

Modern Pastors of Mental Health  
Recovery:  
An Ethnographic Study of the Recovery  
Approach in Wales

Rachel Levarre-Waters

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## Abstract

The recovery approach is now a central tenet of mental health policy in the UK. Despite its ubiquity there is evidence of confusion over its meaning and practice. In addition, recovery is accused of being a new iteration of neoliberalism with a focus on self-responsibilisation. Drawing on historical, ethnographic and discursive research conducted within mental health services in South Wales, this thesis explores how the contemporary recovery approach to mental health has arisen, how practitioners and service users enact it and the challenges and tensions that arise in practising in this way. The study draws on Foucauldian ideas of power and knowledge, with a focus on the role of language in recovery practices.

The historical study showed how a range of past approaches to mental health are reflected in the contemporary recovery approach and explored how these approaches gained the power to define how recovery has been understood over the last few centuries. The ethnographic findings show that practitioners of different professions work to a consistent version of recovery, focussing on 'what works' and promoting service user responsabilisation. Practitioners facilitated recovery through the use of pastoral power and specific discursive strategies. Service users exercised agency in aligning with or rejecting the recovery discourse and the process of engendering recovery subjectivities in service users was complex, unpredictable, and sometimes unsuccessful. I draw on Hacking's (1996) work on looping effects to show how professionals' categorisations of service users had important consequences for the service they received.

In considering recovery as a neoliberal solution to mental health problems, the study highlights the complex assemblages of people, policy, practices, laws and emotions that constitute recovery practice and concludes that in the field of neoliberal rationalities, recovery appears to be struggling to fulfil its programmatic aspirations and goals.

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## A Note on Language and Inequalities

The language used to talk about mental health issues is important as it can perpetuate stigma, act as a barrier to help seeking and create or maintain ways of understanding mental health that are unhelpful for people experiencing mental health problems (Kousoulis 2019). Many terms are used to refer to people who use or have used mental health services. These are contested and have different implications for understandings of mental distress, those who experience it and those who are involved in the system of mental health services.

I chose to follow the ethnographic tradition of employing the terms used by my participants who mainly referred to themselves as patients or sometimes service users at research sites one and three, and residents or housemates at site two. The staff often used the term client. Kousoulis (2019, para 18) warns that identifying someone as a “‘patient” or “service user” ... implies that they are defined by their diagnosis’. In the context of this study, I focused only on the participants’ roles as patients or service users whilst being aware that this was only one limited aspect of their selves.

The terms mad and madness have recently been positively reclaimed by the mad studies movement. However, they remain contested, and for some people, they are offensive (Beresford 2020). I have used the terms mad and madness in discussing the history of mental health to reflect the use of those words in certain periods of history and the term mad in relation to mad studies. I sometimes use the term distress instead of or alongside other terms such as mental illness or mental health problem. The term distress is used to refer to experiences or phenomena such as extreme and distressing emotions or hearing or seeing things that others do not experience. It is a way of referring to these kinds of experiences outside of a psychiatric framework (Cromby et al. 2013).

Research on social causation has shown that mental health has a complex relationship with socio-economic status, ethnicity, gender and sexuality (Pilgrim and McCranie 2014). Particular groups within our society are at greater risk of mental health problems as a result of their social, environmental and economic circumstances. Deprivation, disadvantage and oppression intersect with ethnicity, gender, disability



and sexuality to impact on people's experience of mental distress, diagnosis and use of services (Mental Health Foundation 2020). This area of research is extensive and important and yet lies beyond the scope of this thesis. This thesis will not directly address the issue of mental health inequalities but maintains an awareness that interactions in mental health services take place in this context of inequality and oppression.



# Chapter 1: Introduction

## 1.1 The Recovery Approach in Mental Health

Recovery in mental health has traditionally meant an end to symptoms of mental illness. However, over the last 30 years, it has come to have an alternative meaning, which has both political and practical implications (Pilgrim 2008; Winship 2016). The 'new' recovery is understood as emancipation and the recovery of a meaningful life after the traumatic experience of mental distress (Winship 2016). The recovery approach advocates a new and more equal relationship between professionals and service users. Service users' expertise should be valued, and following from this, they should be in control of both their personal recovery journey and the treatment and support offered by services, which should assist in this journey (Shepherd et al. 2010). References to a recovery approach, or aspects and attitudes compatible with a recovery approach, began to appear in UK mental health policy in the early 2000s (DoH 2001; WAG 2001), and the approach is now accepted as the standard to which all UK mental health services should adhere (Mental Health [Wales] Measure 2010; *Together for Mental Health* 2012).

However, despite its ubiquity in policy, the literature suggests that many practitioners and service users are confused about the meaning of a recovery approach. There is evidence that this vagueness has led to the development of different versions (Pilgrim 2008; Woods et al. 2019; Jorgensen et al. 2020) or enactments (McWade 2016) of recovery and also that professionals' practice may not reflect the version of recovery they describe in research interviews (Osborn and Stein 2017). In addition, the practice of recovery takes place within a complex political context in which various discourses and agendas (such as biomedical and risk management) are used to advocate conflicting approaches. This has resulted in a mental health system often being pulled in different directions, causing uncertainty, tensions and dilemmas for mental health practitioners and service users (Simpson et al. 2016). More recently, attention has been drawn to the potential alignment of recovery policy with neoliberal rationalities of government in which citizens are expected to take responsibility for their own self-management (Harper and Speed 2012; Braslow 2013; Rose 2014).

My interest in the recovery approach is rooted in my own experiences. I qualified as a social worker in 1999 and over the following twelve years, I worked for a number of statutory, user-led and third sector mental health organisations. During this time, I was involved in the growth of the recovery approach, and I experienced some of the confusion and tensions noted in the literature. My experience left me feeling ambivalent. I felt very comfortable with the value base of recovery, and in some of my roles, it had felt like an effective and positive way of working. However, in other roles, it had felt almost irrelevant as I struggled to engage with and support severely ill and marginalised service users who I could not imagine being able to take responsibility for their recovery.

These experiences guided my approach to the topic: I chose to explore rather than evaluate recovery. This led to the decision to investigate *how* practitioners and service users did recovery (as opposed to why or what they thought of it.) I also aimed to explore the challenges and tensions involved in practising in a recovery-oriented way. My study was informed by Foucauldian ideas about power; I focused on the contextualised, local practices of power enacted by professionals, service users and others and considered the interplay between power and knowledge in shaping practices.

## 1.2 Research Approach

I wanted to start by setting the current recovery approach within its historical context. However, in line with my ambivalent stance, I did not want to reproduce a traditional history showing the recovery approach as the ‘natural’ and ‘correct’ culmination of scientific progress or to take a critical approach focused on uncovering and liberating service users from the neoliberal rationalities underlying the contemporary recovery approach. I instead drew on Foucault’s approach to history to explore the conditions of possibility for the recovery approach. A genealogical approach offered a tool for analysis, which allowed me to consider the contingent power relations, which enabled particular discourses to operate as absolute truths in relation to mental health over the last 300 years (Tamboukou and Ball 2003). Foucault argued that ignorance of the

past meant one was limited by it (O'Farrell 2005). The historical analysis enabled me to explore how contemporary discourses, which have the power to constitute the problem and management of mental illness in today's mental health services, have achieved their status of 'truth' through the interplay between knowledge and power and an 'endlessly repeated play of dominations' (Foucault 1977b, p. 150, cited in Hill 2009). It revealed the multiple, contingent and arbitrary factors, which impacted the ability of different understandings of mental distress to be accepted as the 'truth' about mental health problems. A genealogical perspective has enabled me to be sceptical about what previously seemed natural, making it 'open to transformation, revision, abandonment and challenge' (Mendieta 2014, p. 113) and revealing the practices of power, which maintain and strengthen particular modes of understanding and addressing mental health problems over others. I hoped that this approach would help me think about the recovery approach creatively and come to distinctive and helpful findings and conclusions.

My aim to explore *how* recovery was practised *in situ* meant that an ethnographic approach was appropriate. It enabled me to observe recovery practice as it happened, rather than relying on accounts of what practitioners said they did. The longitudinal nature of ethnographic data collection also meant that I could observe potentially different versions, contradictions and tensions over time, rather than relying on data gathered at one point in time, such as an interview. Ethnography has been impacted by poststructuralist ideas, which question the ability of ethnographers to capture participants' realities. It has been accepted that ethnographers cannot represent reality in a straightforward way through their writing, as they are not independent or outside of the society they attempt to describe (Hammersley and Atkinson 2007). My work draws on the poststructuralist writings of Foucault in considering how ideas in mental health care came to be seen as the 'truth' and focuses on the role of language in constructing reality.

### 1.3 Research Sites

The recovery approach should, under Welsh mental health policy, be practised at all statutory and third sector organisations providing mental health support and services.

My three research sites comprised a statutory community mental health team (Llan castell CMHT), a third sector housing organisation (Cartref Hapus Housing) and a third sector inpatient unit (Forest View Recovery Centre)<sup>1</sup>. I chose to study three mental health services in varied settings and contexts in order to identify potential differences in practices of recovery between the settings. More than three sites would have limited the amount of data I could gather at each site and less than three would not have allowed me to observe the practice of recovery in both voluntary and statutory, inpatient and outpatient settings. My reasons for choosing sites one (Llan castell CMHT) and two (Cartref Hapus Housing) were partly pragmatic, relating to accessibility geographically and in terms of gaining management and staff consent for my research. However, they did represent two of the kinds of settings that I wanted to explore (outpatient, statutory and third sectors). Focusing on sites that were welcoming of my research meant it would be easier to gain access to the kinds of situations I wished to observe. I selected Forest View because it was newly established with the explicit purpose of providing a recovery-focused inpatient service. I wanted to see if there were differences between practices of recovery at this site and the other sites, which, although also ostensibly committed to a recovery-oriented approach, had not originally been set up with this purpose.

#### 1.4 Data Collection

I spent several months at each site observing and recording occasions of talk, both formal and informal. I audio recorded formal care planning meetings between staff and service users and interviews with them. I took notes at multidisciplinary and other staff meetings where client case histories and current situations were discussed and also at house meetings between staff and service users at Cartref Hapus. I also observed (sometimes as a participant) and noted more informal instances of talk such as staff chatting amongst themselves and/or with me in various settings, such as the lunch break room, the office, the communal spaces at Forest View Recovery Centre, in their cars whilst travelling to and from service user visits or outside of clients' houses

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<sup>1</sup> Each site has been given a pseudonym.

before and after visits. I also observed and made notes about service users' conversations amongst themselves and/or with me; usually in their homes (including at site three, Forest View) and while doing activities together (such as cooking or gardening at Forest View) or before a member of staff arrived for a planned meeting at Llancastell CMHT or Cartref Hapus. Finally, I made notes about the physical settings, took photos of the offices and accommodation and collected a small number of leaflets and photos of posters from each of the sites.

## 1.5 Theoretical Framework

Much of the day-to-day work of mental health professionals is carried out through verbal interactions with service users. The observations I recorded using the audio recorder and making notes mainly consisted of talking and occasionally arguing, shouting or crying. When a professional met with a service user to carry out their job of supporting them in their recovery, they just talked, usually for an hour or more. It made sense therefore to focus on what was happening during this talk: how did talking constitute recovery-oriented practice?

I chose to combine an ethnographic approach to collecting data with a discursive analysis informed by Foucauldian ideas around power and knowledge. The use of multiple approaches to discourse analysis within the same study raises tensions due to the different assumptions and foci of the different styles of analysis. However, my approach builds on a body of work, which has synthesised various discourse analysis approaches (Wetherell 1998; Edley and Wetherell 2001; Brownlie 2004; Riley et al. 2010). Through using Foucauldian ideas of governmentality alongside a discursive psychological analysis of my data, I have been able to show 'how subjectification processes unfold' (Brownlie 2004, p. 521) in the context of recovery in mental health services. I was interested in how participants used discursive strategies to accomplish particular actions, how they drew on wider discourses as resources in interactions and how they were constructed by those discourses. A discursive analysis enabled me to explore the social actions happening through the interactions and how the concept of recovery was 'described, invoked and consequential for social interaction' (Wiggins 2017 p. 5). My study of Foucauldian ideas alongside the discursive analysis enabled me

to recognise the practitioners' use of power as pastoral and led to an engagement with governmentality literature that focuses on the role of the modern pastor (Waring and Martin 2016; Waring and Latif 2018).

Foucault (1994) identified different forms of power that were dominant in certain time periods in history but all of which continue to exist today in the operation of recovery. The historical study showed that power in contemporary mental health services operates in multiple forms. Juridical power is still exercised through the Mental Health Act, which allows for the involuntary incarceration of people considered mentally ill and at risk. In my study, I observed professionals working through their interactions to justify the use of this power and demonstrate their continuing commitment to non-authoritarian practice. Disciplinary power was exercised daily as staff observed and monitored service users' behaviours and expressed thoughts and feelings, not just in institutions but in the service users' own homes. Service users were encouraged to monitor their thoughts, feelings and behaviours in the absence of staff, sometimes using charts and graphs. Observations were recorded and shared with other professionals. Service users' behaviour was compared explicitly or implicitly to desired or 'normal' behaviour, and plans were made for treatments or support to bring their behaviour, thoughts and feelings into line with what was considered 'appropriate'.

## 1.6 Outline of Main Findings

Practitioners usually exercised pastoral power in their interactions with service users. As modern, secular pastors, they observed and monitored service users' thoughts, feelings and behaviours and showed concern for their wellbeing. They also persuaded and encouraged them to take responsibility for their recovery, to self-manage and work towards independence from services through engaging with the various treatments and supports offered. Pastoral power was exercised in a context of pluralism where multiple approaches and understandings of mental distress were accepted as valid.

The services worked in a multidisciplinary way, with each profession (including psychiatrists, social workers, community psychiatric nurses, occupational therapists, psychologists, recovery workers and (peer) support workers) using their expertise and



knowledge to recommend and provide treatments and support to service users. However, across all the professions and roles, the recovery approach was evident as an overarching framework. It shaped expectations for the kind of relationships that should be achieved between staff and service users and the behaviours and attitudes expected from service users.

In contrast to the findings of previous research, the medical model was not the dominant discourse within the services studied. The professional participants drew on a variety of explanatory frameworks to account for their clients' mental health difficulties and to decide on appropriate treatments. Their explanations of service users' problems often related to past experiences of trauma and/or difficult social circumstances. There was a focus across all professions on moving the service user towards independence and self-management. The concept of recovery, as used by staff, appeared to refer to an attitude of optimism and engagement with proposed treatments and supports, rather than to any improvement in quality of life. I draw on Hacking's (1996) work on the looping effects of human kinds to help explain the complexity of mental health classifications.

Hacking (1996) proposes that the social sciences' aims to categorise people and intervene in their lives have led to the development of new kinds of classifications of people, such as 'homosexual' or 'mentally ill'. As people are conscious of the way they are classified, they can react to these classifications through their behaviour, which is then noted by professionals and feeds into future 'knowledge' about these classifications. My findings suggest that the discourse of recovery has led to professionals observing service users in new ways, leading to new classifications of engaging or non-engaging. As engagement is seen to lead to recovery and non-engagement to non-recovery, these classifications have come to merge with the classifications of a recovering and non-recovering service user, demonstrating Hacking's idea of 'wandering' (Hacking 1995). These categorisations had significant implications for service users.

Mental health professionals across all three research sites practised the recovery approach through the use of specific discursive strategies within a pastoral power

approach to encourage recovery in service users. This included constructing subjects and objects in particular ways, reinforcement of desired attitudes and behaviours and threat of penalties for behaviour that was not in line with a recovery approach. However, this process was not straightforward; there was evidence of resistance, contradictions and ambiguity, and the processes involved were messy and incomplete. Service user agency was an important factor in the success or otherwise of recovery. Although some service users constructed themselves as striving towards responsibility and self-management in line with recovery discourse, others rejected recovery, pathologising themselves through drawing on biomedical discourses to exonerate themselves from taking responsibility.

The thesis contributes to the literature on recovery in mental health services by providing details on how practitioners practice recovery through discursive strategies in their interactions with service users and how service users accept or resist recovery through their own discursive strategies. It also identifies barriers to recovery, which have not previously been noted in the literature.

The concept of neoliberalism has become ubiquitous in the social sciences. It is used to describe a range of post-welfarist forms of government and has come to be accepted as 'one of the most defining features of economic and social governance worldwide' (Higgins and Larner 2017, p. 1). There is a risk that the increasing proliferation of the term neoliberalism across multiple contexts and disciplines without clear definition will lead to it being so broad as to become meaningless (Venugopal 2015). My analysis of 'actually existing neoliberalism' (Brenner and Theodore 2002), helps 'delineate and describe neoliberalism' in mental health services, 'trace its spheres of operation' and 'explain its dynamics' (Venugopal 2015, p. 167). Rather than assuming that processes are straightforwardly neoliberal, it attempts to reveal the ways in which 'neoliberalization' (Peck and Tickell 2002) within mental health services is diverse, complex and contingent.

