve what they want in life" whereby motivating the individual implied effort being exerted by the SP onto the SU rather than elicited by the SU. Nevertheless, the ultimate goal and values were shared with the previous SPs, which included social inclusion, community engagement and enabling SUs. The rehabilitation pathway's designated brochure (appendix 3.3) went into further detail about the ethos of the approach, understanding that sustainable rehabilitation could only begin when SUs are "in the home they want to live in, among the communities they want to be a part of," emphasising a reliance on the SUs capacity for development and autonomy, and focusing on the individual rather than the illness or disability. Like the LSLRH, this acknowledged the reality of what, for many, constitutes the social object that is a 'SU' who seldom are understood as individuals and all behaviour as mere products of their illness.

This programme was described as being 'intensive,' delivered by a team of support workers and only some guidance from consultants where any specific treatment was mandated. The ethos held was that in order to reintegrate an individual into the community successfully, realistic incentives for the SUs had to be gauged. SUs would not only dictate their placement within the community and how or whether they wished to contribute, but in turn assert and reinforce their chosen identity. This rehabilitation method was geared toward SUs who had been exposed to prolonged periods of institutionalisation and relied heavily on

behaviour change subsequent to experiential learning. Based on the largely non-clinical team delivering the support, and the company's independence from political agendas, many passive approaches to achieving recovery were expected as well as statements around deinstitutionalisation dominating the texts produced by this SP.

The Materials

Generally care plans and risk assessments are written by the SP alone with little input from the SUs. These are normally kept confidential and available only to those directly involved in the care of the SU. It was expected therefore that the text would be largely instructional and process-focused. When referring to both care plans and risk assessment, these were labelled service proposals since this was the function they both served – to outline what should be done under different contexts with regards to the SU's care. 8 internal documents were supplied, excluding all patient and practitioner identifiable information, 4 of which were care plans and the remaining risk assessments. 2 care plans and 1 risk assessment were written by the LSLRH, 1 risk assessment and 1 care plan by an NHS CMHT and finally 1 care plan and 2 risk assessments by the private community care SP, RALE.

The topics covered within the first LSLRH care plan (henceforth also referred to as care plan 1) included 'Plan of care,' 'Observation and risk management plan,' 'Diagnosis and MH assessment,' 'Mental Health Act,' 'Section 17 leave,' and 'Access to contraband.' Two tables were illustrated on the first page, one detailing the patient's core team which consisted of a responsible clinician, psychologist, primary nurse, associate nurse, social inclusion worker and OT. The latter detailed the care plan index, which listed the additional topics 'medication and physical health monitoring,' 'visitors and family contact,' 'risks of violence and aggression,' 'risk of substance misuse,' 'risk of absconsion,' and '[SU name] is vulnerable to exploitation,' even though these were not covered in the document. Each topic's table included a section for the SUs name, date of birth (DOB), date of plan, date of review, title, care plan No.,

need/rationale, plan to be followed, lead people to help me, and expected outcome. There was also an 'agree by' section at the bottom of every page with spaces for signatures. This section was signed by the nurse. Signature sections were blank for the responsible clinician, psychologist, OT, keyworker, other and patient on all pages. The patient's comments section was also left blank on all pages. The 'Need/Rationale' and 'expected outcome' column present in each topic's table offered justification for the details outlined under the 'Plan to be followed,' and 'Lead people to help me' columns. All text was written in the third Person and was heavily descriptive, informative, and largely processual writing – i.e. displaying or using step-by-step instructions.

The topics covered under the second LSLRH care plan (care plan 2) included 'Plan of care,' 'Medication,' 'Mental state plan,' 'Section 3 of MHA (1983),' 'Self-care/recovery plan,' and 'Leave & discharge planning.' There was only one table format for each sub-topic, which was four rows long, with first two rows comprising of spaces for the SUs name, 'MHA,' 'title' of sup-topic, date, DOB, NHS number and mental capacity. The next row had five columns each of which address core aspects of the sub-topics including 'problem/needs,' 'expected outcome,' 'intervention,' 'responsible people,' and 'evaluation method.' The final row left spaces for the 'date reviewed,' 'written by,' 'patient signature' and 'copy given to patient Y/N.' All 'date reviewed' and 'written by' sections had been completed. There were no signatures from the patient or any indication in the 'copy given to patient Y/N' sections as to whether a copy had been provided. The 'Need/Rationale' and 'expected outcome' columns of each topic covered justified the 'Intervention' and 'Responsible people' outlined. All text was written in the third Person, was descriptive, and informative, and largely a form of process writing.

The LSLRH risk assessment topics included 'Risk of violence and aggression,' 'Absconsion,' 'Non-compliance with medication,' 'Self harm/suicide,' 'Substance misuse,' 'Vulnerability to exploitation,' 'Sexually inappropriate behaviour,' 'Key risk indicators/triggers,'

and 'Review.' The document consisted of eight tables in total, seven of which outlined details around specific risks, and the remaining table listed reasons to warrant a review. Each risk table consists of one column and six rows, with the first row detailing the specific risk identified, the second any historical behaviour related to the risk, third the key indicators/triggers, and finally probability, severity and imminence in the final rows. The final table consists of one column and two rows with the heading "Review what signs/symptoms/circumstances would prompt an urgent review before evaluation" on top, and the list of the factors to remain vigilant of underneath. The historical behaviour sections dictated the perceived probability, severity and imminence scored. No actions were offered on how to mitigate or manage any identified risks other than to review. Text type was in the third person, descriptive, and informative.

The CMHT's care plan topics included 'SU goals,' 'SP goals,' 'Crisis/contingency plan,' 'Accommodation,' 'Social network,' 'Parenting skills,' 'Work (professional),' 'Mental health stability,' 'Service involvement,' 'Self-harm,' 'Anorexia,' and 'Personality disorder.' The CMHT's care plan document comprised a total of five tables. The first two encompassed the details of the SU followed by the details of the care co-ordinator. The following two tables outlined the goals of the SU followed by the goals of the SP, the actions necessary to achieve those goals, as well as persons involved and any timeframes that apply.

The last table laid out a crisis contingency plan in the event of any relapse in behaviour. It had a section to detail what constituted signs of relapse, followed by actions to reduce harm, who should be involved as well as any timeframes that apply. The goals identified under the "Goals" column justified the actions needed to achieve them under the column "actions to achieve goals". The text type was third person, descriptive, informative and process writing.

The topics covered under the CMHT's risk assessment included 'Risk from others,' 'Risk to self,' 'Risk to others,' 'Risk of neglect,' 'Risk to children,' 'Risk of physical complications,'

'Risk of wandering and/or falls,' 'Memory and cognitive impairment,' 'Challenges to services,' 'Protective factors,' 'Significant known history,' 'Assessment of risk,' 'Risk management plan,' 'Informative sources available,' 'How assessment was made,' and 'Involvement/agreement of person/carer in process.' The CMHT risk assessment comprised of two tables - the first outlining the patient details including their name and NHS number and the second table listing all risks that either involved risk to and from others, to self, to children, risk of neglect, physical complications, wandering and/or falls, memory and cognitive impairment and challenge to services. Toward the end of the second table were sections to account for protective factors, significant known history, initial assessment of risk, and initial risk management plan. Finally, there was also a section offering consideration of the information sources that were available at the time the assessment was conducted, how the assessment was made and any involvement and/or agreement of persons and/or carers in process. If a risk in any of the areas considered was present, this warranted the indicators and management strategy outlined to be implemented. The text type was in the third person, descriptive, informative, and process-driven.

The RALE care plan included the topics 'household tasks,' 'social interaction,' 'personal care,' and 'financial management.' The RALE document comprised of six tables where the first detailed the SUs reference number, the date the document was created and a space for the support manager handling the SU, which in this instance had been completed. The second table outlined all main stakeholders involved, including the SU, the care co-ordinator and the NGHealthcare manager, with a space for their names and contact details on either side of the role column. Tables on every subsequent page were the same layout, with slight variations relative to the topic being covered. All of the topic's tables had dedicated columns to mark whether a SU could undertake a certain action independently, (if not) why the SU could not undertake an action, what staff were to complete to support/facilitate, persons involved, how long intervention is required and the risk assessment that actions relates to. Each row of the

topic's table broken down said topic into more specific activities; under household tasks this included 'washing up,' 'provide themselves with a meal,' 'vacuuming,' 'tidying,' 'shopping,' 'washing,' 'maintaining security,' 'fire safety,' and preparing snacks.' Social interaction covered 'answering the telephone,' 'opening responding to mail,' 'choosing/planning social activities,' 'access public transport,' 'access local amenities,' 'comm with family,' 'comm with friends,' and 'interaction with wider community.' Personal care included 'shower/bathing,' 'personal care,' 'dressing/undressing,' appearance clothing etc.,' 'maintaining healthy diet,' 'medication ordering/collection,' 'medication administration,' and 'comm with health professionals.' Finally, financial management included 'bill payments,' 'bank withdrawals/deposits,' 'purchasing,' 'comm with bank/building society/PO,' 'comm with utilities,' 'day to day money handling,' 'maintain financial security,' and 'budgeting.' At the end of each topic's table there was a row titled 'misc' presumably for any additional activity that had not been considered that might be a specific/unusual need of the SU's. If the SU was considered to be unable to undertake an action, this was outlined under the 'Reason why S/User could not undertake' column and subsequently offer justification for the intervention suggested under 'action to enable.' There were occasions where the action to enable had been filled even though the SU was also marked as able to undertake the action him/herself. This appeared to be around actions where the SU might have been functionally able to undertake the relevant task but at the cost of being put at some level of risk and potentially required some additional support or monitoring. The text type was also third person and overall descriptive as well as informative. Some expository writing was also present however - whereby the writer used explanation and description in an attempt to understand and offer context.

Finally, both RALE risk assessments (where differentiated are also referred to hence forth as RALE risk assessment 1 and RALE risk assessment 2) had the same format and topics covered. Topics included Identified risk (suicide) 'Severity and likelihood,' 'Persons at risk,' 'Baseline risk,' 'Specific risk coefficient,' 'Risk management strategy,' 'Staff training

requirements,' and 'Additional information.' Documents comprised of five tables in total. The first two outlined the SU reference number, date of the assessment, expected review as well as persons responsible for the assessment, their position and signature. In this risk assessment 1 only the operations manager had signed, risk assessment 2 had no signatures. The third, fourth and fifth tables covered all the topics mentioned earlier in the paragraph, where the final table consisted of a space for notes on any additional information that may be considered relevant to the risk assessment document. The specific risk coefficient justified the interventions detailed in the risk management strategy. Baseline risks were those which perceived to be reasonable and expected of anyone, thus did not warrant intervention. Similarly to their care plan, both risk assessments were written in the 3rd person in a descriptive and informative tone, but also had some expository writing present.

The next section outlines the results of the structural analysis. This involved detailed examination of the documents content, format and layout, to understand what information is being selected, or equally any information that is appears omitted, as well as how it is organised and navigated. This section will offer an overview of what is being said within the topics that have just been outlined, and more insight into what opportunities and barriers are present.

4.2 Structural Analysis

LSLRH care plan 1

The topics covered within the LSLRH documents were greatly centred on diagnosis, health assessments and SU legal rights (i.e. MHA and section 17 leave). This conveyed a very sterile and service driven approach, since these items all appeared to hinge on the SPs legal obligations, medical requirements and clinical objectives. In addition, the SU appeared to have seemingly little opportunity to input on his care plan, as there was not any topic that would allow consideration of personal preference or SU requests. The only section within this

document that offered a remote endeavour towards tailored approaches was the diagnosis section, since it detailed specific aspects of the SUs mental state and the specialised treatment it would require. Overall the document was heavily based on a health agenda, rather than appealing to any personal endeavours the SU might have had.

The characteristics suggested that one of the documents was incomplete since there were subheadings on the contents page, which were unaccounted for later within the document. On closer inspection however, some of these were found to be in the risk assessment, and might indicate in fact that the care plan spanned over more than one document. On the care plan, there was a column titled 'lead people to help me' which communicated the impression that the document had either been written by, or from the perspective of, the SU. However, any actual SU involvement appeared unlikely since the document had only been signed by the nurse, while all other signatures including the SU's was absent, and the 'patient comments' section at the bottom of each page had been left blank.

Some of the actions under the column 'plan to be followed' were quite straightforward, stating for example that in the event that an incident occurred (e.g. aggression or self-harm), some allowances would be suspended until further review; it was required that the description and destination had to be recorded prior to taking leave, and AWOL procedures to ensue if the SU had not returned as when expected. These actions clearly communicated to the reader that their outcome was to deter deviance from any agreements made between the SU and the SP. Other plans under this same heading, on the other hand, simply asserted the status quo, such as that the SU "has had her community risk assessment...demonstrates good road safety...[good] use of public transport...[SU] has placed herself in vulnerable positions in the past and is currently talking about personal safety in her 1-1 sessions." The observation here was that these statements did not explicitly support the expected outcome (or the ultimate SP goal) which, in this case, was to enable the SU to continue having leave. Perhaps these would

be more appropriately positioned as a separate need/rationale to merit other or further actions. In this example, this section of the document had lost its purpose since the content had not been written appropriately within its structure – the statements were not procedures, or plans at all, that would support the need for leave as one would expect under the column headed 'plans to be followed' which should presumably outline what should or needs to be done to enable this. Another final observation made when assessing the documents' structural argumentation was the terminology used. One of the need/rationales was that the SU had been 'prescribed unescorted leave…' This observation provoked me to consider what actions, if any, would have existed had this not been prescribed or allowed. Surely, having leave and allowing an individual space is a basic human right, and by implication a need. Regardless of its prescription from a consultant, there is still a need to endeavour towards enabling all SUs within locked facilities towards having leave.

The text was formal and business-driven, which was likely deliberate and reinforced by the document's format and structure, namely through the use of clearly defined sections. These posed limits to what may and may not be included within the boundaries of a section, ultimately restricting the author from any expositive writing. It could be argued that there is a need for this with such documents, since the audience this is written for (nurses and carers alike) will be undertaking the interventions outlined and, to do so effectively, requires information to be written in as clear and concise a manner as possible - to maximise one's ability to understand the nature of a SUs needs thoroughly, but quickly.

LSLRH care plan 2

The topics covered within LSLRH's second care plan were again quite service-driven, however a few new topics were present which appeared to offer more opportunities for the SU to consider personal needs and requests under self-care/recovery plan and leave/discharge planning. Since these were largely focused on life and activities within the community, it was

anticipated at this level that these would offer a greater freedom and variety of options for the SU to pursue personal interests. Similarly to the previous document, the characteristics suggested that the SU appeared to have had little influence or input into the care plan, however. Moreover, it appeared likely the SU had not even seen the document since it had neither been signed by the SU and any explicit indication of it having been distributed had not been indicated in the relevant sections. Only the 'date reviewed' and 'written by' sections had been populated with a date and (the nurse's) signature respectively. The likelihood that the SU had made decisions in this care plan, and by extension pursuing any interests, by this point seemed remote.

The structural argumentation was also similar to the previous care plan in that some of the needs, actions and outcomes appeared to have erroneous connections. Some statements within the intervention did not appear to clearly or directly solve the problem/need defined, or support the outcome intended. With the example of self-care/recovery, the expected outcome was for the SU to have structure to her day and be able to live independently. However, although there were a lot of actions in the intervention to support the outcome to enforce structure in the SUs day, these were all service-driven - imposed by the SP rather than the SU - which defeated the very meaning, and indeed the outcome, of independence. Imposing a structure, routine or activity would rob the SU of opportunities to exercise initiatives independently and instead only establishes a dependency on the SP for queues. Moreover, the intervention permitted the SU's leave to be withdrawn if she did not adhere to the structure set out by the intervention, despite some of the actions set out stated merely to 'encourage', not force the SU to undertake. This withdrawal of freedoms struck as a highly leveraging approach and demonstrated a clearly coercive rather than supportive intervention. It was not clear how the outcome 'to live independently' was being attained by ensuring the SU quite literally follow procedures stipulated by the SP (including, but not limited to showering, doing laundry, cleaning her room, etc.) at stipulated times and even required to participate in every

activity at the facility, rather than defining her own routines and engaging in activities that interested her or took her fancy.

LSLRH risk assessment

The topics covered appeared to capture all the issues relative to the SUs specific diagnosis. Curiously, like many of the risk assessments, the risk of co-dependency was not considered, despite independency being a goal in the LSLRH's care plans above. It may be argued that in setting such a goal, a risk exists that this may not be achieved for various reasons. If such a goal is significant enough to warrant professional intervention to support its success, it is perhaps worthwhile to consider the barriers that may exist to achieving it.

Characteristics of the risk assessment, such as the section demonstrating the imminence of a given risk, suggested this was a working document. Only by updating this with the most recent historical events, would there be an indication of any risk falling imminent. If this was the case, this would suggest the SP engaged in very close monitoring of SUs behaviour. Also, some of the 'key risk indicators/triggers' sections, for 'non-compliance with medication,' 'vulnerability to exploitation/victimisation' and 'sexually inappropriate behaviour' had been left blank. Upon closer inspection of the history detailed for these risks, it appeared these were historical risks that no longer appeared to be present. Even though this has not been uncommon, this observation struck as a rather harsh reality for the SU to face, that such incidents would be remembered and monitored even though they may no longer pose a threat (Goffman, 1991; Bentall, 2010; Leader 2012). Other 'key risk indicators/triggers' sections explicitly stated "unknown" which, by contrast, suggested not much was known about the SU at the time said risk was raised. This too was logged even though, once again, there might not have been any threat at all, but would ultimately add to the SUs MH 'career history.' This begs the question as to how such a paradigm may pre-empt frontline staff behaviour and assumptions about a new SU. It may be more appropriate to keep such historical, or anecdotal,

records in a separate archive so as not to alarm those involved unnecessarily and, equally, offer the SU an opportunity to put what might have been a rather unhappy chapter in their lives behind them – truth be told this is a choice afforded most adults in society.