## 1.7 Thesis Outline and Structure

Following this introduction to the thesis, Chapter 2 will give an overview of the theoretical and empirical literature surrounding the concept of recovery. The literature

review starts by looking at service user writings from the 1980s which began to explore some of the concepts later seen in the recovery approach such as service user expertise and user-led services. I then go on to consider the large body of research, which has focused on the meaning of recovery and the resulting multiple typologies and versions of recovery, as well as tools to measure service users' recovery. I then discuss recovery in UK and Welsh mental health policy before focusing on the development of recovery approaches in mental health services. I briefly outline the resources and measurement tools intended to enable recovery-oriented services as well as looking at the literature on the effectiveness of recovery-oriented practice. I then describe the criticisms that have been levelled at recovery, in particular the accusation that it has been colonised by neoliberalism and has moved away from its original emancipatory aims (RITB 2016).

I end the chapter by showing the limitations of the current literature and demonstrating the need for my study. The findings of recovery studies consistently conclude that attempts at recovery-oriented practice are thwarted by macrolevel policy and discourse. I argue that a historical study of approaches to mental health is therefore required to clarify the complexity and contradictions, which haunt the contemporary recovery approach. The literature on recovery has relied on interviews and surveys to gather retrospective and/or hypothetical perspectives on recovery but has neglected the question of how practitioners practise recovery. I argue that ethnographic discourse analysis enables an in-depth exploration of *how* practitioners and service users practise recovery in specific and concrete contexts.

Chapter 3 explores the conditions of possibility for the emergence of the contemporary recovery approach by offering a historical account of the changing meanings of recovery over the last 250 years. I explore a range of understandings of mental illness/distress, which influenced responses to mental health problems across the eighteenth, nineteenth and twentieth centuries as well as considering changes in organisational arrangements for the care of people with mental health problems in the twentieth century. I argue that an increasing focus on risk in mental health policy and practice, along with a move toward neoliberal policy, meant that recovery became a resource, which has enabled professionals to engage service users in managing their

own risks. It has allowed them to advocate neoliberal values of self-management and responsabilisation whilst ostensibly promoting the humanistic values, which characterised earlier more emancipatory versions of the recovery approach.

Chapter 4 describes the conduct of the research. The epistemological and methodological approach is explained and justified. I then describe the procedures involved in preparing for the research, including the NHS ethical approval process as well as discussing the ethical issues significant to my study. I describe how I gained access to the research sites and offer a brief description of each site, along with an account of how the data was gathered there. I reflect on the fieldwork, especially in relation to my identity as a professional social worker and the impact this had on the research. Finally, I give an account of the process of data analysis.

Chapters five, six and seven describe the findings from the fieldwork. Chapter 5 focuses on instances where recovery seems to be 'working' and shows how professionals exercise pastoral power and use specific discursive strategies to encourage their clients' recovery. Chapter 6 looks at cases where recovery does not seem to be working. Professionals here use the same strategies, but they are rejected by service users. The interactions involve participants managing issues of accountability, stake and responsibility and show that service users sometimes draw on biomedical discourses to construct themselves as unable to engage with recovery. They also sometimes reject the cognitive-behavioural approach that is promoted by staff.

Chapter 7 examines the limits of recovery. It explores what happens when the consistent use of pastoral power and discursive strategies fail to lead to a service user's recovery. When a recovery approach consistently failed, one of two options was taken: discharge from the service or the introduction of an authoritarian approach. These options were presented by practitioners as unavoidable last resorts (Emerson 1981) and were justified by reference to forms of risk. Within the service, the term responsibility was generally used in line with neoliberal ideas of self-management and responsabilisation. However, when justifying a more authoritarian approach,

practitioners drew on an understanding of responsibility in line with a relations of care framing (Trnka and Trundle 2014).

Chapter 8 brings together the findings from the three empirical chapters and discusses them in relation to the literature. In this chapter, I revisit the governmentality literature to consider the role of professionals as modern pastors. I also consider recovery as a neoliberal solution to the problem of mental distress and reflect on the complexity of the processes involved, drawing on the work of Hacking (1996). I suggest some of the implications for practice raised by my study. Finally, I consider the findings in relation to the recovery literature, note the novel findings of the present study and suggest how they might inform future research on both recovery and governmentality.

## Chapter 2: Literature Review

### 2.1 Introduction

Over the last two decades, the recovery approach has moved from a marginal discourse to become a central tenet of mental health policy in the Western world. Recovery-orientation is now a requirement of mental health services in Wales (Welsh Assembly Government (WAG) 2010; WAG 2012), across the UK (Dept. of Health 2001; Scottish Executive 2006; Thompson 2017) and internationally (President's New Freedom Commission on Mental Health 2003; Mental Health Foundation of New Zealand 2008; Mental Health Commission of Canada 2009; Commonwealth of Australia 2009). In addition, the approach has been accepted and promoted by a number of high-profile organisations in the UK, including the Social Care Institute for Excellence (SCIE 2007), the Royal College of Psychiatrists (SCIE 2007), Rethink (Rethink 2021) and Hafal (Hafal 2017).

However, despite its ubiquity in policy, it is not possible to give a precise definition of recovery as the concept remains polyvalent and contested (Pilgrim 2008; Woods et al. 2019; Jaiswal et al. 2020). Most accounts refer to Anthony's (1993) definition of recovery as a 'deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles[.] ... [A] way of living a satisfying, hopeful and contributing life even within the limitations caused by illness' (Anthony 1993, p. 21). Many definitions in the literature also include the notion of recovery as a personal and unique journey, often involving a number of processes, such as developing hope for the future, finding meaning in life, taking control of life and illness and developing a positive identity (e.g. Bonney and Stickely 2008; Leamy et al. 2011; Jose et al. 2015). Recovery-oriented services are generally characterised as recognising the expertise of service users and enabling them to take responsibility for their recovery (Shepherd et al. 2010).

However, around these core features, different versions of the approach emphasise different aspects and may include features that are in opposition to other versions. For example, Pilgrim (2009) distinguishes between recovery through medical

treatment, recovery through rehabilitation and recovery through freedom from coercive mental health services. In addition, some versions of recovery presented in government policy or in organisations' mission statements may differ from the versions actually practised in mental health services where competing organisational agendas and policies impact its implementation (Simpson et al. 2016). The complex history and political implications of recovery as a concept have contributed to the ongoing existence of multiple strands of understanding and associated practices resulting in the concept becoming 'a co-opted, near toothless gospel of hope' (Hopper 2007, p. 877). Shepherd (2017) poses the question 'How did we get into this muddle?' in reference to the huge gap between the various understandings of recovery. One possible reason for the continuing lack of consensus, which has now lasted almost twenty years, is that the ambiguous nature of recovery has benefits for the many interest groups with a stake in the concept (Pilgrim and McCranie 2013). As long as the concept remains vague, it can be moulded to fit the particular aims and beliefs of whichever group is using it to promote their cause, service or policy.

Another potential reason for the longevity of the concept is that it could be considered a keyword (Williams 1975 cited in Ferguson 2007). Keywords have two main characteristics: multiple meanings and entirely positive connotations, which make it difficult to disagree with them. Examples of keywords in the social care field include 'community' and 'personalisation' (Ferguson 2007). Recovery could also be considered a keyword; after all, who could disagree with a recovery approach to mental health problems? The remainder of this chapter will seek to illustrate how this situation has come about through a review of the recovery literature. The next section will focus on the origins of the recovery approach.

## 2.2 The Origins of Recovery

The recovery approach has a number of historical threads; it can be seen in the moral treatment approach of the 18<sup>th</sup> century, in the anti-psychiatry movement of the 1960s and 1970s and in 21<sup>st</sup> century mental health policy (Jacobson 2004; McWade 2016) all of which are explored in detail in the next chapter.

The contemporary recovery approach is often presented as originating in the writings of service users and survivors<sup>2</sup> of mental distress and/or psychiatric services (McCranie 2011; Edgely et al. 2012; Pilgrim and McCranie 2013; Coffey et al. 2019) which were then developed by psychiatric survivors and activists, and eventually translated into recovery-oriented services (Pilgrim and McCranie 2013). Many of these writings contained critiques of mental health services by service users who had diagnoses of schizophrenia or psychosis. In the 1980s and 1990s, despite research evidence to the contrary (Jacobson 2004; McCranie 2010), people with these diagnoses tended to be seen as chronically ill with little if any hope for recovery (Pilgrim and McCranie 2013). Researchers and professionals drew on the ideas in these service user writings to challenge the notion that psychotic illness is necessarily chronic, and to inspire both people diagnosed with serious mental health problems and the professionals who worked with them (Pilgrim and McCranie 2013). The recovery approach is therefore especially relevant to people diagnosed with serious mental illness, particularly schizophrenia or psychosis.

Judith Chamberlain's (1978) book *On our own* is often cited as the start of the drive towards a recovery approach (Edgely et al. 2012). Although Chamberlain did not specifically mention recovery as an approach (Harper and Speed 2012), the book called for service users and survivors to recognise and use their expertise to provide their own mental health services to each other. *On our own* marked the beginning of many personal accounts of recovery that some argue provided the foundation of the service user-led recovery movement (Edgely et al. 2012; McCranie 2011) before the approach became institutionalised in mental health services.

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<sup>2</sup> E.g. Chamberlain 1978; Lovejoy 1982; Leete 1989; Unzicker 1989



However, this narrative of an 'original' service user-led recovery approach has been challenged. McWade (2016) argues that rather than an original service user version of recovery being taken on by services, the early concepts of recovery were instead used by the New Labour UK government of the late 90s and 2000s to develop a more coercive mental health system which silenced both current and historical service user activism, instead strengthening both the medical model and psychiatric practices. In line with this narrative, Harper and Speed (2012) point out how the understanding of recovery often used within UK policy documents draws on the definition of recovery offered by Anthony (1993) which requires the person in recovery to accept that they have a medical illness: '...It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness' (Anthony 1993 p. 21). Harper and Speed (2012) argue that this version of recovery individualises distress, calling for service users to change their 'inappropriate' (p. 12) cognitions and behaviours, whilst neglecting issues of structural inequality.

Service user personal accounts of recovery have characterised it as an individual journey of learning and self-development, focused on finding meaning, ways to contribute, hope and possibility. Deegan (1997, p. 13), a survivor, psychologist and activist, described it as follows:

Recovery does not refer to an end product or result. It does not mean that one is 'cured'. In fact, recovery is marked by an ever-deepening acceptance of our limitations. But now, rather than being an occasion for despair, we find that our personal limitations are the ground from which spring our own unique possibilities. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process. It is a way of life. It is an attitude and a way of approaching the day's challenges.

Deegan (1993), and Coleman (1995) laid out the key concepts of recovery as a social process rather than a clinical one, person-led rather than professional-led and focused on strengths and abilities rather than deficits. The ideas of recovery quickly spread across the Western world. Research on the idea of recovery focussed services moved

away from the assumption of long-term in-patient care and towards more optimistic and specific treatment models such as rehabilitation (Pilgrim and McCranie 2013). In the UK, the move towards a recovery approach in mental health services was led by professionals and policymakers rather than service users (Perkins and Slade 2012), although the user movement certainly played a part in Wales (Newton 2017).

## 2.3 Recovery in UK and Welsh Policy

Ideas associated with a recovery approach first appeared in English mental health policy in 2001 (Perkins and Slade 2012). The first appearance of recovery in Welsh mental health policy is more difficult to pinpoint as the growth of recovery ideas happened at the same time as the move toward the devolution of health policy in Wales in July 1999. However, the 2001 *Adult Mental Health Strategy for Wales* clearly refers to a model of recovery (p. 3) and goes on to discuss principles of empowerment, user control and valuing user expertise (WAG 2001). Health policy across the UK in the 1990s and 2000s supported some aspects of the recovery approach, in particular the calls for increased user involvement, and this contributed to the acceptance of the approach within mental health services (Rogers and Pilgrim 1993; Pilgrim 2008). This issue is further explored in the next chapter.

The development of a recovery approach as part of UK mental health policy and services is not uniformly accepted as positive. It is criticised and contested (Recovery in the Bin [RITB] 2017; Rose 2019); this situation will be discussed later in this chapter. My three research sites were in Wales, and the next section will therefore set out the current recovery policy context for these services.

The *Mental Health Measure (Wales)* (2010) and its accompanying code of practice have a clear recovery theme. There is a focus on involvement and co-production (service users as active stakeholders in developing mental health services) and on a holistic approach to assessing and meeting needs. For example, care coordinators (professionals with responsibility for managing the care provided to an individual service user) must 'support the delivery of care and treatment in a way which is consistent with a recovery ethos, seeing the relevant patient's perspective and

maximising strengths and independence’ (Mental Health [Wales] Measure 2010, p. 21).

The Mental Health and Well-being Strategy for Wales, *‘Together for Mental Health’* (WAG 2012), and its accompanying delivery plan (Welsh Government 2016), set out a ten-year vision for mental health services, which focused on prevention and wellbeing as well as the provision of mental health services. In terms of service provision, the document emphasised the importance of a holistic, recovery and enablement approach, which was to be operationalised in services through care and treatment planning<sup>3</sup>. The delivery plan that accompanied the strategy had to, as one of its actions, ‘increase the availability of recovery-oriented services’ through increasing training in recovery principles for staff, service users and carers and by monitoring care and treatment plans for recovery-focused objectives (Welsh Government 2016, p. 28).

The Social Services and Wellbeing Act (Wales) (2014) came into force in April 2016 to provide the legislative framework for the way that social services are to be delivered in Wales. The key principles of the Act include listening to people and enabling them to take control of their care, supporting them to meet their own wellbeing needs, encouraging co-production and enabling people to become more involved in the design and delivery of the services they use, all of which encourage a recovery-oriented approach to service provision.

More recently, the review of the *Together for Mental Health* delivery plan (Welsh Government 2020) discusses the ‘importance of building in a recovery approach to service development and quality improvement’ (p. 37, action 6.1 ii). It also refers to increasing co-production, user involvement, peer-led services and self-management initiatives. The policy context for recovery reveals a key paradox in the institutional

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<sup>3</sup> Wales (along with the rest of Britain) was required to work within the ‘Care Programme Approach’ until June 2012 when this was superseded by the Part two of the Mental Health Measure (Wales) 2010. The process then became known as Care and Treatment Planning although it continued to contain the main elements of the Care Programme Approach.

practice of recovery: the enforcement of participation, engagement, taking control and responsibility.

Despite the frequent references to recovery and enablement approaches, recovery-focused objectives, recovery-oriented services, principles of recovery and establishing recovery mechanisms in key pieces of Welsh mental health and wellbeing-related policy, no definitions of any recovery-related terms are offered. The discussion in the various policy documents suggests that such approaches are person-centred and holistic, enabling people to fulfil their potential and become independent. The outcomes of the *Together for Mental Health* strategy document (WAG 2012) also refer to individuals having an 'increased feeling of input and control' over decisions related to their care and support. However, the term recovery is also used in a way that suggests it is an end state or cure: 'Access to, and the quality of preventative measures, early intervention and treatment services are improved and more people recover as a result' (WAG 2012, p. 15). The vague use of recovery in policy documents is not surprising given the continuing lack of consensus over the meaning of the term. Numerous studies have focused on gaining an understanding of the concept of recovery but have often continued to demonstrate complexity and ambiguity. Several authors have attempted to clarify the concept through the development of typologies, which I will discuss next.

## 2.4 Typologies of Recovery

A number of categorisations or typologies of recovery have aimed to elucidate the conceptual basis of the term. Jacob and Greenley (2001) distinguish between internal recovery, which refers to the attitudes, experiences and processes of individuals on their recovery journey and external recovery, which refers to the material context, policy and practice of recovery. Liberman and Kopelwitz (2005) split recovery into process and outcome, offering indicators that recovery has been achieved. Davidson and Roe (2007) also suggest recovery as a process and outcome with 'recovery from' meaning the remission of the symptoms of mental illness and 'recovery in' referring to an ongoing process of regaining control and quality of life despite ongoing symptoms. This is similar to Slade's (2009) categories of clinical recovery, which relates to the

remission of symptoms, and personal recovery which is an individual journey of transformation. Braslow (2013, p. 784) proposes three categories of meaning: recovery as a mental health system outcome, a subjective, ineffable experience and a system of values meant to articulate mental health delivery systems.

Pilgrim and McCranie (2013) and Jacobson (2004) offer more extended typologies of recovery. Jacobson (2004) suggests five types of recovery: recovery as evidence, which refers to evidence of the potential of people diagnosed with severe mental illness to experience a remission of symptoms; recovery as experience, which refers to the first-person narratives of people who have experienced recovery; recovery as ideology raises questions about how individuals' recovery should be supported; recovery as policy refers to how this ideology is translated into policy within mental health services and finally, recovery as politics refers to the impact of the material context on the actual practice of recovery. Jacobson's typology focuses on the processes involved in developing a recovery orientation rather than the meanings of recovery, which is appropriate in the context of her exploration of the real-life development of a recovery approach in Wisconsin, USA.

Pilgrim and McCranie (2013) propose four shades of recovery: recovery as a personal journey, an approach presented by many interest groups but most strongly endorsed by service users, which focuses on the unique experiences of each individual gaining control of their life; recovery as critique of services, a way to demand change to services focused on increasing choice and user empowerment; recovery as therapeutic optimism relates to Jacobson's (2004) recovery as evidence and is based on a belief in the possibility of a cure or at least the remission of symptoms and finally, recovery as related to a social model of disability, which calls for society to adapt to and/or value people's psychological differences.

Recovery can therefore be understood as a set of values, a policy, an outcome or a process, a personal, unique experience or a critique of more traditional (medical) approaches to mental health problems. Some researchers have tried to simplify this complex set of meanings by focusing on recovery as it was initially set out by service user activist: a unique, personal journey experienced by an individual in which they

come to terms with their mental illness and develop a satisfying and meaningful life with or without ongoing symptoms (Deegan 1993; Coleman 1995). This research has focused on conceptualising personal recovery and looking for shared elements in the unique recovery journey, which can be used to inform recovery-focused services (Leamy et al. 2011; Bird et al., 2012; Schrank et al. 2012; Slade et al. 2012a; Tew et al. 2012; Williams et al. 2012; Shanks et al. 2013; Bird et al. 2014; Le Boutillier et al. 2015).

## 2.5 The Conceptualisation of Personal Recovery

A significant contribution to the recovery literature has been made by Implementing Recovery through Organisational Change (ImROC), an organisation set up and funded from 2009 to 2014 by the UK Department for Health as part of their supporting recovery initiative. Although a recovery approach had been part of English and Welsh mental health policy since 2001, progress was slow, and many teams had simply renamed themselves recovery teams without incorporating any changes into their medically dominated practices (Perkins and Slade 2012). The work by ImROC was aimed at achieving real change toward a recovery approach. ImROC developed an intervention and model of recovery called REFOCUS based on substantial reviews of the existing literature and models of recovery. They also conducted new research to fill gaps in evidence, including those relating to Black and ethnic minority service users and drew on input from service users and other experts in recovery (Bird et al. 2012; Schrank et al. 2012; Slade et al. 2012a; Tew et al. 2012; Williams et al. 2012; Shanks et al. 2013; Bird et al. 2014; Le Boutillier et al. 2015).

As part of the above programme of work, Leamy et al. (2011) developed a conceptual framework of personal recovery based on a review of 97 papers. The review revealed 13 characteristics of recovery that mainly related to recovery as a unique, personal, non-linear journey, which may or may not involve a cure or intervention by professionals. The 13 characteristics were grouped into five key elements of recovery: connectedness, hope, identity, meaning and empowerment, making the acronym CHIME. Also important was the personalisation of care to suit individual service users. The authors pointed out that the framework was based mostly on research from English-speaking countries and may therefore not be generalisable to minority groups

(Slade et al. 2015). The five key CHIME processes are supported by both previous and subsequent reviews (e.g. Bonney and Stickely 2008; Jose et al. 2015). Further research has developed understanding of the CHIME processes and their importance in recovery.

Connectedness refers to relationships and support of all kinds, including from peers, family, and friends as well as a feeling of being part of a community (Corrigan et al. 1999; Resnick et al. 2005). Hope is an important requirement for recovery; hope that the person can live a meaningful and satisfying life is essential for the person with mental health problems and for those supporting them, including professionals (Bonney and Stickley 2008; Slade 2009; Stickely and Wright 2011). The recovery journey is thought to involve the development of a new and more positive identity, which integrates but is not characterised by the experience of mental illness. Positive growth might include developing understanding, personal development (May 2001b; Chadwick 2002; Repper and Perkins 2003), accepting and integrating the illness into the self-concept (Campbell 2001) and reclaiming a meaningful life (Mayers 2000; Bradstreet and Connor 2005). The process of empowerment relates to personal responsibility, a key feature of the recovery approach. Within a recovery approach, individuals are expected to take control, managing and shaping their own recovery journey whilst liaising with their supporters (Resnick et al. 2005; Pilgrim 2008; Young et al. 2008; Frese et al. 2009; Slade 2009).

The CHIME framework has subsequently been applied to mental health services for minority ethnic groups (Brijnath 2015; Song, 2017; Lim et al. 2019). It has been developed and extended to encompass a more collective notion of recovery (Price - Robertson 2017). In addition, it has been used to develop and evaluate various recovery-related strategies and projects with a range of populations (Benkwitz et al. 2019; Best 2019). The framework has also been criticised (Robertson Stuart et al. 2017) as overly optimistic, professionally imposed and at risk of blaming people for their lack of recovery through a lack of focus on the difficulties and setbacks they face. Robertson Stuart et al. (2017) identified an additional four themes that included difficulties such as ambivalence, disempowerment and financial worries.

The studies included in Leamy et al.'s (2011) review were required to provide a conceptualisation of personal recovery; studies that focused on clinical recovery were excluded. However, the relationship between personal and clinical recovery is complex and the two concepts appear to be correlated (Rossi et al. 2018). Resnick et al. (2004, p. 545) found that the severity of psychiatric symptoms was significantly and negatively correlated with recovery. They suggested that minimising 'the importance of symptoms ... in the recovery process may be unjustified and counterproductive'.

The CHIME framework research involved the (user-led) development of a recovery measure, the Questions about Processes of Recovery (QPR) questionnaire (Williams et al. 2015). The QPR questionnaire is one of the numerous measures of personal recovery that assess recovery outcomes, mental health recovery dimensions and mental health recovery stages or processes.

## 2.6 Measuring Recovery

Systematic reviews by Shanks et al. (2013) and Sklar et al. (2013) and a further, non-exhaustive review by Thompson et al. (2019) have identified 25 unique measures of personal recovery. In the UK, the Recovery Star is frequently used (Tickle et al 2013). Commissioned in the UK by the Mental Health Providers Forum (MacKeith and Burns 2010), it consists of ten domains of life that are described verbally and represented pictorially on a star diagram onto which service users can plot and plan their progress in each domain (Onifade 2011). In addition to measures of personal recovery, there are also a large number of measures to enable mental health services to assess their progress towards recovery-oriented practice<sup>4</sup>.

The lack of testing of psychometric properties is a weakness of recovery measures (Slade et al. 2012b; Shanks et al. 2013; Sklar et al. 2013). There are also issues with criterion validity: the extent to which the tools measure recovery, reliability,

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<sup>4</sup> For example, Recovery Attitudes Questionnaire (Borkin 2000); Recovery Knowledge Inventory (Bedregal et al. 2006); Recovery Oriented Practice Index [ROPI] (Mancini 2006 cited in Williams 2012); Recovery Oriented Systems Indicators [ROSI] (Dumont et al. 2005); Consumer Evaluation of the Collaborative Recovery Model [CRM] (Marshall et al. 2009)



responsiveness to change and feasibility, including resource implications (Burgess et al. 2011; Slade et al. 2012b; Williams et al. 2012; Shanks et al. 2013). Some commentators believe that it is not possible to measure recovery outcomes as they are unique to each individual and that imposing outcome measures reflects a narrow and judgemental understanding of wellness, which is not commensurate with the original values of the recovery approach (RITB 2017). This criticism is part of a broader critique of the recovery model and its place in policy, which will be discussed in more detail later in this chapter. Most recovery measures have been developed by academics and/or service providers for services to measure their performance in supporting people's recovery. The following section will consider the literature on recovery-oriented mental health services.

## 2.7 Recovery in Practice

Williams et al. (2012) define recovery-oriented services as 'the extent to which mental health staff and services attempt to facilitate or promote personal recovery and encompasses the different aspects of service delivery and practices that are believed to do this' (p. 1828). All statutory and government-funded mental health services in the UK are now required to practise in a recovery-oriented way. However, the extent to which this is happening is debatable, with many studies suggesting that recovery is more rhetoric than reality and raising concerns that some services have changed their name to include the word recovery without making any changes to the services they offer (Davidson et al. 2005; Perkins and Slade 2012). In the UK, a number of resources have been developed, aimed at enabling organisations to become recovery-oriented.

In 2011, the English government published its mental health strategy *No Health Without Mental Health* (DoH 2011). One of the workstreams supporting the strategy's implementation was ImROC. ImROC was a partnership between the Department of Health, the NHS Confederation and the Centre for Mental Health. It aimed to transform mental health services at all levels through assisting them to address ten key organisational challenges (Shepherd et al. 2008, 2010). These efforts were wide-ranging and included changing the culture, increasing recovery education and user involvement, achieving recovery-focused risk management and personalisation.

Organisations were encouraged to identify where they fell in relation to each challenge on a scale of three stages from engagement to development and transformation and to plan how to reach the next stage. Although the programme only applied in England, due to a personal contact between a senior Welsh mental health professional and a key person in ImROC<sup>5</sup>, Cardiff and Vale University Health Board were able to gain support through ImROC for their development of the recovery approach and worked with third sector and user-led organisations to develop a recovery charter for adult mental health services (CAVAMH 2011). In Wales during the 1990s and 2000s, there was an active network of service user and third sector groups across the country, facilitating user involvement in statutory and third sector services. The frequent information sharing between these groups helped disseminate information about the recovery approach and maintain motivation for recovery-focused services across Wales (Newton 2017).

## 2.8 Recovery Through Specific Initiatives

Much of the research on recovery practice in mental health services has consisted of small-scale, qualitative studies of specific recovery-focused projects, such as the use of recovery narratives, peer support and user involvement initiatives, shared decision-making, recovery colleges and direct payments. The majority of these studies have recorded positive outcomes. The following section will outline the evidence of their effectiveness, starting with the use of recovery narratives.

Sharing individual recovery stories played an important role in the development of the service user movement and the recovery movement. It enabled service users to build solidarity and hope and develop a collective awareness of stigma and discrimination (Llewellyn-Beardsley et al. 2019). The use of recovery narratives was later taken on by mental health services; both telling one's own story and listening to others' stories are thought to have benefits for service users (Onken et al. 2007; Rennick-Egglestone et al. 2019). In addition, recovery narratives have been used in staff training to increase

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<sup>5</sup> Personal communication; not referenced for reasons of confidentiality.

empathy (Deegan et al. 1996) and provide peer support (Morgan and Yoder 2012). More recently, concerns have been raised regarding the way in which a dominant genre of recovery narratives has come to restrict and constrain what can be considered a recovery narrative. A critical approach is called for that considers potential negative as well as positive impacts on individuals, also considering the use of alternative formats for exploring more varied experiences of recovery (Woods et al. 2019).

Sharing recovery stories has helped service users develop supportive relationships with each other, and this potential for peer support has been harnessed by user and provider-led services. Peer support in the context of mental health services refers to mutually supportive relationships between people who have lived experiences of mental distress (Christie 2016; Faulkner 2019). Repper (2013) suggests 'it occurs when people share common concerns and draw on their own experiences to offer emotional and practical support to help each other move forwards' (p. 4). Peer support in mental health has existed for centuries. For example, in the 1700s, former patients were hired as hospital workers as they were seen to be more understanding and gentler than non-patients (Davidson et al 2012). More recently, the start of the UK service user movement in the 1970s enabled service users to support and advocate for each other (Crossley 1998). In recent decades, as the recovery approach gained influence in mental health services, peer support roles have been developed in voluntary and statutory services (Repper 2013), supported by policy (Department of Health 2012; WAG 2012).

There is a growing evidence base for the positive impact of peer support in mental health services. Research in this area suggests that peer support can increase service users' self-esteem, confidence, sense of empowerment, problem-solving skills, quality of life and hope. It can increase access to work and education, improve relationships and reduce self-stigma, self-reported symptoms, care needs and hospital admissions (Bradstreet 2006; Repper and Carter 2010; Davidson et al. 2012; Boevink et al. 2016; Bellamy et al. 2017). Not all peer support projects achieve these positive outcomes, however, and Repper (2013) suggests this is related to the quality of selection, training and support of peer workers. The increase in peer support roles in the statutory sector

with increasing requirements for training and accreditation has led to fears of the professionalisation of peer support and the loss of its core values (Galloway and Pistrang 2019). In addition, substantial funding is more often given to service-led schemes that focus on individual rather than collective outcomes (Faulkner 2019). Others have noted the tendency for peer support workers to be employed by services to promote particular positive versions of the recovery narrative (Woods et al. 2019). Service user training for the peer support role is sometimes offered by recovery colleges, a recovery-focused intervention originally developed by ImROC.

Recovery colleges take an educational rather than a clinical or rehabilitative approach to improving mental health based on evidence, which points to the effectiveness of education in improving self-management. There is a focus on co-production, co-delivery and co-participation in various courses, such as understanding mental health conditions and recovery, life skills, peer support skills, advocacy, etc. Following the setting up of the first few recovery colleges, ImROC produced a briefing paper (Perkins et al. 2012) that outlined eight key principles for recovery colleges, which included co-production, reflecting recovery principles in all aspects of operation and culture and not being a substitute for mainstream mental health services or education. A number of studies have pointed to the positive impact of recovery colleges. There is evidence that they assist with people's recovery, lead to reduced service use, offer positive benefits for peer trainers, have a positive impact on staff attitudes, equalise the power imbalance between students and professionals and increase service user motivation for change (Meddings et al. 2015; Newman-Taylor et al. 2016). Responding to the recent criticisms of recovery colleges (RITB 2017), including that they are patronising, disempowering and of no value to service users, Perkins and Repper (2017) have acknowledged that some recovery colleges have deviated from the original eight principles. They call for a return to these principles and explain how deviating from them can lead to the kinds of problems highlighted by RITB (2017).

Another initiative aligned with recovery is direct payments (also known as personal budgets). The Care and Support (Direct Payments) (Wales) Regulations 2015 allow for the payment of sums of money directly to service users in order for them to purchase their own services. A number of studies have found personal budgets to have positive

benefits, including improvements in mental health and wellbeing, social participation and relationships, confidence and skills (Tew et al. 2015) and in increasing recovery thinking, processes and mobilising resources (Larsen et al. 2015). There is, however, criticism of direct payment schemes in that they can be complex to administer and that they redirect responsibility from the state to the individual (Spandler 2004; Taylor 2008), an issue that will be explored in more depth later in this chapter. Direct payments aim to give service users more control over their own care by making them the main decision-makers in procuring care services. Another recent instantiation of responsabilization is shared decision-making (SDM), an initiative that aims to increase user involvement in decision-making about their own care.

SDM is an approach to choosing between treatment options that involves both the professional and service user having access to relevant information and taking shared responsibility for the chosen option. This initiative is most closely associated with medically qualified staff and represents one way in which the medical model has been influenced by calls for more egalitarian relationships between professionals and patients (Roter 2000). It is a form of recovery initiative in that it requires increased service user control, choice and responsibility. In psychiatry, the approach is most relevant to discussions about medication, when the psychiatrist and service user should engage in a dialogue to achieve agreement (Pilgrim and McCranie 2013).

Broader user involvement schemes have also been developed, which attempt to harness service user expertise in developing, monitoring and improving mental health services. Service user involvement in services is supported by numerous health, social care and mental health policies and guidance (WAG 2010; Participation Cymru 2011; WAG 2012). Shepherd et al. (2010), in their 'implementing recovery methodology report' (discussed above), identify redefining user involvement as the seventh key challenge for organisations wanting to become recovery-oriented. To reach the final stage of transformation, service users and carers should be accepted as equal partners in care whose knowledge and experience are of equal value to professional knowledge. In addition, structures should be in place to ensure meaningful service user control over care processes, service development and governance (Shepherd et al. 2010, p. 14). The language of partnership in this report reflects the move towards

consumerism in health and social care services, which will be discussed in the following chapter.

Evidence regarding the impact of involvement suggests it can lead to positive outcomes for service users and services, including improved information and accessibility of services (Crawford et al. 2002), improved coordination of care and relationships between service users and practitioners and improved service user self-esteem and confidence (Nicholls et al. 2003; Coulter et al. 2007; May et al. 2009). However, there is also evidence of barriers to involvement, including power differentials, defensive practice, tokenism and resistance from medically trained staff who perceive user involvement as a threat to their expertise (Neech et al. 2018). Many studies suggest that user involvement has a limited impact on service providers' attitudes and decision making, and service users frequently report dissatisfaction with the outcomes of their involvement (Omeni et al. 2014). User involvement in inpatient settings has proved to be particularly challenging (Storm and Davidson 2010).