Lack of spaces for any signatures suggested that not all stakeholders involved were necessarily aware or agreed to the risk management strategy set-out. Then again, this may have been recorded elsewhere like the missing content for the subheadings listed on the contents page of the first care plan. There was no structural argumentation present, since the document merely reflected a log of incidents and monitoring tools (such as using scales of severity and imminence). Finally, as there were no risk management strategies offered within the risk assessment, this explained why there was comparatively less process writing than observed in other LSLRH documents. The document was still very descriptive and business-driven nevertheless, whereby all risks appeared to have been accounted for, presumably so as to ensure maximum visibility of any known issues.

CMHT care plan

Unlike its counterparts, the topics covered in the CMHT care plan included a dedicated space for SP and SU goals, which appeared a quite transparent approach, since any conflicts of interest could be captured immediately here. The tables' baseline topics for service monitoring were 'SU goals', 'SP goals' and 'Crisis contingency plan' – these were the headings written by the SP and presumably present before any SU gives their input. The remaining topics found emerged from the text within these headings, i.e. one of the goals was for the SU to have specified accommodation, and social networking was identified as an important aspect to consider in her community living. These characteristics therefore offered an opportunity for the SP and SU to identify the positive aims that serve both party's interests (i.e. living independently, forming new social networks, etc.) while reserving counteractive events to be managed under the crisis/contingency plan, which was in essence a risk management plan.

The structural argumentation was not entirely solid - for example, the SU had identified that she wished to expand her social network. However, the action to enable this was for the SU "to arrange with NG Healthcare how her 10 hours of support [was] to be utilised to provide support now [SU was] in the community." In this instance, the action did not directly or necessarily support the SU goal - but instead transferred responsibility to another SP.

CMHT risk assessment

The topics covered appeared like a 'checklist' - this was presented in a list which covered all possible sources of threat to and from the SU. Where a risk was not present, the topic for it was still listed but marked as 'no' making explicit that within that specific context no risk existed. This was very thorough by ensuring all areas of potential threat have been considered. This section of the document however, did not go into much detail about specific risks, but served rather as a log describing how each risk area was specific to the SU. For example, this SUs risk to children was that her lack of experience might have meant a limited ability to look after her only and recently born child. The section entitled 'Initial Assessment of Risk' however offered some detail with a summary of the current status of the risks, whether they were exacerbated under particular circumstances and an estimate of its imminence while the 'initial risk management plan' detailed the services that were involved. What struck as unusual was that there were not any mitigation strategies offered, other than advising the SU to discuss any self-harm thoughts with staff. This might have been because another SP appeared to be involved which would presumably have its own risk management strategy in place, satisfying this need. It was nevertheless unclear how speaking to staff would mitigate the risk of self-harm, and indeed why then this should be made explicit other than for monitoring purposes. Surely, this should not be under the risk management strategy, since it does not in fact manage said risk, and instead be under a review plan or similar section. Similarly to the LSLRH, there was a section of text that appeared misplaced within the risk management plan stating

that the SU 'strongly [denied] experiencing any self-harm thoughts and she [had] reported that her 'focus [had] been primarily upon [her son].' This statement would be more appropriately included under the 'initial assessment of risk' section as this would indicate a low level of risk and a strong desire of the SU to refrain from this. Like the LSLRH care plan, this section of the document was not used as intended and appeared to lose some of its structural purpose as a consequence, and suggested that the document was not always filled out carefully or with much attention to detail.

Any risk identified was recorded within the 'initial assessment of risk' and 'initial risk management plan.' However, as noted within the characteristics for this document, no clear line of argumentation was offered and the only risk that appeared to be of concern, since it was the only risk considered under the management plan, was around self-harm. It was advised that the SU discussed any thoughts with staff 'in order to reduce the risk to herself and [her son].' However, no clear indication was made as to why or how this would reduce risk, other than alert the SP that a risk may be imminent. There is no indication of what direct action would occur as a consequence of the SU self-harming, which would be appropriate in this section and perhaps worth the SU considering, seeing as she would be subject to this action as part of her care plan.

RALE care plan

The topics covered within the RALE care plan, by contrast to the above documents, had no emphasis on medication or diagnosis. More attention was afforded to fundamental aspects of community and independent living, with the emphasis placed on making one's lifestyle more 'ordinary.'

Characteristics appeared checklist-like where all fundamental areas were broken down into more specific components, in an apparent attempt to consider all possible aspects of independent living and what it may mean for him/her. The SU for which the care plan was

written for appeared to have memory difficulties, therefore under the activity 'shopping' it was stated that while she was functionally or physically able to carry this out she also "may be a bit confused at bigger stores like Tesco…never had to do weekly shopping before [and therefore lacks] experience and confidence…on occasion may forget where [she] left the trolley, where are the check-outs…etc." This therefore justified some monitoring activities by staff to assist in the event the SU struggled. It was also noted that there were additional rows provided titled "misc" at the end of each topic presumably to also account for any activities that were not already on the baseline document, perhaps for extreme or unusual cases. This appeared a very open and flexible approach to offering care, and particularly suited for tailoring the lifestyle needs and preferences of any individual.

The structural argumentation was quite clear in this document. There were a few examples where the writer had also tried to offer understanding of the SUs behaviour for reasons outside the remit of the diagnosis, such as that the SU simply lacked experience, and as a result may have low confidence in the community and not know exactly what to do under all contexts. The text type therefore had some elements of expositive by the author's attempt to understand why some of SUs behaviour existed and communicate this to readers. There were examples given around past experiences, in a report manner, which offered the reader some illustration of the SU's behavioural rationale. For example, it is stated that when the SU was agitated she could find it difficult to engage with others and become verbally abusive as a result. This example was of particular interest for two reasons – firstly, this text type was not present on any of the previous documents, which drew on records of past behaviour, which simply stated whether or not a SU had behaved a given way and the strategy to implement should this reoccur. Secondly, rather than stating that the SU was generally verbally abusive, it was asserted that she may become so under particular contexts or circumstances (i.e. when agitated). This second observation demonstrated that the author had been careful not to make

a fundamental attribution error by asserting that the context was responsible for the behaviour, rather than the behaviour being inherent to the SU.

RALE risk assessments (1 and 2)

The topics covered were identical across both RALE risk assessments only dedicated to different specific risk. There were two levels of risk considered within each document, which were not differentiated in other documents. These were the baseline risk and specific risk coefficient. The baseline risks were those which were to be expected under normal circumstances. For example, anxiety as a result of being in unfamiliar contexts is a common experience felt by many young adults when leaving the family home for the first time for example. The specific risk coefficients on the other hand, were the risks unique to the SU, which may warrant attention or management.

The characteristics differed in some fundamental ways to other documents. One example was that the document was dedicated to one identified risk. Each risk was therefore discussed in great detail, including rationales for occurrence as well as associated or secondary risks. A separation was also made between risks that were to be expected and permitted – i.e. the baseline risk - from those which were specific to the SU and may have warranted intervention – i.e. the specific risk coefficient. The additional information section offered further opportunity for detail, should the previous sections not have permitted this. In the self-harm risk assessment for example this section included details around some of the symptoms to be expected if the SU were to have consumed doses of rat poison, as she had been known to do so in the past. By contrast to previous documents therefore, this was particularly detailed with a strong focus on the SU's experiential background, rather than the SP's needs.

The baseline and specific risk coefficients appeared a particularly useful distinction since it meant readers could separate risks that were considered reasonable, perhaps even positive, from those that should raise alarm. The SU's perceived vulnerabilities in this type of

documentation were also largely understood in terms of context as a consequence, in that behaviour was explained as much as possible by the SUs life experiences, rather than evidence of the diagnosis.

The next section outlines the results of the word frequency analysis conducted on each service proposal to offer consideration to any potentially re-occurring statements ahead of doing any more in-depth analysis. This was followed by a structural analysis – that is, consideration of the topics covered, characterisation of the document itself (including its format and a visual description of any tables, graphs or other visual content), structure of argumentation and finally the text type (whether a narrative, expository, descriptive, written in the first or third person etc.). The final part of the analysis involved identification of the discourse strands (identifying what the text was doing) and their prevalence (how frequently this was occurring) in each service proposal as well as across each SP.

4.3 Discourse Strands

Word Frequency

Word frequency and stemmed word analyses were conducted to gain a sense of what service proposals were mostly saying. This was done for all proposals, and then broken down into more component parts to gain a sense of each SP as well as each document's orientation. Only the top 10 and 5 words for service proposals and documents respectively were considered, since any more than this did not offer much more insight. Nevertheless, consideration was given to any topics or words found to be unusually infrequent or all together omitted was considered in the discussion.

Word frequency queries on similar words (including stemmed words or synonyms) were conducted to capture the possibility of the same statements being made in different ways. The words self and harm were removed from the query since all documents were written about

SUs prone to self-harm, causing these to frequently appear high on the list. Had there been more material available for examination, there would have been greater SU variance and perhaps symptomatic behaviour would appear further down the list by comparison to statements about management. In addition, the text was stripped of its format for the purposes of the word frequency queries, to minimise the appearance of words such as 'name' or 'date' since all documents had a space for the SU and practitioner to sign on every page and the date documents was written. These words were considered contaminants since they would not aid or offer any insight in examining SP management styles and approaches.

The word frequency results are displayed in table 1.0 in descending order, with the most frequently occurring word placed at the top. This analysis was run on all documents, followed by each SP and, finally, on each individual document. Where the analysis was run on individual documents only the top five were examined as any words found in addition to this represented a very low (handful) frequency. The first observation made was that the term 'User' was the most frequently stated word across all RALE documents, suggesting a lot of comments were made about the SU. Although most other terms differed, both RALE and LSLRH used the term 'Staff' to a similar extent, and all SPs frequently used the term 'Support.'

By contrast to its counterparts, the LSLRH had a more conservative and institutional feel as implied by the frequent use of terms such as 'Assessment,' 'Risk,' and 'Issues.' LSLRH was also the only SP with the term 'Nurse' appearing which added a clinical nature. RALE on the other hand, conveyed a more proponent tone as suggested by the frequent occurrence of terms such as 'verbalised,' or 'needed' and was the only SP to make any statement on 'Experience.' The CMHT's position was not made particularly clearer by this exercise. Similarly to the LSLRH, the terms 'Assessment' and 'Healthcare' both suggest an institutional position.

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Table 1.0 – Word Frequency Results

Rank #	All documents	All LSLRH documents	LSLRH CPs	LSLRH RAs	All CMHT documents	CMHT CP	CMHT RAs	All RALE documents	RALE CP	RALE RAs
1	Staff	Leave	Leave	Risk	Support	Support	Assessment	User	Staff	User
2	Support	Staff	Nurse	Triggers	Using	Healthcare	Reported	Staff	Care	Management
3	Leave	Mental	Staff	Incidents	Services	Using	Regarding	Care	Monitor	Staff
4	User	Nurse	Mental	Indicators	Assessment	Engage	Risk	Support	Needed	Make
5	Take	Issues	Support	Reporting	Regarding	Currently	Services	Make	Support	Support
6	Care	Take			Healthcare			Management		
7	Risk	Support			Engage			Experience		
8	Issues	Assessment			Currently			Verbalised		
9	Place	Risk			Staff			Needed		
10	Assessment	Rights			Working			Intent		

Summary of Discourse Strands

Four core elements were found across the proposed approaches of all care plans and risk assessments; factual information (about the SU or generally that may impact on care); choice (both allowed to the SU and agreed tolerances for staff intervention); conditions of care (specifying the actions that must be carried out by the SU or SP as per the agreement); and finally, justification for actions (both perceived rationale for the SU's behaviour and staff interventions to be carried out). These were broken down into sub categories to indicate where actions related to the SU or the SP. The first part of this section introduces each of the four core strands found including six excerpts, three relating to the SU and three related to the SP. The second section illustrates their prevalence across each SP as well as within each service proposal.

Factual information

All of the texts frequently referred to past events or known facts about the SU, which were often used for justifying some course of action. This was likely considered in designing the care plan as this would impact or inform any risk assessments. Facts were found to either be about the SU, or general circumstances.

Examples of factual information around the SU included:

"[SU]'s tenancy ends in July 2013"

"[SU] is in the community"

"[SU] has not self harmed since Nov 2012"

Examples of general factual information included:

"Children's services are involved"

"[SU]'s parents and sister have also been supportive"

"Deescalating techniques are in place"

Factual information about the SU, such as past behaviour, was largely referred to in risk assessments as this would give a better indication of its severity and likelihood, but was also considered in the care plan if this had any bearing on the interventions. General factual information included anything that the SU or SP would not necessarily have any control over, but which may have had a bearing on the interventions.

Choice

This category captured statements that suggested choice had to be taken or was permitted. Elements of the SU choice had to be accounted for as this would dictate whether or when certain interventions were implemented.

Instances of SU choices that were accounted for, which would influence care (such as assessments) or interventions, included:

"[SU] can seek support from NG Healthcare"

"[SU] has identified that she wants to expand her social network within the Warwick area"

"[SU] frequently verbalises a desire to self harm when in distress"

SP choices were minimal, but present. These generally entailed a tolerance, within which staff could exercise choice over management:

"…to have her mental state assessed prior to going on leave and leave is granted as per Section 17 leave form if the staff nurse feels her mental state dictates this."

"Staff are encouraged to call line management even if not necessary to seek support and reassurance as well as briefing and debriefing since incidences of self-harm are distressing."

Justifications

Justifications were statements made to support an outcome or an intervention. Surprisingly few justifications for actions were made overall, however, where justification was offered this was either to justify the intervention to be followed, or the SPs understanding of why the SU would behave in certain ways.

Justification for interventions included:

"…[SU]'s mental state to be monitored by staff and appropriate nursing interventions to be maintained to prevent deterioration in [SU]'s mental health"

"The psychology team will carry out assessments of her cognitive function to assist the team in developing [SU]'s care appropriately and effectively"

"[SU] is detained under Section 3 of MHA (1983), requiring legal parameters to be met"

Argumentation for SU behaviour included:

"…feels that she does not wish to self harm, due to the impact this may have upon [her son]"

"When [SU] is anxious, frustrated or experiencing psychotic phenomena her risk increase"

"It is difficult to understand payments via direct debit as she does not have experience and knowledge"

Care conditions

Care conditions consisted of statements that demanded or required a precise action or outcome – for example, 'the SU/staff must do X'. The vast majority of the content across all care plans and risk assessments entailed dictating what must be done and accomplished. These conditions could be either expected of staff or SUs. This was considered to explore the limits of care and account for how much was imposed on, rather allowed to, the SU.

Examples of SU conditions included:

"[SU] to attend DBT twice per week until September"

"[SU] to continue to be compliant with her prescribed medication"

"[SU] to shower and bath before leaving her room in the morning"

Examples of staff conditions included:

"…staff to ensure that [SU] takes her medication in front of nursing staff"

"Multi Disciplinary Team to ensure [SU] is detained within lawful statutes laid down by the MHA"

"If however unsuccessful due to [SU]'s mental state at the time, nursing team are to continue attempts to engage [SU] in discussion about her section and assess capacity"

Prevalence of Discourse Strands

LSLRH Care Plan 1

The majority of statements within this document were conditional (60.55%) - either requiring SU or Staff to follow particular routines or practices set out by the SP. By comparison very little argument for the interventions was offered (8.87%), as was factual information about the SU (7.92%), and virtually no statements around choice were present (1.81% staff choice only). For example, "Staff [were] to discuss with [SU] any issues regarding her

medication...Staff to engage [SU] in discussions about her rights under Section 3 of the Mental Health Act...[SU] to shower or bath before leaving her room in the morning..." Some statements came across as quite forceful even - "If however unsuccessful due to [SU]'s mental state at the time, nursing team are to continue attempts to engage [SU] in discussion about her section and assess capacity..." The last statement in particular conveyed a highly active and coercive approach, since it essentially maintained that staff should continue to engage a SU potentially during times of mental distress.

Any explicit or clear justification was limited, such as around the SUs medication - "[SU] is on 200mg clopixol, antipsychotic depot injection every week, and oral medication... [and]...needs to understand her prescribed medication, its benefits, and side effects." The plan did explicitly state that this was to aid the SU's recovery, albeit with little explanation as to how, but also that the SU had been noncompliant in the past thus implicitly further justifying this requirement in an attempt to avoid this behaviour repeating itself, rather than to directly improve the SUs well-being. The reasons for the SU's noncompliance had not been considered. This was perhaps an example of taken for granted knowledge that medication treats illness and by extension makes one 'better' but in many cases, as discussed throughout the literature (sections 1.1, 1.2 and 1.4), strong medication such as anti-psychotics present a lot of side-effects which may lead to a number of other health complications (Bentall, 2010). Any discomfort the SU might have experienced as a result of her medication might be worth considering to support any mitigation strategy. This section instead instructed staff to persuade the SU of the psychological, however directly unobservable, merits and continue to emphasise this to support continuation - "[SU] to identify the benefits of her medication and side effects...[SU] to be offered information on her medication, for which patient friendly pharmacy leaflets are to be given and discussed...staff to ensure that [SU] takes her medication in front of nursing staff."