A small body of research has explored the practice and impact of recovery approaches in inpatient and/or involuntary patient settings. The evidence in this area is conflicting. Some studies suggest that a recovery approach is possible and beneficial in an inpatient setting (Courtney and Moulding 2014; Ray et al. 2019). However, other studies have found that recovery-oriented practice is very limited in inpatient settings (Waldemar et al. 2018), and a review by Waldemar et al. (2016) questioned whether it was possible to work in a recovery-oriented way in involuntary and inpatient settings at all.

As well as developing specific projects designed to be recovery-focused, many mental health services have attempted to transform the routine care they offer to service users. Until recently, research on the effectiveness of recovery practice was mainly limited to small-scale, local studies and/or studies of specific recovery-focused initiatives. However, in the last few years, a number of studies have attempted to explore the impact of recovery-oriented practice on a larger scale. The following section will consider the evidence for the effectiveness of recovery-oriented practice in routine patient care.

## 2.9 Recovery in Routine Care

In Wales, a large-scale mixed methods study of care planning and coordination (Simpson et al. 2016) showed how the recovery-focused processes imagined by policymakers may be very different in practice (Hannigan et al. 2018). The COCAPP study (care planning and care coordination in community mental health) was carried out across six NHS mental health provider organisations in London, Cardiff and Swansea and aimed to explore what made care planning collaborative, recovery-focused and personalised (Simpson et al. 2016). The mixed methods project gathered data on three levels through a comparative analysis of national mental health policy, questionnaires for service users and staff across the six community mental health teams and individual service user and staff interviews as well as a review of individual care plan documents.

The findings suggested that recovery was reconceptualised at the macro level to focus on organisational needs relating to competing priorities and contexts such as risk management, austerity measures and commissioners' requirements for data monitoring. The researchers, therefore, argued that the recovery practice is becoming less true to the original values of the approach. Furthermore, neither service users nor professionals valued the care planning process other than as a record for professionals. The study concluded that the key instrument in recovery was a positive therapeutic relationship with a skilled, respectful care co-ordinator (Simpson et al. 2016). This finding pointed to the importance of the interactions between professional and service users in the practice of recovery.

Two randomised controlled trials have assessed the impact of a recovery intervention on outcomes in statutory mental health services. The REFOCUS research by ImROC ran between 2011 and 2012 and was a cluster, randomised controlled trial across two NHS Trusts in England involving 27 statutory community mental health teams. Around half of the teams received the recovery intervention that involved training for staff on recovery values and interacting with service users. Effectiveness was measured using the Questionnaire about Processes of Recovery (QPR), developed through user-led

research, along with additional measures of hope, quality of life, empowerment, wellbeing, met and unmet needs and service costs (Williams et al. 2015).

The trial found no significant effect of the REFOCUS intervention on recovery compared with usual treatment, although staff rated patients in the intervention group to have improved functioning compared to control group patients. The authors identified the lack of full implementation of the intervention as the main reason for the lack of impact, along with the length of time some of the patients had been receiving traditional treatment prior to the intervention and the high rate of participant attrition, which impacted the study's statistical power negatively. Insufficient leadership and organisational culture were also suggested as important barriers to an effective recovery practice (Slade et al. 2015; Shawyer et al. 2017).

Qualitative analysis (Wallace et al. 2016) suggested that some service users found the intervention helped them develop collaborative and hope-inspiring relationships with staff, whereas others were not aware that the intervention had been used or struggled to articulate any benefits of it. The authors again concluded that this was due to the lack of full implementation.

An adapted version of the REFOCUS intervention known as REFOCUS-PULSAR was trialled across 18 community mental health services in Victoria, Australia (Shawyer et al. 2017). The study took place over two years, with one group receiving the intervention in year one (Step one) and the other in year two (Step two). The QPR was used to measure recovery at three points: baseline, one and two years. The results showed a small but significant difference in QPR scores for patients in the intervention group. The study was negatively impacted by the major reform that happened in community mental health services over the time of the trial. This study also failed to fully implement the intervention due to organisational barriers: they struggled to provide the intervention training to doctors and were also prevented from making recovery-oriented changes to relevant paperwork.

Both of the randomised controlled trials were unable to fully implement their intervention due to organisational barriers, including systems and cultures that did not support a recovery-orientation. The COCAPP research on care planning demonstrated



the impact of organisational processes and systems, competing policy agendas and financial constraints on the practice of recovery. Research exploring the challenges of enacting a recovery approach has consistently found barriers at the level of systems, agendas and discourses that militate against individual professionals' efforts at recovery-focused practice.

Many papers that investigate barriers to recovery conclude that the approach is more rhetoric than reality (Davidson et al. 2005; Slade and Haywood 2007; Perkins and Slade 2012, Evans et al. 2019). The literature suggests that the ongoing dominance of the medical model presents a strong challenge to professionals who wish to work in a recovery-oriented way. Often, recovery-focused practice is expected to fit into a predominantly medical system focused on clinical tasks, diagnosis and symptom reduction, with the accompanying imbalances of power between professionals and service users and a deficit- rather than a strengths-based approach to practice (Hoy 2008; Shera and Ramon 2013; Davies and Gray 2015; Le Boutillier et al. 2015; Cusack et al. 2017).

Risk discourse also appears to have a significant impact on professionals' efforts to be recovery-focused. There is evidence that mental health workers experience a role conflict when trying to consolidate their accountability for outcomes with their desire to work in a recovery-oriented way (Samele et al. 2007; Sawyer 2008). The COCAPP study (Coffey et al. 2016a) found that service users were rarely involved in discussions about risk because the workers did not want to alarm or upset them, which limited service users' opportunities for self-management and recovery. Holley et al. (2016) found that recovery-oriented practice was constrained by risk-averse team cultures and practices and that in the face of these pressures and worries about their responsibility for outcomes, staff tended to retreat to an illness management model of recovery, which focused on symptom reduction and long-term monitoring. This led to the lowering of recovery expectations and contributed to an understanding of recovery as clinical, focused on symptom reduction rather than personal experiences and improved quality of life regardless of symptoms. Shared decision making intended to be a genuinely collaborative process had instead resulted in service users colluding with workers' suggestions. For example, they might stay in supported accommodation

for longer before trying to live independently. This process of shared decision-making allowed service users to demonstrate their ability to take responsibility through agreeing with staff and accepting limitations on what they were allowed to do. Holley et al. (2016) called for a less idealistic appraisal of how services can practise recovery in the context of risk management and call for more explicit policy guidance on this issue as well as increased support at a local level.

Aspects of government policy around the management of health and social care services were also seen as detrimental to a recovery approach. Organisational systems were often influenced by a new public management approach and were focused on outputs (rather than outcomes), the throughput of clients, administrative tasks and performance management, which was not conducive to a recovery approach (Hoy 2008; Gilbert et al. 2013; Shera and Ramon 2013; Spitzmueller 2014; Davies and Gray 2015; Le Boutillier et al. 2015; Hannigan et al. 2018).

The findings of the COCAPP study (Simpson et al. 2016; Hannigan et al. 2018), the two RCTs (Slade et al. 2015; Shawyer et al. 2017) and numerous papers exploring the challenges in practising in a recovery-oriented way, all point to the crucial importance of dominant discourses and government policy as barriers. Issues of the dominance of medical approaches, the risk agenda and processes associated with new public management are identified repeatedly as preventing a recovery approach. However, despite these findings, many studies continue to conclude that the lack of conceptual understanding of recovery is what hinders its successful implementation (Le Boutillier et al. 2011; Salyers et al. 2011; Piat and Lal 2012; McWade 2016). Le Boutillier et al. (2011) identify a number of factors essential to good recovery practice, including organisational commitment and support structures but conclude that the key challenge for services is a lack of clarity about 'what constitutes recovery-oriented practice' (p. 1475). Other, more recent studies continue to propose further research and training as a solution to this problem. Jaiswal et al. (2020) conclude that more research was required to conceptualise recovery, which would 'facilitate clinicians' engagement in meaningful and effective recovery practice' (p. 11). Gyamfi et al. (2019) and Cusack et al. (2017) propose that professional training and development should focus on enabling professionals to fully understand the concept of recovery. They

suggest that a better understanding of the concept by professionals will lead to improved implementation and embedding of recovery into practice.

There is, however, a body of work that has started to recognise the importance of wider organisational contexts on professionals' practice of recovery. Jackson-Blott et al. (2019), in their Wales-based review of recovery-oriented training for mental health professionals, acknowledge the need for wider organisational change to enable the translation of recovery knowledge into practice. The COCAPP research project (Simpson et al. 2016) and work by Le Boutilier et al. (2015, 2014) discusses how organisational priorities and agendas can impact professionals' understandings and subsequent practice of recovery. The research literature has begun to recognise the impact of multiple and overlapping understandings of mental health on the contemporary practice of recovery. However, further research is required that explores these competing agendas and policy contexts in more detail. An exploration of the multiple historical constructions of recovery and how the term came to be associated with different kinds of values and practices over time will help inform current understandings of the practice of recovery in contemporary mental health services.

## 2.10 Limitations of the Literature

In addition to the seemingly impossible task of clarifying a process that has 'infinite variation' (Jaiswal et al. 2020, p. 10), the current literature is limited by the research methods used, which do not show how mental health professionals actually practise recovery. The research literature on recovery in mental health services is mainly based on retrospective accounts given by mental health professionals on how they enact a recovery approach in their work or descriptions of what they understand by a recovery approach without reference to how it might be applied with any particular client. Mental health professionals may have a theoretical understanding of recovery, which they are unable or unwilling to put into practice (Waldermar et al. 2016; Zuaboni et al. 2017). Osborne and Stein (2017) found that mental health practitioners were able to articulate recovery-oriented values, such as giving control to service users, but they seemed unaware of the discrepancy between these values and the descriptions they

offered of the aspects of their practice that appeared to be in opposition to recovery values. The research on practitioners' accounts of recovery may simply be reflecting recovery rhetoric, which may or may not be translated into their everyday practice with service users. Research is now required to elucidate the practice of recovery in specific, concrete contexts.

In 2009, Pilgrim argued that without the detailed ethnographic study of professional practice in the varied scenarios that arise in mental health services, it would not be possible to understand the relationship between recovery rhetoric and action. Following his call, a small number of ethnographic studies of recovery have been published. Using interviews and field notes, Spitzmueller (2014) documented the struggles of front-line mental health workers in Chicago to maintain recovery-focused values and activities in a context of constraints related to new financial and management arrangements. Lorenzo-Myer's (2016) study of a peer-led rehabilitation centre in the USA drew on recorded interviews with staff and clients as well as field notes taken from observations of staff–client interactions to demonstrate the importance of moral agency in mental health recovery. This study focused on service users' experiences rather than staff practices of recovery and showed how social conditions such as poverty and homelessness mitigated against service users' efforts to act like and be accepted by the people they wanted to become.

Ringer and Holen (2016) and Waldemar et al. (2019) studied hospital wards and outpatient services in Denmark. Both of these studies focused on the role of language in recovery and drew on field notes taken from observed interactions between staff and patients. The Waldemar et al. (2019) study used a focused observation guide based on a measure of the recovery orientation of services in order to structure field notes around particular principles of recovery. Ringer and Holen (2016) analysed their field notes to identify three discourses used in staff–patient communications that had impacts on the way in which patients could understand staff or make themselves understood. Each of these ethnographies has advanced our understanding of the practice or experience of recovery. However, the analysis of the interactions in each was based on the researchers' field notes rather than transcripts or recordings. Given the importance of language in the field of mental health care (Harper 1995; Juhila et al.

2003) and the importance of therapeutic relationships with staff for recovery (Simpson et al 2016), research that enables a fine-grained analysis of language through the use of recordings and full transcripts would allow for greater insight into the way that mental health professionals use language to practise recovery.

### 2.11 Critiques of Recovery

Although much research has identified barriers to recovery practice and areas in which it does not currently seem to be effective and/or possible, these studies usually suggest ways in which the practice of recovery might be improved to benefit service users and are in favour of a continuation of the recovery approach in mental health services. However, another stream of recovery research has taken a more critical stance, questioning whether the approach can ever be genuinely empowering (e.g. Harper and Speed 2012). In the governmentality literature, these studies redefine the recovery approach as the application of certain bodies of knowledge and associated practices of power that represent a new iteration of neoliberalism. In the next section, I will introduce the concept of governmentality before discussing how a particular rationality of government, neoliberalism, is argued to impact the practice of recovery.

### 2.12 Governmentality

Originating from Foucault's work on the art of government, the concept of governmentality focuses on the rationalities of government in modern states. This presents a new understanding of power as embedded in systems of thinking that rationalise the practice of government to those who practise it, making certain kinds of thoughts and practices possible (Tremaine 2015). Whereas previous approaches to analysing power focused on the power of the state through formal political authority, Foucault proposed a wide definition of power (Dean 2010) that allowed for the consideration of any exercise of power that aimed to shape or guide the behaviour of the self or others. Governmentality studies, therefore, apply an analysis of power as the study of 'techniques and procedures by which one sets about conducting the conduct of others' (Foucault 2010, p.4).

An essential element of governmentality is the way in which individuals manage their own behaviour in line with powerful discourses. Within this framework, power operates as a productive force, moulding and encouraging particular normative subjectivities through discursive practices. People are influenced by the promotion of such subjectivities and come to subjectify themselves in the way desired by those governing. As Rose (1999) explains: 'When it comes to governing human beings, to govern is to presuppose the freedom of the governed. To govern is not to crush their capacity to act, but to acknowledge it and utilise it for one's own objectives' (p. 4).

Studies of recovery and related emancipatory initiatives in mental health services have highlighted the impact of neoliberalism. Neoliberalism is characteristic of advanced liberal societies and was defined by Foucault as a rationality of government in which 'the overall exercise of political power is modelled on the principles of a market economy' (Foucault 2008, p. 131, cited in Lorenzini 2018, p. 155). The neoliberalist approach to government promotes unhindered markets, the reduction of the welfare state and the marketisation of welfare services as the way to achieve economic prosperity and social welfare (Bockman 2013; Spolander 2014). It is also associated with a new public management approach within services which has led to more explicit standards and performance measurement, a focus on outputs rather than process, a stress on frugality in resource use (Hood 1991, Lawler and Bilson 2010) and the use of contracts and contractual relationships in contrast to a focus on mutual trust in relationships (Banks 2011). Within this rationality, it is not just organisations that are expected to become competitive, individuals are also expected to enterprise themselves: 'individuals are assumed to be rational, self-interested actors who, rather than government, can best determine their own needs and aspirations and who have the agency to pursue the realisation of these goals' (Stanford and Taylor 2013, p. 480).

Pollack (2010) explains how the notion of empowerment, a key feature of the recovery approach, has developed a new, individualised meaning in the context of the neoliberal welfare state. Strategies for empowerment focus on modifying the subjectivities of those who are socially excluded, making their lack of inclusion and empowerment a personal problem and obscuring the role of social factors. Within a neoliberal framework, empowerment 'codes the subjective substrate of exclusion as

lack of self-esteem, self-worth, and the skills of self-management necessary to steer oneself as an active individual in the empire of choice' (Rose 2000, p. 334).

In the governmentality literature, responsibilisation is defined as a process by which subjects, including social work clients, become responsible for tasks that would previously have been the responsibility of others, usually the state, or that would not have been seen as a responsibility at all (O'Malley 2009). Many writers have pointed out the fit between an individualistic version of recovery and neoliberal notions of individual responsibility (Harper and Speed 2012; Braslow 2013; Rose 2014). Harper and Speed (2012) link the development of the recovery approach to neoliberal identity politics: 'focussed on individualising disparate group struggles rather than collective struggles around redistribution' (p. 9). McWade (2016) goes further than this to describe "recovery-as-policy'... as a form of neoliberal state making' (p. 64). She argues that recovery ideas were used by the New Labour government in the 2000s to introduce more coercive laws and to strengthen both biomedical and state power.

Recovery in the Bin, a user-led, internet-based group started in March 2014, is critical of what they term the colonisation of the recovery approach by mental health services, commissioners and policymakers. They see the recovery model as a symptom of neoliberal capitalism and aim to increase awareness of the way in which the delivery of recovery-oriented services is shaped by neoliberalism and market forces (RITB 2017). Depending on how its ambiguous features of self-responsibilisation, empowerment, user control and other related concepts are interpreted, the professionalised and institutionalised recovery approach can be seen as sharing some key features with a neoliberal rationality of governing. Diana Rose (2014) has warned, the original liberatory discourse of recovery 'has become instrumentalised and mainstreamed such that it is aligned perfectly with our neoliberal present' (2014, p. 217).

The literature on governmentality has been criticised for not exploring how governmental discourses (such as recovery) are translated into the formation of subjectivities, a lack of focus on human agency and an assumption that this process of subjectification is a one-way, linear process. The governmentality literature has tended

to focus on the content of government texts rather than how these texts come to influence people's behaviour (Martin and Waring 2018). The current studies of recovery in the governmentality literature do not, therefore, address Pilgrims' (2009) call for research that can go beyond the rhetoric to explore how recovery is actually practised. However, more recently, a section of the governmentality literature has drawn on Foucault's concept of pastoral power to explore the role of modern pastors, such as health professionals, in shaping, disseminating and translating governmental discourses into action (e.g. Wilson 2001; Holmes 2002; Rose 2007). In the next section, I will outline the concept of pastoral power and show how it has been used to demonstrate the way in which health professionals translate governmental discourses in order to mould and shape patients' behaviours, wants and goals in line with neoliberal ideals of the responsibilised citizen.

### 2.13 Pastoral Power

Foucault (1994) has identified a number of regimes of power that have been dominant at different times in history. Pastoral power moved from a tradition of the Christian church in which the pastor watched over and guided the moral behaviour of his flock to a form of power exercised over the whole state through the multiplication of its agents and aims. Rather than focusing on salvation after death, the state form of pastoral power promised salvation in this life, and salvation took on a broader meaning to include health, wealth and security. Pastoral power is exercised by organisations that aim to care for and support individuals, and by doing so, to save them from suffering or living life wrongly (Foucault 1994a). Modern pastors, such as health care professionals, have a dual role in both supporting and caring for their clients whilst also promoting morally desirable behaviours. They observe, monitor and occasionally control clients' behaviours whilst also working to 'nurture self-governing subjectivities' (Rose 2007; Jones 2018; Waring and Latif 2018, p. 52).

Waring and colleagues have developed this work on pastors to look at the relational practices of modern pastors and consider the limits of their influence or scope for resistance (Waring and Martin 2016; Martin and Waring 2018; Waring and Latif 2018). Waring et al. (2015) drew on a Foucauldian approach to explore the changing



dynamics of power in the work of community pharmacists in response to a new policy: the new medicines service. The new policy aimed to increase patient adherence to newly prescribed medications by extending the community pharmacists' role. Pharmacists were to encourage patients to discuss their experiences of taking the medication and to use this to promote the correct adherence to the medication prescribed. Waring et al. (2015) noted how the way in which the pharmacists became involved in monitoring, educating and managing patients' behaviours constituted a form of pastoral power: they worked to mould their patients' subjectivities, encouraging responsible and informed self-management.

Drawing on the findings of this study, Waring and Martin (2016) developed a model of the way in which pastors translate discourses into actions. It involves four practices: constructive practices in which modern pastors find or come across discourses and ready them for articulation in ways relevant to their particular community; inscription practices, which involve the integration of discourses into systems, routines and everyday norms of practice; collective practices, which involve (re)defining the boundaries of the community and instigating and maintaining activities that reinforce appropriate subjectivities and finally, inspection practices, which consist of monitoring and regulation (pp. 141–145). The concept of the modern pastor provides a useful tool for thinking about the recovery approach as a set of practices of power. It allows for a more sophisticated analysis of power beyond those of domination, and for the identification of the complex assemblages of groups and individuals who exercise power. My study builds on the work of Waring and colleagues to explore the role of mental health professionals as modern pastors, looking at how they translate recovery policy into practices and how they work to induce recovery-aligned subjectivities in their clients. An examination of the actions of mental health professionals as modern pastors enables the consideration of the recovery approach as a possible new iteration of neoliberalism whilst allowing for recognition of practices of resistance and the exercise of power by all stakeholders, including service users.

## 2.14 Conclusion and Research Questions

The research literature on recovery has illustrated the challenges involved in both conceptualising and practising a recovery approach in the complex political and organisational contexts of mental health services. Studies have consistently shown that professionals' efforts at recovery-oriented practice are negatively impacted by macrolevel policy and discourse. Further research into the historical origins of these competing discourses and policies may help illustrate and clarify the complexities and contradictions that plague the contemporary recovery approach.

The recovery literature has relied mainly on interviews or surveys to gain retrospective and hypothetical accounts of recovery and has neglected the question of *how* mental health professionals enact recovery in practice. A small number of studies have used an ethnographic approach to explore this question. However, none of these were undertaken in the UK, and in addition, they have all relied on field notes relating to observed interactions between professionals and service users, rather than recordings. In the UK, policy directs that the recovery approach must be enacted through the care and treatment planning process,<sup>6</sup> meaning that care planning meetings between staff and service users are a crucial site for the practice of recovery. Previous social constructionist research in the field of mental health has shown how language does not just reflect reality but actively creates and negotiates concepts such as recovery. Ethnographic study using recorded observations of professional-service user meetings will therefore enable a more precise and detailed analysis of how professionals and service users enact recovery through their use of language.

In line with the theoretical framework, this thesis seeks to understand recovery as a manifestation of power/knowledge relations drawing on the Foucauldian concept of a history of the present. Following a historical study of the origins of the various versions and threads of recovery, I use an ethnographic approach to data collection, including recorded observations of meetings along with a discursive psychological analysis, to

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<sup>6</sup> Known as the Care Programme Approach in England.

show how mental health professionals enact recovery through the exercise of pastoral power.

I chose to investigate three specific questions in relation to recovery:

What are the conditions of possibility for the development of different understandings and practices of recovery in the UK?

How are mental health professionals currently practising recovery across services for people with mental health problems in Wales?

What challenges, dilemmas or tensions are encountered in the practice of recovery by staff and service users?

The next chapter will answer the first research question through a Foucauldian-inspired history of recovery since the 1700s.

## Chapter 3: The History of Recovery

### 3.1 Introduction

The previous chapter explained how ideas related to a recovery approach appeared in the personal accounts of service users in the 1980s and 1990s, and how some of these concepts began to form part of mental health policy in the UK in the early 2000s. A large number of studies since then have found evidence of confusion about what is meant by a recovery approach amongst both professionals and service users and that a range of overlapping versions or enactments of recovery are in practice. Much research has attempted to define and categorise these versions, to measure the effectiveness of recovery-oriented practice and suggest ways of improving it. In this chapter, I will seek to understand these different versions of recovery as manifestations of power/knowledge relations, drawing on the Foucauldian notion of a 'history of the present' (Foucault 1977/1991, p. 31).

I have attempted to produce a critical and effective history (Dean 1994) that problematises contemporary recovery through exploring its past. I have aimed to avoid producing either a celebration of recovery as progressive or critiquing it as another form of social control and instead tried to illustrate some of the complexities and contradictions in the history of recovery, which have contributed to its current forms (Dean 1994; Skehill 2007). In line with Foucault's approach to historical enquiry, I have not tried to reveal the 'truth' of the history of mental illness and recovery but to explore the conditions in which it became possible at different periods in history to proclaim certain statements about recovery as the 'truth'. The history of recovery in mental health is extensive and complex, and this historical overview will therefore focus on selected themes and events, which I believe are the most relevant to changing understandings of recovery.

My ethnographic work illustrated a number of features in contemporary practices of recovery, some of which have appeared more recently and some have been present for many centuries. Staff in the services I studied took what would now be termed a biopsychosocial approach (Engel 1977) to mental illness. Various understandings of mental distress have impacted treatments and/or services since the 1700s, although each has gained more prominence at certain times. This chapter will explain how each of these approaches originated, how they understood recovery and the means needed to achieve it, along with an exploration of how each approach gained the power to shape the response of mental health services. The first part of the chapter, therefore, focuses on the historical development of bodies of knowledge that underlie past and often current understandings of recovery. The second part of the chapter focuses on changes in arrangements of the delivery of mental health services through deinstitutionalisation and community care. The move to community care for the majority of mental health patients led to significant changes in the understandings of recovery, the treatment required and the form of patient–professional relationship most likely to lead to recovery.

I argue that moving care and treatment from hospital to community settings decreased the power of the biomedical model and increased the power of a psychosocial approach due to the different needs of patients who had been discharged

into the community compared with the long-stay inpatient. The particular form of community care services that developed in mental health meant that multidisciplinary teamwork became usual practice, and this contributed to the strength of both the psychological and social models of mental illness/distress.

I trace the development of a pastoral mode of power (Foucault 2007) in the various approaches to recovery. Foucault discussed the growth in importance of the confession as part of the exercise of pastoral power. In the act of confession, a person would reveal their inner world to an expert who would use their expertise to interpret its meaning. The pastor also acts as a relay of surveillance and discipline whilst promoting self-reflexive, self-governing subjects (Martin and Waring 2018). People experiencing mental illness or distress have often been expected to confess their innermost thoughts and feelings to various 'experts' so that they could interpret them and reveal the 'truth' to the patient. This process is perhaps most obvious in the practice of psychoanalysis but can be seen in the practices of a number of past and contemporary mental health professions. Another aspect of pastoral power relates to the notion of responsibilisation in which patients are encouraged to become independent, self-managing citizens. A focus on the development of self-discipline leading to responsible behaviour can also be seen at times within this history. More recently, neoliberal policies have led to the juxtaposition of a risk and responsibilisation agenda alongside the need to empower service users within a recovery approach. I show how this context has led to contemporary mental health professionals becoming allies in the management of risk and how the recovery approach has become a resource to engage individuals in managing their own risks.

This historical overview starts in the 1700s and is loosely chronological. However, as differing understandings of mental illness and recovery have co-existed since the 1700s, it is not possible to clearly separate the approaches by time period. Many contemporary and historical mental health professions and/or movements promote multiple approaches to mental illness and recovery. This section, therefore, presents a simplified picture of the different approaches in terms of their associations to the various mental health professions in order to preserve a clear structure. For example, I have presented psychiatry as underpinned by the biomedical model without exploring

the work of social psychiatrists. Behavioural, cognitive, cognitive-behavioural and humanistic therapies are all presented as 'psychological' approaches without a discussion of the role of counsellors, religious personnel and unqualified laypeople in providing these therapies. The emergence of the community mental health team as a way of providing services proved to be important in terms of its impact on the understandings of recovery. I therefore chose to include a separate section that outlines some relevant history in relation to the main professions that made up these teams.

In the 1700s, some approaches to madness concerned the body and its processes. What we might now call psychological and social understandings were also apparent in the moral treatment approach. The next section describes the underlying beliefs about recovery associated with each of these approaches and explains how the biomedical approach eventually gained dominance through the efforts of biological psychiatrists to dismiss the moral treatment approach, along with the impact of overcrowding in asylums.

### 3.2 The Biomedical Model of Mental Illness

Many early theories of madness in the Middle Ages and beyond drew on the Greek teachings of Hippocratic medicine. Illness, including mental illness, was considered to be linked to an imbalance of the humours of the body: blood, choler (yellow bile), phlegm and melancholy. Treatments were physical and included bloodletting, purgatives and strict diets (Porter 2002). These early medical theories existed for centuries alongside religious ideas of possession, witchcraft and the revenge of angry gods (Scull 2011). In the 1700s, a new approach emerged, known as moral treatment, which advocated psychological and social treatments for the mind rather than the brain. This approach was initially very successful (Scull, 1975). However, by the mid-nineteenth century, biological psychiatry had come to be dominant in shaping understandings of mental illness. The biomedical model has remained a dominant way in which mental illness and recovery are understood; contemporary mental health treatments are offered in medical settings and often overseen by psychiatrists

prescribing physical treatments. An exploration of the development and growth of this approach can therefore assist in understanding current practices of recovery.

The growth of biological psychiatry as a branch of medicine was strongly linked to the building of public asylums in the nineteenth century. From the mid-1800s to the early 1900s, British government policies aimed to reduce spending on the poor through making institutional care, such as the workhouse, the only option for those who could not support themselves. Following media reporting on the horrific conditions in private madhouses and workhouse infirmaries, public concern contributed to legislation intended to improve conditions for insane people (Hutton 2011). The Lunatic Asylum and Pauper Lunatic Act (1845) required each county to build a public asylum, and the Lunatic Act (1845) established a central body, the Commissioners in Lunacy, which was to oversee and inspect asylums and madhouses. The new laws reflected the general trends in policymaking at the time; institutionalisation was a response to poverty in a time of rising costs. However, the laws also helped strengthen the power of the emerging medical model of madness by giving the medical profession a significant role in the management of the insane. A proportion of the Commissioners in Lunacy was required to be medical doctors; physicians were to take control of the asylums and play an essential role in certifying people as insane or recovered. In addition, the mad were referred to as patients. The new laws, therefore, represented an acceptance of the medical model of mental illness and the expert knowledge of the psychiatrist in diagnosing and treating these kinds of problems.

The psychiatric model of mental illness was based on a disease model and drew on the pre-existing knowledge of physical illness. The model proposed that mental illness was caused by brain pathology. Mental illness was understood as a variant of physical illness, and the theory was reductionist: any change in psychosocial functioning was understood as due to underlying biological causes (Ramon, 1985). Recovery in early biological psychiatry was understood as the end of the symptoms of mental illness, which would be brought about by biological treatments.

The large numbers of mad people confined to asylums over the eighteenth century enabled the scientific study of madness as a branch of medicine like any other, which

led to a rise in the status of psychiatry and psychiatrists (Sutherland 1855). Psychiatric research in the nineteenth century was focused on the identification and classification of mental diseases. The aim was to find specific disease entities through evidence of physical pathology, and various theories were proposed as to the underlying physical bases of mental disorders (Ion and Beers 2002a). The increasing numbers of patients in asylums allowed psychiatrists to conduct larger-scale studies and develop new statistical methods of research (Barrett 1998). However, the outcomes of research contributed to therapeutic pessimism; in the 1880s, with very few exceptions<sup>7</sup>, no evidence of brain pathology had been found in mental illness. Illnesses were named on the basis of their circumstances or symptoms, but psychiatrists found no clear evidence of pathology. Emile Kraepelin developed an influential system of classification based on the course and outcome of illnesses. His delineation of two separate disorders: dementia praecox and manic depression are still in use today in the distinction between schizophrenia and bipolar disorder.

However, his work also contributed to therapeutic pessimism as he proposed that dementia praecox (the precursor to schizophrenia) was incurable and marked by progressive dementia and cognitive decline.

Given the lack of observable pathology, diseases were therefore identified by the doctor through the study of symptoms and signs that were thought to reveal the underlying disease. Foucault has referred to this way of looking at patients as the medical gaze (Foucault 1973). Hsu and Lincoln (2007 p. 23) explained how it objectified the patient, focusing only on the diseased part: 'Facilitated by the medical technologies that frame and focus the physicians' optical grasp of the patient, the medical gaze abstracts the suffering person from her sociological context and reframes her as a 'case' or a 'condition'.

The belief in an underlying biological cause of psychiatric illnesses, along with the method of the medical gaze, led to a particular kind of relationship between doctor

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<sup>7</sup> Neurosyphilis, multi-infarct dementia and thyroid deficiency



and patient. The contents of the patients' symptoms, such as hallucinations or delusions, were considered meaningless as they were caused by brain pathology, and therefore, the patient had no insight or expertise to offer. The mode of power underlying biomedical psychiatry was paternal: the doctor was considered the expert, and the patient expected to comply with their orders passively.

Another aspect of the early biomedical model that impacted the doctor–patient relationship was the concept of degeneration, which proposed that some individuals had morally defective genes that led to problems, such as alcoholism, crime and insanity. The theory was supported by many eminent doctors of the time, including Kraepelin who was particularly concerned about the threat of hereditary degeneration:

Attention must be focused above all on the fight against all those influences threatening to destroy future generations in particular hereditary degeneration and genetic defects. (Kraepelin and Engstrom 1992, pp. 268–269)

Degeneration theory contained ideas about the kinds of people who became psychiatrically unwell: those whose psychic and moral manifestations included laziness and dislike of work. This belief contributed to the different statuses of the doctor and patient. Asylum patients were not only seen as unwell and unable to help themselves but as morally weak and inferior to the doctors who treated them. Degeneration theory, with its belief in the inherent inferiority of the mentally unwell along with its pessimistic prognosis, helped separate the mentally ill as being very different from normal people and led to stigma, the remnants of which can still be detected in popular culture today (Barrett 1998).

Despite the failure of most of their treatments and their lack of knowledge of the cause of mental illness (Scull 1975), the psychiatric profession remained confident that biological causes and effective treatments would eventually be found for mental illness. Their commitment to arguing for the truth of biological psychiatry can be seen in their responses to the moral treatment approach to mental illness, which emerged in the 1700s and continued for some time alongside, and sometimes in combination with, biological psychiatry. The moral treatment approach eventually faded in

popularity. However, it introduced some ideas about recovery that remain influential to the present day and can be seen in contemporary recovery practices. The initial success of the approach was troublesome for the medical profession as it suggested that no medical qualifications were needed to cure madness and thus represented a threat to the psychiatric profession (Goldstein 2001).