Another example of limited justification was around the SU's routine. The need or rationale in this section was "self-care/recovery plan" for which the intervention was for staff to "encourage [SU] to wake up in the morning between 0800hr-0830hrs" and the SU to "...shower or bath before leaving her room in the morning...clean her room before breakfast…and do her laundry on the stipulated day...participate in every activity at [LSLRH1]." As above, these examples were highly active in approach to recovery where by the SP was both dictating and applying treatment - the hours to wake up and execute tasks have been 'stipulated' rather than defined by the SU. The SU had not even a choice over the activities she was to engage in, let alone whether she wished to participate in them at all. It was not clear to what end the SU is to exercise this routine. Perhaps there would be more purpose to this if the SU had a job to present at or a meaningful relationship. However, in the institutional context, this routine had no meaning since it did not appear to fulfil any personal ends for the SU. A final observation that suggested a highly active approach was that the SP was always instigating actions - opening the discussion, ensuring a need, encouraging, offering, etc.

LSLRH Care Plan 2

Similarly to care plan 1, the majority of the second care plan consisted of statements around the conditions of care (34.53%), circumstances under which interventions were to be carried out, and the time frames/circumstances for further review. This supported the original prediction that this SP would offer active approaches to rehabilitation. By contrast to the preceding document, however, significantly more argumentation was offered (22.90%), particularly for the interventions proposed (18.89%) - "[SU] will be managed on Level 1 general observations [since] [SU] has been mostly settled in behaviour and mental state...[SU]'s mental state will be observed on observations as 1:1 with named nurse which will take place weekly, to allow [SU] to express her thoughts and feelings...The psychology team will carry out assessments of her cognitive function to assess the team in developing the [SU]'s care

appropriately." The main justification found for the conditions proposed were around the safety of the SU. Only two needs were not around safety - these were understanding SU rights, and preventing deterioration of mental health. This suggested a poor alignment of agendas between the SP and SU, seeing as safety, rights and mental health, presumably, are not the only things of importance to the SU. These are in fact the SP's minimal obligations if it desires to remain in business. The SU's personal needs, such as hobbies or interests, on the other hand appeared to have been neglected and unaccounted for when justifying the routines and interventions imposed.

LSLRH Risk Assessment

This document served more as a log than an instruction. As such the majority of statements were largely around factual information (57.19%) with little exposition, which meant there was almost no argumentation (8.98%) or intervention (6.43%). For example, "there [had] been some reported history with non-compliance, with prescribed medication. However, since her admission at [another locked rehabilitation hospital] there [had] been no issues except in her early admission where she required IM medication at times of increased agitation. No issues yet since her admission at [LSLRH1]" - As there had been no significant reoccurrences since admittance, it was presumably for this reason that the probability of non-compliance occurring had been recorded as low. The only intervention stated was around when the next review of the current risk assessment should take place, which it stated must do so in the event that any of the risks logged take place or the SU was moved into the community. As stated earlier in section 4.2, it is a harsh reality that all incidences associated with a SU are kept recorded even if they had not occurred in years and in truth are not a risk at all. Especially where it is not intended to update a risk assessment until a new incident occurs

or the SU is discharged. If a given SU did not repeat an incident, and was deemed unfit for discharge for over a year the imminence and probability of the risks originally recorded would then remain the same and over time would in fact become increasingly inaccurate over time.

CMHT Care Plan

This document appeared more holistic in that many statements accounted for both SU preference as well as the SP's needs. The CMHT's care plan appeared quite passive and relaxed by comparison to the LSLRH - For example "[SU] has identified that she wants to expand her social network within the Warwick area and therefore is using support to access this with NG Healthcare and independently". This then helped inform the conditions placed for "[SU] to arrange with NG Healthcare how her 10 hours support is to be utilised to provide support now [SU] is in the community". The condition itself does not require or intend for the CMHT to intervene or become involved in any way, but instead places responsibility on the SU to dictate the arrangements of her care. The prediction that the CMHT would not be as aligned to biopsychatric models as seen in LSLRH is supported by this observation. The prediction did however underestimate the CMHTs alignment toward passive approaches as suggested by the amount of SU choice afforded in their proposal (18.68%).

There was limited argument offered for some of the conditions imposed (1.88%) however, particularly around the SP goals - take for example the SP goal to "support [SU] to maintain current stability in her mental health" for which the action to achieve is for the "[SU] to continue to engage with DBT, and appointments with [the Care Coordinator] from CMHT." DBT (Dialectical Behaviour Therapy) is presumed to be having a positive effect, otherwise it would not make sense to be recommending the SU continue to attend sessions, but this is not explicitly stated. This could equally have been one of many therapies already offered to the SU, however too early to know its efficacy. The reasons or benefits for continuing the sessions were therefore elusive and perhaps limited since no other strategy had been proposed to

achieve the same goal. This also appeared to be evidence of a biomedical discourse since the statement relied on the taken for granted knowledge that behaviour therapy or medication are the sure routes to maintaining mental stability, by contrast to meaningful relationships or purpose, such as in employment. The second, and final SP goal was for the SU to "continue to attend meetings with Children's services regarding [SU]'s ability to parent [her son]" for which the 'action to achieve goal' was to "continue to attend meetings and provide feedback to children's services and express concerns and positive aspects regarding [SU]'s parenting." This goal appeared rather short-sighted since the SU was to continue attending these services to no clear end. Perhaps a more appropriate goal might have been for the SU to be able to care for her child confidently and independently, which would still justify going to Children's Services for assistance and learning. This actual statement however suggested the SU should maintain dependence on Children's Services for the foreseeable future since no timeframe for further review had been explicitly stated.

CMHT Risk Assessment

Similarly to the LSLRH, the CMHT's risk assessment also functioned as a log. There were no actions to be followed or mitigation strategies offered around the risks identified, or even any expository consideration of the SUs behaviour. The document simply contained a historical account of the SUs behaviour, and based on this information made assumptions about the probability and severity of those behaviours reoccurring. There was a small section at the end of the document detailing the risk management strategy, which simply stated how frequently the CMHT were visiting the SU, the additional support services she had access to and the advised action for the SU to take in the event of any relapse. The risk assessment therefore did not offer any additional insight into the CMHTs approach to care, since there was not any intervention outlined. All actions with regards to existing risks appeared to have been referred to another SP that had involvement with the SU, making the CMHT appear quite removed

from the SUs circumstances. The CMHT was not therefore passive in delivering treatment, but passive overall in their level of involvement.

RALE Care Plan

The majority of this document consisted of statements around intervention (20.04%), however these were largely supported by known facts (17.86%) and some argument was offered on the procedures proposed (8.91%). Around the topic of shopping for example it was stated that SU "maybe a bit confused at bigger stores like Tesco Warwick. She never had to do weekly shopping before...[this] is lack of experience and confidence...[and] [SU] shows some memory difficulties. On some occasions may forget e.g. where left trolley, where are the check-outs or what to buy..." The action to enable the SU to overcome these issues was for staff to therefore "...stay with [SU] and monitor, support and advise when needed… Try different techniques to make [SU] as much independent as possible... To create situation where [SU] can generate personal coping strategies... Monitor and record." The action to enable in this instance was focused on opportunities for the SUs to define coping strategies and become independent, implicitly allowing choice to the SU and even encouraging freedom and choice to the staff on the use of different techniques.

Another example around bank withdrawals stated that "She has to practice to become more confident...[therefore] Staff to supervise [SU] when she uses cashpoint. Record any concerns." Rather than actively engaging the SU, many of the instructions were around monitoring and recording the behaviour or allowing space and privacy if friends or family were interacting with the SU. The statements were too unobtrusive to be described as interventions even, but would be more appropriately described as close observations and 'safety net' approaches. For example - "There are some occasions when [SU] is approached by her friends when in a community. Staff to leave them to give some space and privacy...Staff to supervise [SU] when she uses cashpoint. Record any concerns...[SU] seems to budget her own money

very well. Staff at present more to monitor and contact with care co-ordinator if any concern occurs...Staff to not discuss [SU] with family. They need to be referred to [Care co-ordinator] if needs a chat. Staff to protect [SU]'s right to privacy and confidentiality." The only statements requiring engagement with the SU were around incorporating deescalating techniques at times of verbal aggression. Most interventions were therefore perceived as highly passive since staff were never instructed to directly engage with the SU as such unless a negative event (in this case episode of verbal aggression) occurred, for which specific deescalating techniques were outlined.

The observations made indicated that the document had a closer alignment to psychosocial models of service as evidenced by the contextual explanations and the SUs behaviour being understood in terms of learned behaviour or lack of experience rather than resulting from pathological explanations. Unlike the previous documents however, a strong endeavour to preserve the SUs right to autonomy and therefore SU empowerment is conveyed by the proposed methods and even text type, since this was more expository and contextual.