### 3.3 The Moral Treatment Approach

The moral treatment approach did not have a well-developed rationale but agreed that whether or not mental illness originated in the mind or the brain, treatments should be focused on the mind (Scull 1975). Madness was seen as a 'breakdown of internal rational discipline' (Porter 2002, p.105), however, mad people were not seen as entirely irrational:

Lunatics are not devoid of understanding, nor should they be treated as if they were, they should be treated as rational beings. (Thomas Bakewell 1805, madhouse keeper, cited in Scull 2011, p.45)

The response to madness in the moral treatment approach was the instilling of routine and self-discipline through work and recreation, appeal to reason and the development of desirable moral traits (Peloquin 1989). The moral treatment approach drew on religious teachings, in particular those of the Quakers, to guide their approach to patients. They claimed to practice the Quaker principles of care, respect and equality between humans, regardless of age, gender, class or mental state. They provided comfortable surroundings, minimal restraint, a good diet and organised activities for patients. The approach was also guided by its belief in individual responsibility for an appropriate lifestyle and behaviour along with a duty to support and guide others in their spiritual journey. Recovery in the moral treatment approach related strongly to regaining self-control, which would lead to appropriate behaviour. Treatment aimed to move patients from coercive external control to self-discipline through constant observation, staff modelling appropriate behaviour and rewards and punishments (Brigham 1844; Porter 2002). Patients were expected and encouraged to feel ashamed if their behaviour was not orderly or polite:

...the patients must conduct themselves with gentleness towards each other, otherwise, they are subject to the disgrace of dining, and taking their other meals alone! (Philaethes 1840, p. 386)

In 1864, W. A. F. Browne, a respected psychiatrist of the time, gave a lecture entitled *The moral treatment of the insane*, which revealed the striking similarity of the approach to a number of contemporary beliefs about recovery<sup>8</sup>. The moral treatment approach reflected some ideas of personalisation in its proposal that the environment should be adapted to the person rather than vice versa and also, in line with contemporary person-centred approaches, that the physician must get to know the individual mind of each patient and provide individualised activities. Browne (1864) stated that ‘the physician should draw on the patient’s abilities and sane understanding to help them to rouse, restore or regulate the disordered parts of their minds’ (p. 312), an approach that would now be known as strengths-based. He also advocated that the more well patients could assist and guide the less well patients, in line with the contemporary notion of peer support. Patients were encouraged to develop healthy routines in the same way that contemporary patients may be advised to sleep well and eat properly. Finally, physicians were also expected to listen to their patient and provide comfort and reassurance: ‘unceasingly dispel doubt and despair by words of wisdom and consolation’ (Browne 1864, p. 312) in the same way that is expected of all mental health professionals in the current era.

Despite its focus on the mind over the body and the differences in the treatments recommended, the moral treatment approach had some significant factors in common with the early biomedical approach as well. Both approaches believed that the asylum and its routines were therapeutic for patients even without additional treatments (Elkins 2016). In addition, both were concerned with morals. In the biological psychiatric approach, the mentally ill were seen as morally inferior to the doctors. In

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<sup>8</sup> The resemblance of the moral treatment approach to contemporary beliefs is also discussed by Borthwick et al. (2001)

the moral treatment approach, despite its protagonists' claims to equality, this was also the case:

In many senses an asylum should be a grand moral school and reformatory, as well as a hospital. For although the blight of alienation falls upon the purest and highest spirit, the blight falls heaviest and most poisonously upon those of imperfect character, of ungoverned passions, and degraded propensities.  
(Browne 1864, p. 315)

The actual practice of moral treatment included, like in the medical approach, an unequal power relationship between patients and staff. Staff, including the senior managers of the asylums, were not required to be medically qualified, and their status came from their religious and moral superiority. Patients were punished if their behaviour did not meet the moral standards required (Von Feuchtersleber et al. 1847; Goldstein 2001). Although the moral approach could be seen as kind when compared to the horrific conditions in the early madhouses, it was still harsh and patients were controlled through fear as well as encouragement:

[T]he principle of fear, which is rarely decreased by insanity, is considered of great importance in the management of patients. (Samuel Tuke 1813, cited in Read and Dillon 2013, p. 17)

Although both the biomedical and the moral approach viewed patients as inferior, the moral treatment approach saw less of a difference between the mentally unwell and the rest of the population and believed that the mad could be encouraged and taught to improve their moral behaviour:

[I]t was discovered that the insane were tractable, teachable, closely assimilated to the sane, where their surroundings were the same...' (Browne 1864, p. 313)

The moral treatment practitioners practised a form of pastoral power. Whereas the psychiatrists saw patients as passive and reliant on the doctor to cure them in order to achieve recovery, the moral treatment practitioners required patients to learn self-

control and become responsible citizens capable of behaving appropriately without external discipline.

Scull (1975) provides a detailed account of the way in which moral and medical treatment advocates competed for dominance in managing the mad. He shows how, although members of the medical profession publicly admitted their lack of expertise in treating insanity, they managed to retain control of the asylums. In 1819, the House of Lords voted against a reform bill that would have lessened medical doctors' control over the asylums, but this process left the profession vulnerable to accusations of inefficacy. Following this, there was a proliferation in the medical literature promoting what Scull (1975, p. 252) calls 'an ingenious metaphysical argument' in which they equated the mind with the soul. To suggest that the mind could be vulnerable to disease would therefore be in opposition to the Christian doctrine that the soul was immortal, and this understanding supported their argument that mental illness was caused by a diseased brain.

Goldstein (2001) suggests that medical psychiatrists eventually appeared to accept that a combination of moral and medical treatment was the most effective and that this allowed them to avoid the issue of whether unqualified staff may be as competent as doctors at curing madness. Goldstein's claim is supported by the writings of W. A. F. Browne, who, in 1837, stated that insanity was 'strictly a bodily disease having its origins in organic lesions of the brain' (Browne 1837, pp. 4–7). However, in his 1964 lecture on moral treatment (referred to earlier), he promoted the use of both physical and moral treatments:

You may pour in iron to supply rich and stimulating blood, phosphorus to repair the waste of nervous tissue, stimulants to call forth agreeable sensations, and cannabis indica to embody these sensations into happy and hilarious visions; but unless you send through the eyes and ears multitudes of pleasing impressions, unless you unceasingly dispel doubt and despair by words of wisdom and consolation, unless you create a vicarious pain or a vicarious interest, unless you make a sense of duty react upon selfish sorrow, unless you call forth some dormant or neglected habit or taste, or initiate a pursuit or a

study by imitation or compulsion, you do much, but you do less than what you are competent to do, and then what is required. (Browne 1864, p. 312)

Extracts from nineteenth-century medical journals suggest that the conflict between medical and moral approaches continued throughout the rest of the nineteenth century. In 1855, a report of the Commissioners in Lunacy presented the moral treatment approach as attractive in appearance but ineffective at treating mental illness:

We do not know of a more painful sight than an admirably constructed and arranged asylum for the insane, replete with domestic comforts, and abounding in evidences of extreme solicitude for the contentment or happiness of the inmates, but containing no marks of any medical intentions or operations; all the patients at work, and none in the infirmary; no case books, or at all events no records of treatment; no medicines, except stimulants for the aged and infirm, and an occasional dose of salts or castor oil for those who may need them; and above all, a medical Superintendent who openly professes to have no faith in the efficacy of medicine... What a pity that so beautiful an appearance should have no brains. (1855, p. 4)

The asylums continued to promote moral treatment through pleasant surroundings, patient involvement in ordinary daily activities, etc., but rather than leading to recovery, it was increasingly promoted as complementary to medical treatment, which was promoted as the only effective response to mental illness. Soutar (1897, p. 514), writing on 'recoveries from mental disease', argued that the existence of underlying physical pathology causing mental illness was universally accepted and that without a medical approach to treatment, no amount of moral treatment would help the patient recover:

In every asylum in the land, this is now recognised as the cardinal truth underlying the treatment of insanity. Without this, the discipline, the ordered life, the appeals to our patients by pleasing externals, by attempts to arouse dormant interest, by encouragement, by warnings and often by frank explanation, all invaluable aids in treatment would be of absolutely no avail.

He went on to conclude that most of the recoveries discussed were 'undeniably the result of definite medical treatment, they are victories of the physician over disease' (p. 514). Moral treatment required high staff to patient ratios in order to avoid restraint and maintain supervision. The rapidly growing numbers of patients in asylums over the second half of the nineteenth century, therefore, made a moral treatment approach unsustainable. Despite the initial attempts to replicate some aspects of the moral treatment approach within a medical framework by the medical superintendents of the new public asylums (e.g. Barnwood House 1880), overcrowding and understaffing led to the return of physical restraint (Rogers and Pilgrim 2001). Therapeutic pessimism began to take hold, and the success of asylums came to depend more on their ability to contain people than to cure them. The control of psychiatry over the mentally ill in asylums was maintained through laws rather than their success in treating mental illness (Mellett 1981).

The belief that many patients could not be cured, along with the failure of biological treatments for the majority of 'curable' patients, led to a 'dead end' for biological psychiatry. The asylums became containers for the chronically sick with no hope of recovery, and psychiatry, as a profession, commanded little respect (Shorter 1997, p. 65). It was around this time that Sigmund Freud proposed a new approach to mental illness.

### 3.4 Freud and Psychoanalysis

Although few professionals in today's mental health services would describe themselves as Freudian psychoanalysts, Freud's ideas influenced subsequent approaches to mental illness and can be seen today in the practices of a range of mental health professionals.

The development and growth of psychoanalysis reflected a profound change in the understandings of mental illness, treatment and recovery. Recovery in psychoanalysis, as in medical and moral treatment approaches, meant the end of symptoms of mental illness (Freud et al. 1976, p. 327), but understanding of the causes of illness and the proposed treatment to attain recovery were very different. Although it bore some resemblance to moral treatment, in terms of its focus on therapeutic relationships, it

was different in key ways. Unlike the moral treatment approach, which encouraged patients to take responsibility for their behaviour within a moral framework, the therapist in psychoanalysis aimed to effect changes in the patient's mind, which would lead to recovery. Recovery in psychoanalysis was enabled through psychoanalytic techniques reliant on a particular kind of therapist–patient relationship and based on a theory of the mind.

Freud used a number of psychological concepts in order to explain the symptoms of mental illness. A vital aspect of his theory was the unconscious. He proposed that emotionally traumatic experiences caused conflicts that were repressed into the unconscious, resulting in the symptoms of mental illness. He argued that the memory repressed any traumatic experiences into the unconscious to protect itself from reliving the unpleasant feelings:

... the memory's disinclination to remembering anything which is connected with feelings of unpleasure and the reproduction of which would renew the unpleasure. (Freud et al. 1976, p. 103)

Analysts were to focus on creating transference, explained by Freud as unsatisfied or repressed wishes and experiences from the past that were transferred onto the analyst. In this way, the patient might come to see the analyst as a person from their childhood, such as an authoritarian father. Once this transference had been achieved, the patient could live through traumatic situations from their past in the safety of the therapy room and work through them to a satisfactory conclusion (Freud 1924; Cobb 2015). Recovery, therefore, happened when the analyst had identified the unconscious conflict and had brought it into the open through the process of transference. This was expected to end the symptoms of mental illness and lead to recovery.

The therapist–patient relationship was considered key to attaining recovery in psychoanalysis. Unlike biological psychiatry, where it was the physical treatment that was expected (or hoped) to cause recovery, in psychoanalysis, it was the nature of the relationship between the analyst and patient that led to recovery. The term talking



cure was coined by Anna O<sup>9</sup>, a client of Freud's colleague, Joseph Breuer, who found that her symptoms disappeared after simply talking to him about her experiences and emotions. This idea of catharsis was the cornerstone of psychoanalysis (Murray 1983; Leahey 2001), which maintained that recovery could be achieved simply by talking openly about the problem. The practice of psychoanalysis offered a clear illustration of the importance of the confession (Foucault 2008). Only the therapist could interpret the patient's innermost thoughts and feelings to reveal the truth hidden in the patient's unconscious. However, psychoanalysis did not advocate another element of pastoral power – it did not promote the self-governing subject (Martin and Waring 2018). Only the analyst could bring about recovery through their interpretation and revelation of the patient's underlying unconscious conflicts. This was expected to result in recovery without the patient needing to consciously manage their behaviour or take responsibility for their conduct.

That the contents of the mind could be altered through communication with a therapist was new, and it provided a more attractive option for many people experiencing mental health difficulties who could afford it. This contributed to the popularity of psychoanalysis along with the fact that Freud was a charismatic and persuasive speaker (Brody 1970; Fisher and Greenberg 1977, cited in Clare 1985). In addition, before and during the war, many Jewish psychoanalysts and their patients fled Europe and moved to Britain and the USA, which contributed to the spread of psychoanalytic ideas across the Western world. This geographical spread of psychoanalytic ideas contributed to the profound influence it had on the perception and expectation of recovery in mental illness. Another possible reason why psychoanalysis was so quickly accepted, at least by the general public, was due to its therapeutic optimism. Whereas the medical model promoted a pessimistic view of mental illness in which many individuals were doomed by their genetic makeup to suffer progressive deterioration, Freud's theory did not support the idea of hereditary insanity and criticised biological psychiatrists for relying on this thesis:

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<sup>9</sup> Anna O was an alias used for Breuer's patient, Bertha Pappenheim.

[I]ndeed, we may doubt whether there is any justification for it at all, when we learn that such symptoms occur too in distinguished people of particularly high capacities, capacities important for the world at large...' (Freud et al. 1976, p. 300)

Shortly after Freud proposed his new theory, the first World War started, and soldiers of all ranks and social classes fell victim to a form of mental illness, which became known as shellshock. This was damaging to the biological psychiatrists' argument that mental illness was caused by inferior genes and instead supported the idea behind psychoanalysis, that traumatic events led to mental illness.

Psychoanalysis represented a new understanding of mental illness: the mentally ill were no longer classed as biologically different or having a tragic and unavoidable genetic predisposition to incurable illness. Now, they could be understood as people who had been exposed to some traumatic experience that had altered their mind, but who, through developing a relationship with a skilled psychoanalyst, could be relieved of both the cause and symptoms of their illness.

Shorter (1997) describes psychoanalysis as a short-lived hiatus in the progress of biological psychiatry, soon consigned to the margins by scientific progress. However, many of the key principles and practices of modern forms of talking therapy can be seen in Freud's original work. The requirement in most contemporary, accredited counselling training programmes for potential therapists to undertake personal therapy to become aware of how their own experience might impact the way they interpret clients' experiences was recommended by Freud (Freud et al. 1976, p. 43). In addition, his advice to analysts to refrain from offering their interpretations to the patient until the patient had come close to the realisation themselves, his recommendation that counsellors should protect themselves and maintain a professional distance and encouraging a healthy attachment to the therapist through being non-judgemental (Freud 1924) are all reflected in modern counselling approaches (McLeod 2013; British Association for Counselling and Psychotherapy 2016).

Freud's theory and practice also influenced the work of the 'mental hygiene movement', which had a significant impact on thinking and practice in mental health care. I will now discuss the mental hygiene movement and the new ideas it brought to the understandings of recovery.

### 3.5 The Mental Hygiene Movement

Both the biological and psychoanalytic approaches to mental illness were based on a theory of causation. They focused on the cure of mental illness and relied on the expertise of one professional, a psychiatrist or a psychoanalyst, to cure the patient. As psychoanalytic training was restricted to psychiatrists, all psychoanalysts were also psychiatrists (Abma 2004). In 1909, the mental hygiene movement first emerged, bringing with it new ideas about the correct approach to mental illness, which included a focus on prevention, the identification of people at risk of mental illness, multiple causative factors and the use of a team approach, all of which are visible in contemporary mental health policy and services.

The origins of the mental hygiene movement lie in the work of Clifford Beers, a former mental hospital patient in the USA who wrote *A mind that found itself* (1908) based on his experiences in three different mental hospitals (Bertolote 2008). The book was influential and in the following year, Beers, along with William James and Adolf Meyer, set up the National Committee for Mental Hygiene, an organisation that still exists today under the name Mental Health America.

The original aim, stemming from Beers's horrific experiences as an inpatient, was to improve the care and treatment of asylum patients which soon expanded to focus on the prevention and early treatment of mental health problems (Toms 2010). The movement recognised a wide array of both biological and environmental causative factors in mental illness, including genetic and prenatal factors, infections, alcoholism, drug addiction, head trauma, poisons, vitamin deficiency, poor parenting and maladjustment to various life events and situations (Rosanoff 1938), all of which could work alone or in combination to result in mental illness. It, therefore, drew on both biomedical and psychoanalytic theories without pitting them against each other as well as introducing the idea of social factors as influencing mental health. The

movement promoted the prevention of mental illness through various means, including, but not limited to, eugenics (sterilisation and the use of contraception for those deemed to be unfit mothers), the prohibition of alcohol and improved control of infectious diseases. Some of their recommendations related to better conditions in general, such as a good diet, safer working conditions, sufficient rest and the possibility of secure paid work for all. An important tool in the prevention of mental illness was improved parenting. Childhood was seen as a risky time where the seeds of future mental illness might be sown through, for example, overindulgence or the lack of a strict schedule (Rosanoff 1938). The movement was concerned with the impact of home and family life on mental adjustment, social efficiency and responsible citizenship and stressed the importance of correct parenting in preventing mental illness (Mullan 1914). It advocated the promotion of healthy thinking habits because:

suspiciousness, sensitiveness, seclusiveness, brooding, anxiety, fear, fretting, overwork, over excitement, despondency etc., if not dealt with could go on to cause mental wreckage. (Mullan 1914, p. 174)

In terms of treatment, the movement supported some biological treatments, including brain surgery, and drew on psychoanalytical theory to promote treatment via psychotherapy to correct maladjusted personalities (Rosanoff 1938; Toms 2010).