RALE Risk Assessments

Like previous risk assessments, both RALE risk assessments relied heavily on historical behaviour and known events (36.36% of statements in risk assessment 1 and 18.84% in risk assessment 2) to inform of their probability of reoccurrence and severity. However, specific interventions could be found here (27.81% in risk assessment 1 and 27.51% in risk assessment 2), rather than on the care plan as was the case with other documents. The interventions were, again, largely non-invasive since they allowed room for SU decision-making - for example staff were "to offer to dispose of rat poison, or any other potentially harmful substances in the event that S/User express[ed] a desire to consume this...If S/User [was] seen/heard crying staff to leave the room to allow S/User space to calm down...If S/User verbalise[d] intent to self-

harm, staff [were] to ask S/User what she want[ed] to do about this, in an attempt to overcome distress in more constructive ways...Staff [were] always to be a listener if S/user wish[ed] to talk...If S/User [had] self-harmed staff [were] to advise S/User to go to A&E or see a doctor. If S/User [was] unable to give a response or say "I don't know" then [staff were to] leave the room to allow S/User time to think about this option and report to Support Manager immediately..."

Given the amount of text and detail available in the document, the percentage of choice statements appeared proportionally lower than factual statements or conditions (9.22% in risk assessment 1 and 2.66% in risk assessment 2). Staff actions in this case, however, were non-intrusive or forceful. They were instead more passive since the actions were to offer guidance, rather than carry out activity on behalf of the SU. In this example, staff were instructed always to clarify the options available, but ultimately reserve the decision-making process firmly within the hands of the SU. This conveyed a highly passive approach since it always required the SU to dictate the trajectory of events, therefore supporting the original prediction for this SP.

5. Discussion

5.1 Overall Findings

Two predictions were found to be accurate – that the LSLRH would be highly active and that RALE would be highly passive. The CMHT however appeared to be a different breed of services, since it was found that they offered very limited intervention directly and instead referred SUs to other SPs. What could be said about this observation was that the CMHT were passive agents in their involvement. Some other lessons have been learned in addition to these outcomes however, which should be considered in future whether for research purposes

or service improvement, which are considered under the conclusions and recommendations section of the thesis.

The overall tone across all LSLRH was formal. Statements such as that the "[SU] will be prompted to attend community at 0930 hours… [SU] must be compliant with medication… [SU's] will be seen by her responsible clinician… shower or bath before leaving her room… clean her room before breakfast… prepare her own breakfast without assistance from staff…" for example, conveyed a rather dictatorial and sterile quality, stipulating precisely what actions and behaviours must be carried out with no opportunity for spontaneity. All statements largely began with "SU/staff will…" –conveying clear rules on what should happen, when and by whom. Even where choice and flexibility was attempted, as appeared to be the case with allowing the SU to choose her solicitors, certain controls had been put in place – i.e. "A list of solicitors will be given to [SU] to choose a representative of her own choice." Since the list had been compiled by someone other than the SU, any choice was in actuality limited to the options provided.

The final, and most telling assertion made in LSLRH documents, was "the need [for the SU] to understand the treatment being provided and for her to give valid consent" under the 'plan to be followed' section for ensuring the SU is aware of her rights. This statement should perhaps read that the SU should be made aware that treatment cannot progress without her consent, therefore should be made aware of the implications of her treatment and not receiving this in order to inform her decision. However, what the statement appears to convey instead is that she must not decline, she must simply consent.

Overall, the text across the CMHT's document largely consisted of "SU has/is…" statements suggesting the document drew on a lot of factual information about the SU and perhaps relied on lessons learned from other SPs. Most statements around any perceived requirement for intervention referred back to the SP supporting the SU to call for action,

rather than the CMHT recommending any action directly. The CMHT documents were generally a large record rather than strategic in nature, having less involvement with the actual recovery of the SU, but more the monitoring of it. CMHT role was therefore highly passive, by delivering recovery through referral and monitoring rather than delivering support directly to the SU.

Like CMHT documents, RALE gave a lot of consideration to the SU's past behaviour and known circumstances. Statements were more contextually-oriented, always referring to the SU's background to understand the current behaviour pattern and the opportunities presented in the current environment. Documents contained many "SU may..." statements, which referred always to the possibility of behaviour occurring and what to do in such events, rather than giving any certainty - "SU may forget…may find difficult to engage with others…may feel angry…may forget to [take medication]…" By comparison, LSLRH and CMHT were quite restricted in that interventions were presented to result from linear assumptions – e.g. SU will [do action] for which staff must [carry out X response]. The level of staff action required, was not too dissimilar to the LSLRH. However there was a fundamental difference in the instructions presented in the RALE care plan, in that they systematically focused on the beneficial outcome to the SU in a developmental/learning capacity whereas the LSLRH care plan attempted to justify their interventions simply from a risk-avoidance perspective.

In the literature, a lot of evidence suggested that there is insufficient opportunity available to SUs to assert themselves and define their needs (Masterson and Owen, 2006; Campbell, 2005: 80-81; Cutcliffe and Happell, 2009; Bentall, 2010; Leader 2012). By contrast, other research argues that great strides have been made toward more SU-led services already (Lakeman, McGowen and Walsh, 2007; Ritzer, 2007). One of the aims of this research was to explore these beliefs and examine the extent to which they may be true. Results showed that the LSLRH appeared to be in danger of repeating the mistakes observed by Masterson and

Owen (2006), where practitioners fail to consider additionally necessary aspects of empowerment, including availability of options and confidence in one's ability to make decisions, as exemplified by the list of solicitors provided to the SU to choose from, which suggested a doubt in the SUs ability to do their own research independently of the SP. In addition, and as highlighted in the SEU report (2004), the results also suggested that none of the SPs had considered the SUs ability to work, or even that this was a realistic goal. Even if this were not a realistic goal, it could be argued that this should be something to work towards in the long-term. There is perhaps all the more reason to begin addressing the issues as to why this may not be a realistic goal so that when it came to discharge, the SU would have some knowledge at his disposal around what he would like to do and how he should proceed to achieve this. Although SPs have attempted to address the problem of 'knowing what to do' with vocational services, as discussed in the literature, this has been treated as an end rather than a means. Thus the extent to which this informs SUs of what they should or can do for a living when, or indeed if, they leave hospital is questionable.

Similarly, the results suggested that little or no particular emphasis was made on meaningful relationships outside the hospital discourse in SP care proposals, which was another important factor identified by the SEU report (2004). We could argue that, particularly for SUs in long-term care, not having any role models outside the mental health discourse will only perpetuate goals that remain within the system. How should SUs know what they might want to achieve beyond the healthcare agenda, if they do not know what the outside world has to offer.

It was also highlighted in the literature that SUs had often complained about not being listened to, taken seriously, or informed enough about their medication (Campbell, 2005: 80-81; Cutcliffe and Happell, 2009; Bentall, 2010; Leader 2012). Unfortunately, one of the limitations of the study was that the SUs perception of the care being delivered was not

assessed, and any perceived shortfall in this respect could not be verified. That in mind, the results only suggested that the LSLRH did appear particularly sensitive to the SUs needs or right to withdraw as was found to be the case with the example around non-compliance with medication. Although the SU had been non-compliant in the past, no assessment for the reason around this was offered. Instead an increase in active approaches was adopted whereby the proposed intervention directed staff to remind the SU of the merits of the current medication, in an attempt to maintain compliance.

Finally, the issue of divergent agendas, identified by Perkins (2001), was also discussed in the literature as a large barrier to recovery that has often been overlooked. The results did in fact suggest that this may well be the case particularly for the LSLRH – take for example the condition that the SU had to take part in all activities available, strict daily routines imposed, and the absence of any section taking the SUs wishes into consideration. It may be the case that the SU's wishes were documented elsewhere, nevertheless, the argument I propose is why, if it were the case, that they should be considered outside the scope of the SUs care plan in the first place. The RALE document also does not reserve a dedicated section for this (like the CMHT's "SU's Goals" section) but did nevertheless include consideration of SUs preference within sections.

As the study used examples from only three SPs, the results were by no means generalizable, but did nevertheless offer a glimpse of how mental health care organisations currently work with service users. In addition, the particular method did not allow the assessment of SUs perceptions of the care being delivered, which could offer some verification of the power struggles perceived within the text. It is certainly recommended that if any future research of a similar nature is conducted that this is explored as it would have been particularly useful to verify whether, for example, SUs do still experience some level of 'civil death' as observed by Goffman (1991), and whether CPAs have become mere perfunctory

exercises as described in the literature as this would be an important observation for SPs around the UK to be mindful of. Most regrettably, the present study could not verify whether the health paradigm has offered SUs a route to exercising power that they would not otherwise possess if they were relieved of services, as such a finding would imply that SUs have much greater decision making power than originally considered, and perhaps lends much greater significance to the dangers of co-dependent relationships.

5.2 Theoretical Implications, Practical Applications and Limitations of the Research

Throughout this discussion, the most significant finding was the limited number of opportunities within the LSLRH service proposals for the SU's input on their care plan, despite their website supporting the empowerment of patients and using recovery and person-centred approaches. This was evidenced by the topics covered on their service proposals, as demonstrated in section 4.3, which merely reflected minimal health and safety obligations of the SP. Even SU needs such as leave had been prescribed, which led me to consider whether this would have been identified as a goal without prescription since this should be a basic human need. By the same measure, if such goals should be prescribed in order to be a recognised need of the SU, this might explain why meaningful relationships were also omitted in their care plans. What was observed in addition to the above was that the same SP threatened to withdraw said privileges, like leave, if the SU failed to adhere to the actions assigned to her. SPs have not come that far since Goffman's (1991) observation of the asylum mentioned in section 1.4 of the literature, since it would appear the same leverages are in place to maintain SU compliance by using 'house rules.' As discussed in the literature such processes make poor preparation for independent living. It was also demonstrated in section 1.1 that elements such as social relationships in particular have been a great barrier to SU reintegration into the community (SEU, 2004), so perhaps there is good reason for these not

only to be included in all service proposals, regardless of their prescription, but also recognised as a basic human need that should always be strived towards, rather than leveraged against the SU.

Another issue observed was the various inaccuracies on service proposals. SPs on a few occasions included actions that did not appear to necessarily support the desired outcome. This meant the SP was stipulating actions to be carried out by staff and the SU without much, if any, clear merit. In one example, the SP was to continue to persuade the SU to take her medication because it was explicitly stated that the SU had been non-compliant before. What had not been explicitly stated, however, was whether this medication was indeed improving the SUs outcomes and well-being. Moreover, at no point did the SP at least include an evaluation of the SU's reasons for refusing to take her medication in the past. The unquestioned assumption that medication makes one better, which was presumably the reason its prescription had 'gone without saying' in this example, could be an indication of taken for granted knowledge.

As a consequence of the observation made in the last paragraph, one of the final concerns remaining was that the current system was not critically self-evaluating or challenging of its own decisions. While SUs may, and should, take some responsibility for any health complications further to their lifestyle choices - such as lack of exercise, smoking, perhaps even self-inflicted injury - any remaining responsibility must ultimately be apportioned to those who care for them, particularly in locked wards where the SU's choice is highly limited, down to what they eat, what they do and who they see. While we might not be able to fix the harm SUs have inflicted upon themselves, and nor should we as much as safely possible when in our care, we must first attempt not to cause harm through their treatment - as per the physicians first Hippocratic oath 'first do no harm' (Bentall, 2010). How is it then, that a SU can be seen for a mere 15-30 minutes to decide the intervention, with only a review up to six

months later, or only when the SU is discharged or relapses as was found to be the case with the LSLRH risk assessment results outlined in section 4.3? Worse still, is that such decisions may be taken as gospel down the hierarchy, to the nursing staff who spend significant amounts of time with the patients with an abundant opportunity to observe and know them, and yet do so with little critical consideration regarding the benefits and indeed appropriateness of the interventions proposed in care plans and risk assessments alike.

It is perhaps appropriate at this point to ask whether there is a danger, particularly with EBP, that in many cases nurses take for granted a given treatment that has been offered, because they presume it would only be so if it had been a success with other patients. As a consequence, however, might they then neglect the signs that suggest it is not working for their own SU? Moreover, could it be that the first time nursing staff meet their patients is on paper and, if so, does this not predispose and pre-empt them to feel a certain way about him or her - have certain prudence and expectations, which then form apprehensions and presumptions about the SU, shape their intolerance toward a facet or behaviour? It is perhaps precisely these circumstances that lead practitioners to become overly cautious to the point of disengaging SUs when an escalation is predicted, and manage an incident that in actuality never even materialised. This shuns SUs from themselves and others, ultimately narrowing the range of people, and by extension mind-sets and culture, with whom they can engage; leaving merely those who derive from a clinical setting to learn from. These are in fact so few examples of how to live and opportunities for learning. This appears good reason to take special attention with how we describe our SUs on paper and include SUs as fully as possible in shaping their treatment, to take care not to discriminate against them, misjudge their preferences or right to protest. We should perhaps take care to clearly justify any actions, not only from the perspective of safety and benefit to the institution and community, but firstly and most importantly, from the SU's unique personal needs and preferences in addition to their physical requirements. To accept him and her as a whole person, capable of real feelings,

in need of meaningful relationships and a right to his own personal life journey. Having considered the importance of language in shaping our reality, and the discourses exercised within the texts examined in this thesis, I would highly recommend further examination of service proposals, but also their level of influence on carers and nurses alike who spend a significant amount of time with SUs. That being said, future research should also consider the extent to which any nurse or mental health practitioner can truly influence a SU's freedom if the context in which they work imprisons them too. We should therefore also look beyond the agent, and consider the macro-systems that perpetuate a discourse of disempowerment between SUs and SPs by, for instance, examining staff documentation and management.

One final example of SPs failure to be critically self-evaluating is telling of the reality we recreate for SUs. In this excerpt, the goal for the SU to become independent was to be achieved by having her undertake a number of tasks – set out by the SP - on a routine basis such as, getting up at a particular time every day, making the bed and washing laundry, etc. What this action conveyed was the SP's failure to understand the very meaning of the term independence, since it is not the action being carried out but its instigation that would define whether one is being truly independent. At the bottom of these actions one can read the following: "No leave to be facilitated if [SU] fails to adhere to the above structure of activities." Once again a SP has failed their opportunity to truly empower their SU and instead reinforced a prescribed lifestyle.

Given the above observations, it felt appropriate at this point to recommend that future research look at involving SUs more both in the research design as well as participants. Regrettably, this was a possibility that fell outside the scope of my study. As suggested by Peter Beresford's work mentioned earlier, such involvement could offer SUs a powerful avenue of expression and opportunity to challenge and influence mainstream discussions (Beresford, 2006). Through research one can not only disseminate knowledge but also offer

opportunities to support and validate it. Before one can even begin addressing the

disempowerment of SUs however, there remains a challenge around changing current

assumptions about what constitutes valid 'knowledge' as discussed in section 2.3 of the

literature review and again in section 3.1 of the methodology. It would appear that positivist

schools of thought, particularly in research, reserve far more power and high regard in the

eyes of policy, business and profession than reflective approaches (Beresford, 2006; Beresford,

2013), even though I have found that personal first-hand experience has been seemingly

irreplaceable in other areas of life, such as with developing one's career. Why should current

EBP lend greater validity to evidence found in numbers over experience when trying to support

intentions to personalise treatment? Should such research not begin with, and refer back to,

first-hand experience on which to build and base large-scale quantitative investigations? If the

subject under investigation is excluded from the discussion, then we already know not all has

been considered since a key stakeholder – in this case the SU - will have been omitted. How

can we know, with any certainty therefore, that what is of importance has been captured

without all things having been considered including the SU's experiences? I am not suggesting

that the 'objectivist' approach is not of importance, but rather that it is one that only offers

one perspective and interpretation of knowledge, meanwhile there is another remaining fairly

unexplored, which is that of the subject. This seems a paradoxical approach to research

particularly when attempting to 'personalise' treatments.

On the subject of research methodology, while the reductionist approach only offers

one interpretation of knowledge and bears its own limitations, which were explored in section

3.1, so too does the reflective and introspective approach embraced here. Although the

qualitative approach adopted here has allowed for a detailed and in depth discussion, it has

undoubtedly relied heavily on my individual skills as a researcher (Bentall, 2010) and been at

the mercy of my own biases and idiosyncrasies (Harper and Thompson, 2012; Coolican, 2009).

It is not only certain that I have shaped and guided this research to consider specific areas of

disempowerment, but also entirely possible therefore that I have missed some other aspects of the discussion that maybe considered to be just as important to others. The fact that this has been written from my perspective makes it inevitable that I have only brought what I believe to be important to this discussion. Hence the recommendation in the above paragraph to consider the involvement of SUs in the design of research as well as other stakeholders, particularly in research of a qualitative nature.

In addition to the current qualitative approach being limited by my own skillset and biases, there has been some challenge with maintaining and demonstrating rigor. Rigor not only refers to whether components under investigation are measurable and well defined, but whether the appropriate research tool has been selected and offers insight to an appropriate level of precision, ensures the discovery of a full range of relevant as well as salient themes and any relationships that may exist between them, etc. (Harper and Thompson, 2012; Coolican, 2009). My approach to addressing this difficulty was to first ensure the research question was well defined and what was to be investigated was therefore clear. This would also help guide how this should be approached – in this case, examine the disjuncture between SP intentions to empower SUs and what they proposed in their service proposals indicated that this was, to some extent, an exploratory piece of work and would therefore require a research tool capable of discovering themes and topics as well as any patterns that may exist between them. However, actually demonstrating that the appropriate level of rigor had been adopted - that every theme and topic had been uncovered for example - was the greater challenge and would perhaps require making the data used available to readers. As this raised ethical issues particularly around maintaining appropriate data protection, this was not possible and, as stated earlier, it is entirely possible given my own biases that themes or topics worthy of discussion had been missed.