In Britain, a number of organisations came together to promote mental hygiene: the Central Association for Mental Welfare (CAMW), the National Council for Mental Hygiene (NCMH), the Tavistock Clinic and the Child Guidance Council. The movement was the first to introduce the idea of a team of mental health specialists working together to help a patient, and it promoted the employment of social workers, nurses and psychologists as well as psychiatrists. The development of both social work and psychology as recognised professions in mental health were closely linked to the child guidance clinics where they played key roles. Although the psychiatrist was the head of the team who decided on diagnosis and treatment, the social worker often carried out the treatments recommended by the psychiatrist and had an important role in communications between the child, parent and clinic (Stewart 2012). The psychologists' work expanded from administering psychometric tests to being involved

in more holistic assessments and providing forms of therapy for children (Stewart 2015). Social work practice was significantly influenced by the mental hygiene movement. By the 1930s, social work practice was underpinned by psychoanalytic theory in a range of settings, including the child guidance clinics and psychiatric hospitals. Social work training routinely covered psychoanalytic theory and there was a proliferation of books and articles promoting its use in social work interventions (Applegate 2004). Both social workers and psychologists were supported by the 1944 Education Act that made maladjustment a condition that had to be addressed by education authorities and therefore strengthened the psychosocial approach over the medical approach of the psychiatrists (Stewart 2015).

Within the mental hygiene approach, as in biological psychiatry and psychoanalytic approaches, the professional (which now included the nurse, social worker or psychologist) was the expert, and the patient had to adhere to their advice. The movement recognised the importance of external factors, such as a poor diet and unsafe working conditions on mental health; however, they also saw poor parenting, particularly by mothers, as responsible for mental health problems in their children. In its focus on preventing mental illness, particularly through parenting, the movement introduced the idea that the risk of mental illness could be identified and reduced. The principles of mental hygiene applied to everyone and all could be considered at risk of mental illness:

Mental hygiene as a philosophy of prevention is an ideal and a guiding principle working wherever possible with the assets of life before the differentiation into the 'normal' and the 'pathological'. (Meyer 1930, cited in Abma 2004, p. 103)

The mental hygienists practised pastoral power to some extent in that they advocated caring for and guiding people towards improved mental health whilst also holding them responsible for behaving in a way that would reduce the risk of mental illness in themselves and/or their children. However, they also subscribed to theories of biological causes and therefore understood some patients as having incurable biologically-based diseases, which could not be relieved through better self-control or taking responsibility. Some of the ideas of the mental hygiene movement continue in

mental health services today, such as the belief in multiple and combined causes of mental health problems, professionals working in teams with the same patient and the possibility of preventing mental illness through good parenting, adequate living standards and the early identification of individuals at risk.

Although other professions such as social work were strongly influenced by Freudian ideas, only qualified psychiatrists were able to become psychoanalysts. This meant that psychiatry retained control of the care and treatment of the mentally ill despite the addition of psychological causes of mental illness. However, this began to change when psychologists, who until the 1940s had focused on research and testing, started to use their theories to treat patients. At the Maudsley Hospital in London, although there were separate departments of psychiatry and psychology (Waddington 1998, cited in Marks 2015), psychologists acted as assistants to the psychiatrists, using medical and sometimes psychoanalytic theories to treat patients. The dominance of the biological psychiatrists and the fact that psychologists were forced to use medical theories may have strengthened their efforts toward the development of new psychological approaches to treatment (Fishman and Franks 1992 cited in Marks 2015). The psychologists conducted their own research influenced by the work of evolutionary biologists and using animal studies to understand human behaviour (Eysenck 1994). Their studies of learning and related behaviour led to the development of behavioural therapy and, eventually, cognitive and cognitive behavioural therapy. Cognitive behavioural therapy is recommended by the current National Institute for Health and Care Excellence (NICE) guidelines for the treatment of a wide range of mental health problems, and, not surprisingly, it was considered the best route to recovery for many of the patients who participated in my study. The next section will explicate the beliefs underlying behavioural and/or cognitive therapies and examine how they eventually came to be so popular in contemporary mental health services.

### 3.6 Behaviour Therapy

In behaviour therapy, mental distress was caused by faulty or unhelpful learning, and recovery involved relearning a more adaptive response (Eysenck 1959, cited in Rachman 2015). Unlike in biological psychiatry and psychoanalysis, the problem was

behaviour rather than a disordered brain or mind: 'there is no neurosis underlying the symptom but merely the symptom itself. Get rid of the symptom and you have eliminated the neurosis' (Eysenck 1960, p. 3).

Behavioural therapy at the Maudsley was based on Pavlovian and Watsonian learning theories<sup>10</sup>. Pavlov's experiments with dogs led to the Pavlovian conditioning theory that proposed that animals could learn to respond to a neutral stimulus if it was associated with one that produced an unconditioned or automatic response. Watson's work argued that psychologists should only focus on observable behaviour rather than unconscious processes (Watson 1913). His experiments with Little Albert, a young child, showed that it was possible to create a conditioned emotional response to a neutral stimulus by pairing it with a feared stimulus, that the fear response could be transferred to other neutral stimuli and that the response persisted over time even without reinforcement (Watson and Rayner 1920). In the behavioural approach, like in the biomedical and psychoanalytic approaches, even adult patients were passive. They followed the instructions of the psychologist that were designed to enable them to learn adaptive responses that constituted recovery.

Psychologists initially experienced a strong opposition to them treating patients. The ideas of behaviourism were new, and it was difficult for behaviourists to have their work published in journals. Rachman (2015) described the movement of psychologists from testing to treating patients as 'gradual, discreet and sneaky', happening as it did during a time of the dominance of biological and psychoanalytic approaches (p. 2).

Many psychologists at the Maudsley carried out research with patients, providing evidence of the effectiveness of behavioural modification techniques in treating neuroses (Gwynne Jones 1956; Shapiro and Ravenette 1959). As psychologists moved on from the Maudsley, they introduced behavioural techniques to other hospitals. For

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<sup>10</sup> A key figure at the Maudsley, Hans Eysenck, was critical of both Thorndike and Skinner's theories due to their failure to explain why some patients engaged in self-defeating behaviours (See Eysenck 1981, p. 344).

example, at Middlesex Hospital, Victor Meyer developed the use of flooding<sup>11</sup> techniques to treat obsessive-compulsive disorder (OCD) (Meyer 1966; Rachman 2015). As well as for the treatment of outpatients with neurosis, behavioural modification techniques were also used in mental hospitals as part of rehabilitation programmes. Token economy systems became popular as a way of encouraging patients to develop social skills that would be needed for their discharge into the community (Burns 1970).

The behaviourists' interest in evidencing the outcomes of their treatments coincided with the NHS concern over the efficacy of its treatments in the context of the late 1940s post-war budget constraints. This contributed to the growth of behaviour therapy as an accepted NHS treatment even early on in its development (Marks 2015).

Behaviourists faced ongoing challenges from inside their discipline from psychologists who argued for the existence and importance of studying mental events despite the challenges in doing so (Calkins 1930; Roback 1937). The experimental methods used by behaviourists were eventually developed by cognitive and cognitive behavioural therapists (Eysenck 1994). The principles and theories of behaviourism have since been incorporated into contemporary therapeutic models, including acceptance and commitment therapy and dialectical behaviour therapy (Jackson-Brown 2015). These cognitive behavioural therapies are recommended by the current NICE guidelines and are offered to many contemporary patients with the expectation that they will lead to recovery.

### 3.7 Cognitive and Cognitive Behavioural Therapies

The pioneers of cognitive and cognitive behavioural therapies came from different theoretical backgrounds but were united by a belief that cognition played an important role in people's responses to both external and internal events (Dobson and Dozois 2001). In cognitive and cognitive behavioural therapy, mental distress or the

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<sup>11</sup> Flooding techniques involve exposing the patient to an extreme anxiety-provoking event and enabling them to remain in or frequently face the situation until their anxiety has subsided that is thought to cure the fear.



symptoms of mental illness are related to dysfunctional thinking and beliefs arising through faulty learning, and recovery involves the modification of these beliefs. The patient is assumed to be in control and must take an active role in their recovery. Unlike psychoanalytic approaches, the cognitive behavioural model is explained to patients, and it is thought that their understanding will enhance their recovery (Knapp and Beck 2008).

Albert Ellis's rational emotive-therapy (RET) is generally considered to be the first cognitive therapy (CT). Neurosis in RET was understood as 'disordered ... uncontrollable emotion' that comes about as a result of 'illogical, unrealistic, irrational ... childish thinking' (Ellis 1959, p. 38), expressed in people who did not have intellectual disabilities: 'Neurosis, in other words, consists of stupid behaviour by a non-stupid person' (Ellis 1959, p. 38).

Ellis' theories differed from the behaviourists in that he believed in free will (Marks 2015) and (in common with psychoanalytic approaches) the importance of the patient's childhood experiences. However, he was also critical of the Freudians and rejected the psychoanalytic idea of repression in favour of a conscious process of belief formation (Ellis 1959; Marks 2015). The therapist's role in RET was to enable the client to recognise his/her illogical thinking, show how they caused the client's unhappiness, demonstrate exactly how they were illogical and teach the client more adaptive ways of thinking (Ellis 1959) that would result in their recovery. Another pioneer of cognitive therapy was Aaron Beck who was originally a psychoanalytic psychiatrist. Beck's research suggested that depressed clients experienced automatic negative thoughts that impacted their emotions and behaviours. He argued that by encouraging clients to identify and assess these thoughts, they developed a more realistic understanding of their situation that increased their emotional wellbeing (Beck 1967).

Despite the significant differences underlying behavioural and cognitive therapies, they did eventually integrate, perhaps because it was very difficult to explain the efficacy of behavioural techniques without any reference to thought processes, and some later forms of behavioural therapy that included verbal conditioning were hard to classify as purely behavioural (Marks 2015).

More recently, a third wave of CBT approaches has developed that focuses on the client's relationship with their thoughts and emotions rather than the content thereof (Hayes and Hofmann 2017). These third-wave CBT approaches include dialectic behaviour therapy (DBT), which was developed to treat people with personality disorders. DBT was developed in North America by Marsha Linehan (1994), following her own experiences of hospital admission for self-harm. It draws on the principles of CBT but also incorporates mindfulness, acceptance and dialectics, the main dialectic being the synthesis between acceptance and change (Feigenbaum 2008). It also focuses on learning and practising new skills rather than changing thoughts. The aims of DBT are to reduce parasuicidal and life-threatening behaviours and to reduce behaviours that interfere with therapy and the person's quality of life (Linehan et al. 1991, cited in O'Connell and Dowling 2014). DBT is generally delivered over 12 months and consists of four elements: individual therapy, group skills training, access to therapists in times of crisis and homework. DBT is currently recommended by the NICE guidelines for the treatment of women with borderline or emotionally unstable personality disorders for whom reducing self-harm is a priority (NICE 2009). It was frequently offered as a treatment to participants in my study with these diagnoses. It was understood as leading to recovery by enhancing the patient's ability to manage and control their emotional responses.

A large evidence base has been established for CBT, and it is now promoted by the NHS as an appropriate treatment for a range of diagnoses (NHS 2019). The kinds of thought distortions originally identified by Beck in the 1950s are still in use in modern forms of CBT (Grohol 2019). Knapp and Beck (2008) suggest that contemporary cognitive behavioural therapies can be split into three main types: coping skills therapies that help patients develop skills for coping in problem situations (Meichenbaum 1993, 1985, cited in Knapp and Beck 2008), problem-solving therapies that emphasise the development of general strategies to cope with a variety of difficulties (D'Zurilla and Goldfried 1971) and restructuring therapies that aim to change distorted thinking and promote adaptive thoughts (Ellis 1959; Beck 1967).

The cognitive behavioural approaches viewed the patient very differently from biological and psychoanalytic approaches: the patient was seen as actively involved in

their treatment and recovery. The theory behind the treatment would be explained to the patient who was considered capable of understanding and using it to aid their recovery. The imbalance of power between therapist and patient was therefore not so great as in previous modes of treatment, and for the first time, the patient became at least partly responsible for their own recovery. A pastoral mode of power can clearly be seen in cognitive and cognitive behavioural therapies. The patient is expected to confess their thoughts and feelings to the therapist, then the expert therapist interprets these and reflects this interpretation back to the patient who is expected to take responsibility for changing and managing their thoughts and behaviours. Cognitive behavioural therapies focus on enabling the client to learn skills that will help them manage their own behaviour in future situations without needing the guidance of the expert, hence becoming independent, self-managing citizens.

The idea of free will and patient responsibility, inherent in cognitive behavioural therapies, can be seen in the contemporary recovery approach. It was also strongly present in a parallel development in relational therapies; humanistic therapy. The underlying values of humanistic therapies can be seen in contemporary approaches to mental health across all professions and are particularly relevant to the recovery approach.

### 3.8 Humanistic Therapies

Humanistic therapies arose in response to the limitations and potentially negative impacts of behaviourism and psychoanalysis, which dominated psychology in the first half of the twentieth century (Thorne 2007, cited in Davies et al. 2010). Although humanistic therapies arose partly in opposition to some aspects of psychoanalysis, they also drew on some neo-Freudian ideas. The neo-Freudians adapted and developed Freud's ideas in ways that sometimes led to very different forms of psychotherapy. Where Freud had proposed that humans were motivated by sexual and aggressive urges, the neo-Freudians began to see a role for social motivations and the importance of developing interactions within society. Karen Horney (1950), Carl Jung (1991) and Frieda Fromm-Reichmann (Fromm-Reichmann et al. 1953) all developed psychoanalytic therapies that saw humans as striving for self-realisation

and suffering as a result of hiding or repressing their true selves. Key figures in humanistic psychology, including Carl Rogers and Abraham Maslow, drew on these ideas to develop their own humanistic therapies (Gunn et al. 2015).

Like psychoanalysts, humanistic therapists saw mental distress as originating in the mind rather than the body. However, the symptoms of distress were understood as resulting from imbalance rather than illness. In humanistic approaches, the individual is viewed as an integrated and self-regulating whole, but if this balance is disturbed, distress and dysfunction can arise (UKAHPP 2021). Recovery, therefore, involves the person finding their true self, regaining their inner balance and reaching their potential.

Unlike behaviourist and psychoanalytic approaches, humanistic psychology considers the importance of values, intentions and meanings (AHPP 2020). All humanistic therapies share a number of core beliefs, including that humans are neither naturally good nor bad but seek security, love, belonging and truth and, given the right conditions, will tend towards reaching their full and true potential. In this approach, recovery refers to an ongoing process as people can continue to strive toward their full potential throughout their lives. Problems or distress are considered in a person-focused rather than a disorder-focused way. The reduction of the symptoms is not usually an explicit goal of person-centred therapies, and unlike in biological psychiatry and psychoanalysis, it does not constitute recovery. It may, however, occur as the person increases self-acceptance and experiences personal growth through therapy. In addition, clients are treated as experts in their own distress (Churchill et al. 2010). In humanistic approaches, humans are considered self-aware and as of possessing free will and, therefore, are responsible for their choices.

Maslow (1943), Rogers (1951) and Kelly (1955) were key contributors to the humanistic approach. Maslow (1943) developed a hierarchical theory of human motivation. He theorised that when basic needs, such as physiological needs or needs for security and belonging, are satisfied, a higher level of motivation and self-actualisation can occur. Roger's (1951) person-centred therapy also promoted the idea of a self-actualising tendency. Recovery, in a humanistic sense, did not involve the

concept of disease or disorder; Rogers considered normal, neurotic and psychotic misleading labels (Rogers 2004). He believed that distress and dysfunction were caused by incongruence that occurred when an individual sacrificed his/her true self in order to gain positive regard. These experiences and feelings cannot be integrated into the self-structure, and the person may develop defence mechanisms to protect their self-concept. In Roger's theory, the client's self-actualising tendency, and hence recovery, would be allowed to emerge when the therapist was congruent and showed unconditional positive regard and empathy (Rogers 1957).