6. Conclusions and Recommendations

The present study's aim, to examine the extent to which mental health service providers' (SP) intention to empower their service users' (SU) is realised in their service proposals, was successfully pursued by examining the intentions perceived on their websites followed by a CDA of the service proposals of three SPs. Following a review of the literature, it was found that two basic approaches to treatment, i.e. passive and active, could be adopted that either facilitated or challenged SU empowerment and, to some extent, their recovery. The literature also helped shape the hypothesis that multi-occupancy facilities, such as mental health wards or units, would be inherently active in their approaches to treatment whereas community-based services were predicted to be more passive, which was later revealed to be largely supported by the results with the exception of the CMHT.

Most significantly, the analysis of the data for the LSLRH in particular suggested little may have changed in this context over the last decade since many opportunities for SU choice and control remained limited – an observation also made in previous research in similar contexts (Perkins, 2001; SEU, 2004; Masterson and Owen, 2006; Campbell, 2005: 80-81; Cutcliffe and Happell, 2009; Bentall, 2010; DoH, 2011; Leader 2012). Nevertheless, the results found for RALE offered some optimism in the context of community care, where a more reflective approach to care-planning was taken. It is recommended, given the importance of language in shaping discourse and reality, that further research of this nature is conducted to better inform service providers on how to best communicate treatment so that it is not perceived and consequently delivered in aggressive ways, but rather that a more passive approach may be embraced to better prepare our SUs for what awaits following discharge and a life recovered.

On a final note, I would like to take this opportunity to make clear the personal reasons for embarking on this project. Many times I have seen SUs and practitioners struggle to be candid with each other, which often meant SUs were defaulted to a child-like role parented by their consultants – a common power struggle as discussed earlier, which frequently led to the SU

remaining in services and failing to pursue a truly fulfilling life journey. In addition to this, I only knew few who had also experienced this or made similar observations. As a consequence, it has been rather lonely not only to know of these errors, even injustices, and have no-one with which to consult who shares this sentiment. This paper has been my opportunity to reach out to a wider audience of like-minded individuals who will, hopefully, embrace a vision of a system that is not only more effective but, most importantly, just.

7. References

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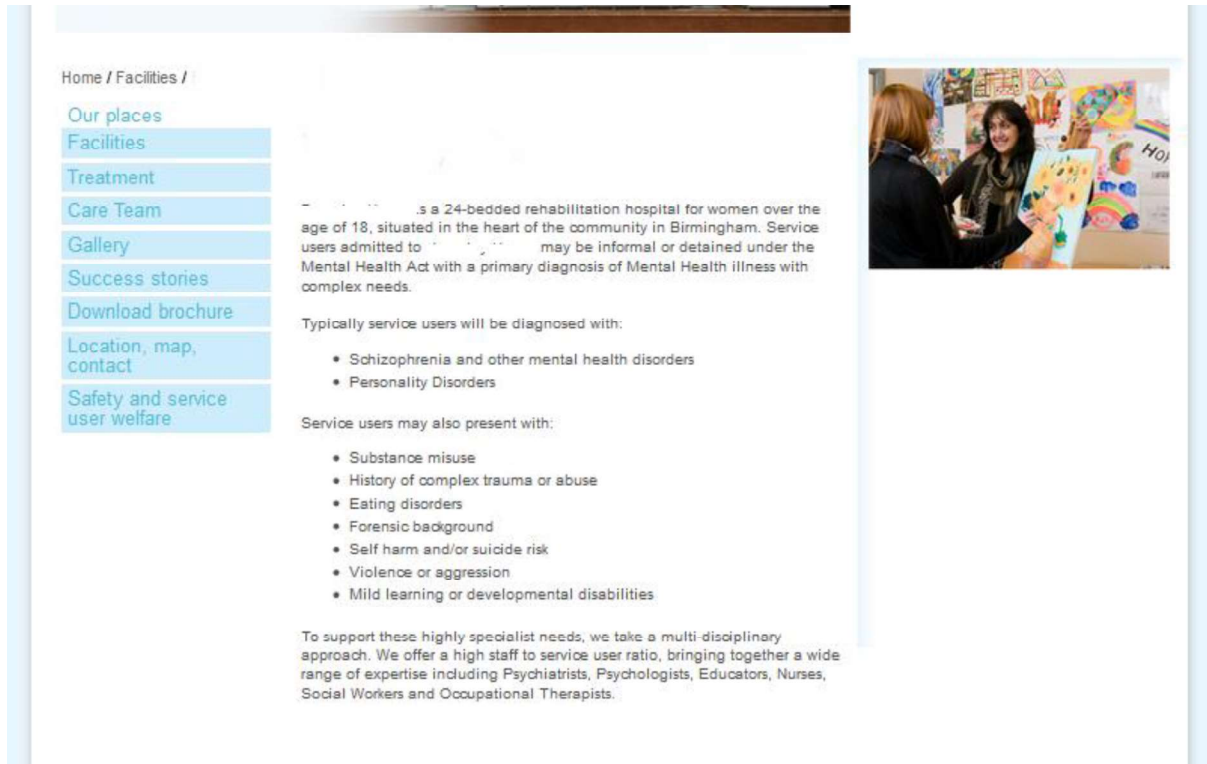World Health Organisation (1973), *International Pilot Study of Schizophrenia.* Geneva: World Health Organisation.

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8. Appendix

Appendix 1 – LSLRH Website and Brochure extracts

Appendix 1.1 –Main page

Home / Facilities /

Our places
Facilities
Treatment
Care Team
Gallery
Success stories
Download brochure
Location, map, contact
Safety and service user welfare

.... is a 24-bedded rehabilitation hospital for women over the age of 18, situated in the heart of the community in Birmingham. Service users admitted to .... may be informal or detained under the Mental Health Act with a primary diagnosis of Mental Health illness with complex needs.

Typically service users will be diagnosed with:

- Schizophrenia and other mental health disorders
- Personality Disorders

Service users may also present with:

- Substance misuse
- History of complex trauma or abuse
- Eating disorders
- Forensic background
- Self harm and/or suicide risk
- Violence or aggression
- Mild learning or developmental disabilities

To support these highly specialist needs, we take a multi-disciplinary approach. We offer a high staff to service user ratio, bringing together a wide range of expertise including Psychiatrists, Psychologists, Educators, Nurses, Social Workers and Occupational Therapists.

Appendix 1.2 – Facilities page

This **i**
viewed in the Lanchester Library Coventry University.

Appendix 1.3 - Treatment page

This **i**
viewed in the Lanchester Library Coventry University.

Appendix 1.4 – Care team

This **i**
viewed in the Lanchester Library Coventry University.

Appendix 1.5 – Gallery page

This **i**
viewed in the Lanchester Library Coventry University.

Appendix 1.6 – Success stories page

This **i**
viewed in the Lanchester Library Coventry University.

Appendix 1.7 – Safety and SU welfare page

This **i**
viewed in the Lanchester Library Coventry University.

Appendix 1.8 – LSLRH Brochure

This i
can be viewed in the Lanchester Library Coventry University.

This i
be viewed in the Lanchester Library Coventry University.

Appendix 2 – CMHT website

Appendix 2.1 – CMHT Mental Health page

This i
the thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2 – CMHT website

Appendix 2.2 – CMHT Our Services Page

This i
of the thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2.2 – CMHT Our Services Page

Appendix 2.3 – CMHT Veterans Project Page

This i
thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2.4 – CMHT IAPT pages

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Appendix 2.5 – CMHT Care Clusters Page

This i
the thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2.6 – CMHT Your IPU & You Page

This i
thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2.6 – CMHT Your IPU & You Page

Appendix 2.7 - CMHT Community Care Page

This i
the thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2.8 – CMHT Acute Care Page

This **i**
the thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2.8 – CMHT Acute Care Page

Appendix 2.9 – CMHT Rehabilitation page

This i
of the thesis can be viewed in the Lanchester Library Coventry University.

Appendix 2.10 – CMHT Referrals Page

This i
version of the thesis can be viewed in the Lanchester Library Coventry
University.

Appendix 3 – NGHealthcare RALE programme Website and Brochure extracts

Appendix 3.1 – NG Healthcare RALE programme Website

This i
viewed in the Lanchester Library Coventry University.

Appendix 4 – Mental Health Recovery Star (MHRS)

This i
the thesis can be viewed in the Lanchester Library Coventry University.

REGISTRY RESEARCH UNIT
ETHICS REVIEW FEEDBACK FORM
(Review feedback should be completed within 10 working days)

Name of applicant: Kathleen Dunham ....

Faculty/School/Department: [Faculty of Health and Life Sciences] ARC Psychology

Research project title: Exploring active and passive social practice in mental healthcare service proposals

Comments by the reviewer

1. **Evaluation of the ethics of the proposal:**
2. **Evaluation of the participant information sheet and consent form:**

3. **Recommendation:**
(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

	Approved - no conditions attached
	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary
X	Not required

Name of reviewer: Anonymous...

Date: 19/03/2014...