Kelly, an American clinical psychologist, developed personal construct theory (Kelly 1955), which became popular in the UK. Personal construct theory argued that people developed constructs or rules for interpreting events, situations and other people, and these rules were based on their experiences and could be modified through further experience. Personal construct therapy was nondirective and aimed to enable people to explore their own constructs without therapist influence (Winter and Reed 2020). Kelly developed idiographic measures, and his approach was cognitive and pragmatic, which fitted with the dominant scientific approach to psychology in the UK at that time (Pilgrim and Parry 2015).

The humanistic approach to therapy has some important values in common with the modern recovery approach: the understanding of recovery as an ongoing process of personal growth rather than the end of symptoms, the belief in the expertise of the client and their ability to self-actualise (or recover) with the right support and the belief in clients as having free will and hence responsibility for themselves and their behaviour. The change in the relationship between the distressed individual and the therapist was reflected in language too: the distressed person became a client rather than a patient, a term that positions the individual as actively choosing to use the services of a therapist to assist in their recovery, as opposed to a patient passively receiving treatment from an expert to cure their illness. The humanistic therapist was a facilitator of change rather than a curer of illness, and the patient had the power within them to self-heal. Like cognitive and cognitive behavioural therapists, humanistic therapists also exercised pastoral power: they encouraged their clients to share their innermost thoughts and feelings, helped them interpret them and guided

them in their self-development to become independent citizens, able to manage their emotions and maintain their own mental health.

At the same time as the psychotherapeutic approaches to mental illness were introducing new understandings of mental distress as psychological and linked to experience and the social environment, advances were also made in biological psychiatry with the advent of the first effective psychotropic drugs. The development of effective drugs initially appeared to strengthen the biomedical model of mental illness and allowed psychiatrists to criticise the theories of social and psychological factors drawn on by other professions (Long 2011). However, various problems with the drugs became apparent and ultimately, these contributed to a more negative public perception of biological psychiatry. Psychotropic drugs continue to be widely prescribed in contemporary mental health services despite the fierce debate over their effectiveness and iatrogenic effects as well as concerns about the ethics of the psychopharmaceutical industry (Moncrieff et al. 2005; Hutton et al. 2013; Moncrieff 2015; Moncrieff and Steingard 2019).

### 3.9 The First Effective Psychotropic Drugs

Often touted as ‘the first drug that worked’, chlorpromazine was developed in the 1950s in Parisian laboratories (Shorter 1997, p. 246). For the first time, a drug almost completely eliminated the symptoms of psychosis, allowing patients to live a more ordinary life without the horrific and/or lethal side effects of previous drug treatments. Lithium had been used medically, including psychiatrically, as early as 1847. However, it was not widely known, and the initial literature was quickly forgotten. In 1949, in Australia, Dr John Cade used lithium citrate and lithium carbonate on manic-depressive patients with impressive results. His findings were confirmed by others (Noack 1951; Schou 1952, cited in Shorter 2009), but due to the concerns about its safety, the drug did not undergo clinical trials until 1960 and was eventually approved for use in the UK in 1966 (Shorter 2009). Antidepressants and tranquilisers were also developed by drug companies in the 1950s, and by the 1980s, they were prescribed for millions of people, mainly women, across America and Europe (Dowbiggin 2011; Scull 2011).

The discovery of effective drugs for mental illness helped maintain the role of the doctor as only medically qualified doctors could prescribe drugs. It also strengthened the claims that there was an underlying pathology for mental illnesses and allowed psychiatrists to dismiss the ideas of social and psychological factors in mental illness (Long 2011). In addition, the prescription of drugs for anxiety and depression meant that psychiatrists and GPs became involved in managing the mental health of millions of people outside of hospitals. However, the newfound enthusiasm for biomedical drug treatments was short-lived as the new drugs started to cause problems. The side effects of the antipsychotic drug largactil, hailed by some as a miracle cure for schizophrenia, were first noticed in the USA. Those who took it on a long-term basis started to show odd movements of the tongue, cheeks and jaw similar to those seen in Parkinson's disease. These side effects were not thought to be significant in a hospital environment but became more troublesome when patients were discharged into the community (Shorter 1997). The unpleasantness of the symptoms meant that many patients who had been discharged from hospital simply stopped taking the drug, became ill and returned to hospital, leading to the phenomenon of the revolving door (Garrido and Saraiva 2012). In addition, the problem of women's addiction to tranquilisers became apparent, and evidence emerged of the side effects and dependency caused by prescription tranquilisers (Kales et al. 1969; Lader and Petursson 1981; Ashton 1986, 1987; Woods et al. 1987; Dowbiggin 2011)

The discovery of effective psychotropic drugs may have initially strengthened the medical model, but ultimately, concerns about the negative side effects and the dangers of addiction, along with revelations about potentially corrupt research and immorality in the psychotropic drugs business (Moncrieff et al. 2005; Hutton et al. 2013; Moncrieff 2015; Moncrieff and Steingard 2019) led to increased suspicion and criticism of the biological psychiatric approaches to mental illness. These concerns expressed by various groups contributed to the anti-psychiatry movement, the key figures of which were mainly psychiatrists themselves. The anti-psychiatry movement had a significant impact on public thinking about psychiatry, changing it from a mainly positive view in the 1950s to a more critical perspective by the mid-1970s (Dowbiggin 2011). The movement contributed to the shift in policy to community care for mental

health patients as well as prefiguring the mental health service user movement, both of which had significant consequences for the current understandings of mental illness and recovery. I will outline the key elements of the anti-psychiatry movement below before discussing deinstitutionalisation.

### 3.10 The Anti-psychiatry Movement

The term anti-psychiatry is used to describe a prolonged period of challenge to psychiatry between the 1960s and 1970s. The movement centred around a core group of charismatic individuals and their writings (Crossley 1998). Despite being known as a movement, the key figures leading it only agreed on the idea that psychiatry was their common enemy, but their reasons for opposing it varied and sometimes even conflicted. In addition, several of them objected to the label anti-psychiatrist (Berlim 2003; Burston 2018). The proponents of the movement questioned the theoretical principles upon which biological psychiatry was based. They rejected the idea that mental illness was a real disease entity and/or that it was biological in origin, and hence questioned the authority of psychiatrists to detain and treat people diagnosed as suffering from these diseases.<sup>12</sup> The anti-psychiatrists promoted a relationship of equality between the distressed individual and those who supported them, in line with the contemporary recovery approach.

Much of the underlying principles of anti-psychiatry drew on labelling theory (Goffman 1968) that proposed that psychiatric diagnoses were labels that, rather than

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<sup>12</sup> Foucault's work was influential in the anti-psychiatry movement (Shorter 1997). However, he did not define his own work as anti-psychiatry (O'Farrell 2005), and his focus differed from the key figures discussed in this section. The anti-psychiatrists questioned the truth of the knowledge base of psychiatry and on that basis, questioned the right of the psychiatrists to exercise power over those labelled mentally ill. Foucault's work instead explored how this knowledge base came to be understood as the truth by focusing on the practices of power (Foucault 2008). His argument that psychiatrists had merely swapped physical restraints for 'the far more insidious chains of science and moral training' (O'Farrell 2005, p. 36) supported the anti-psychiatrists' arguments about the unacceptable power of psychiatry.



identifying biological illness, reflected what society found unacceptable. Diagnoses were given to people who violated the social norms of their community. Goffman's studies of asylums showed how patients (and staff) became institutionalised and reinforced the chronicity of mental illness. The ways in which patients resisted this institutionalisation were interpreted as the symptoms of mental illness, showing the impact of the label in interpreting their subsequent behaviour (Goffman 1961). Goffman's work highlighted the negative consequences of asylums and contributed to the ideas of deinstitutionalisation, which began to feature in the government's plans from the early 1960s.

The key figures in the anti-psychiatry movement proposed different ideas as to the causes of mental distress. R D. Laing initially suggested it was caused by dysfunctional families (Laing and Esterson 1970) before arguing that schizophrenia was a gift enabling deep insight (Laing 1967). Cooper (1965) drew on Laing's early theories to propose that schizophrenia was a 'microsocial process' in which a family member was selected arbitrarily to become schizophrenic (1965, p. 11). Szasz (1961) argued that a behaviour labelled as mentally ill was in fact intentional and performed by people who had problems in their lives<sup>13</sup>. Basaglia understood mental distress as the result of social violence toward and the exclusion of the poor and weak in society (Berlim et al. 2003).

For the anti-psychiatrists, mental distress was therefore not an illness to be recovered from but an experience to be coped with and learned from (Cooper 1965; Laing 1967), a behavioural choice that could be changed (Szasz 1961) or an experience of oppression that was to be recognised and fought against (Berlim et al. 2003). The anti-psychiatrists' ideas of suitable responses to mental distress differed. However, they all promoted a different kind of relationship between patients and staff to that of any of the previous approaches. The movement drew on humanistic ideas to some extent in

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<sup>13</sup> Szasz did not see himself as a proponent of anti-psychiatry and in fact, was very critical of the movement (Berlim et al. 2003).

its proposal that patients' expertise should be valued but took this to a more extreme position.

For some anti-psychiatrists, the notion of relationships with staff was not relevant as no treatment from staff was required<sup>14</sup>. However, most of the proponents of the anti-psychiatric ideas discussed the idea of staff assisting patients in some way. Staff did not need to be qualified in any field and may have been unpaid. Additionally, patients could help other patients in their journeys of discovery. For Laing and Cooper, staff and fellow patients were understood as supporting and accompanying people on their existential journeys (Cooper 1965; Chapman 2020). They were seen as equal and as both experiencing 'madness' in some form. Patients' views were at least, if not more valid than the staff's (Cooper 1965). Laing and Cooper, along with others, put this belief into practice in the form of various experimental alternatives to the asylum. In 1962, Cooper established Villa 21, which was a ward at the Shenley Mental Hospital in Hertfordshire where Cooper worked. Villa 21 accommodated 19 young men with diagnoses of schizophrenia, personality disorders or emotional crisis. According to Cooper's rules, the patients were treated by group and community therapy only; no drugs were administered. The regime was permissive; the only hospital rules enforced related to nudity and sexual activity (Wall 2013). The experiment ended when Cooper left in 1966, concluding that it could not fully work due to the constraints imposed by the wider institution (Shenley Hospital). In 1965, under the auspices of the Philadelphia Association, Cooper, Laing and others established Kingsley Hall and several other therapeutic communities that aimed to break down patient–doctor boundaries by having them live together (McGeachan 2014). Laing's son, Adrian, explained: 'The philosophy was to find one's true and authentic self, to let go of the preconceived ideas of one's false self as imposed by the family and society at large' (1994, p. 108, cited in McGeachan 2014).

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<sup>14</sup> Basaglia advocated increasing patients' political awareness and encouraging action to reject their social exclusion, including violence (Berlim et al. 2003).

Within the anti-psychiatry movement, patients were seen as autonomous and responsible for their choices and behaviour (Szasz 1961; Cooper 1965), a perspective visible in both the moral treatment approach and the contemporary recovery approach. The anti-psychiatrists enabled the questioning of psychiatrists and their medical expertise. They challenged the dominant discourse of madness as mental illness and the authority of the medical profession to assume control over mental health issues. They showed that many people without medical or other qualifications could be helpfully involved in the care of people with so-called mental illness. Like the humanistic therapists, they raised the status of the patient in the staff--patient relationship. However, as well as recognising the expertise and power of the patient in their own recovery, they also challenged and downgraded the expertise of the professional, suggesting that no professional could claim any special expertise when it came to alleviating mental distress.

Although the original anti-psychiatry movement is generally considered to have come to an end in the 1970s (Crossley 1998), a number of contemporary anti-psychiatry trends can be identified in the current literature, including mad studies (Lefrancois et al. 2013), psychopolitics (Spandler et al. 2015) and critical psychiatry (Bracken and Thomas 2001 2010). These streams of work promote different but sometimes overlapping perspectives on psychiatry and mental health services, reflecting key themes of the original anti-psychiatry movement and the diverse interests of the contemporary service user movement.

Mad studies calls for the end of psychiatry and staff-led mental health services, which presumably includes the recovery approach as practised in these services.

Psychopolitics and critical psychiatry, however, do not reject psychiatry but call for improved mental health services (Cresswell and Spandler 2016). In relation to critical psychiatry, Thomas and Bracken (2004) propose that services engage with service users' understanding of their distress and support a user-led concept of recovery. In addition, Recovery in the Bin, an online, user-led community, focuses on the critique of the colonised version of recovery practised in UK mental health services (Recovery in the Bin 2016).

The anti-psychiatrists' critique of psychiatry and its role in social control, along with Goffmans' work on the negative impacts of institutions in the 1960s and 1970s, was one of a number of factors that contributed to deinstitutionalisation, the movement of tens of thousands of long-term psychiatric (and other) patients into community settings. In the next section, I will explain how this change in the arrangements for the care of mentally distressed individuals led to a focus on multidisciplinary team work and an increasing acceptance of a greater range of understandings of recovery.

### 3.11 Deinstitutionalisation

A number of conditions and events led to the large-scale movement of psychiatric patients from institutions into community settings over several decades from the 1980s to the 2000s. Some commentators argue that the development of the first effective psychotropic drugs was an important factor in the closing down of the asylums (e.g. Shorter 1997), however, others argue that they contributed to, but were not responsible for, deinstitutionalisation (Murphy 1991). Goffman (1961) had drawn attention to the negative effects of long-term hospitalisation. Incarceration was now understood as contributing to the patients' difficulties rather than alleviating them. In addition, a number of scandals in the 1960s and 70s revealed poor care and abuse in several large institutions (King's Fund 2020), which included the Ely Hospital in Cardiff. Related to this critique of psychiatric services, alternative ideologies developed, which supported a shift to community-based services. The concept of normalisation, originally developed in Scandinavia (Nirje 1970), was influential in the UK.

Wolfensberger defined normalisation<sup>15</sup> as 'utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible' (1982, p. 28).

The idea of community care began to appear in British mental health policy as early as 1946. The National Health Service Act 1946, The Mental Health Act 1959 and the white

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<sup>15</sup> Wolfensberger's theory of normalisation is separate from Foucault's concept of normalisation. It refers to offering people with disabilities normative environments and the choice to undertake normative activities and was a response to the large institutions of the time that did not reflect normal social environments, hence preventing patients from having a normal life.

paper *Better services for the mentally ill* in 1975 all encouraged the provision of community care facilities. In 1961, the then health minister, Enoch Powell, gave the rather dramatic Water Tower Speech, proposing the closure of asylums (Powell 1961). This was followed, in 1962, by a hospital plan for England and Wales (NHS 1962) that proposed the restructuring of services to include psychiatric beds in local general hospitals and the development of community care services by the local authorities. The plan included a proposed reduction of psychiatric hospital beds in Wales from 151,899 in 1960 to 92,090 in 1975 (NHS 1962, p. 275). In the 1980s, reports by the Audit Commission (1986) and Griffiths (HMSO 1990) criticised the progress of community care provision, and in 1989, the government produced the white paper *Caring for people* (HMSO 1989) that, unlike previous policy, required the provision of community care facilities. Following the recommendations of the Griffiths report (HMSO 1990), the white paper made local authorities (rather than the NHS) responsible for the overall provision of community care, helping strengthen the role of social care professionals and their psychosocial approach in the care of people with mental health problems. The psychiatric profession expressed some resistance against the local authorities taking responsibility for mental health care. In a response to the Griffiths report, the Royal College of Psychiatrists (RCP) stated that:

The NHS should have overall responsibility for the care of the mentally ill' as 'the Health Service contains by far the largest fund of expertise in the assessment and care of the mentally ill. (RCP 1988, p. 385)

Although the local authorities were ostensibly responsible for arranging mental health services, the funding arrangements made them reliant on the health authorities to approve packages of care, meaning that health professionals still retained some control over what care was provided (Tudor 1990). The Griffiths report and the subsequent white paper made local authorities responsible for organising care in the community but not necessarily providing it; they could award contracts for work to third or private sector organisations (Murphy 1991). This provided opportunities for both sectors to grow, and by the 2000s, numerous services, including housing, day services and counselling, were provided by mental health charities, such as Mind and private companies.

In the early 1970s, English and Welsh policy had advocated the separation of health and social care services, but this led to difficulties with interprofessional collaboration, and by the late 1970s, the DHSS (1978) encouraged multidisciplinary work in the interest of patients. Community mental health centres (CMHCs) became a popular way of providing mental health care in the community. The first centre opened in 1977, and by 1987, 127 centres were already open or had funding agreed on, and a further 155 were planned (Sheppard 1991). The CMHCs took a wide variety of forms but were generally staffed by social workers and community psychiatric nurses, along with occupational therapists, clinical psychologists and psychiatrists. They emphasised multidisciplinary teamwork and used psychosocial methods of intervention to assist with the patients' resettlement into community settings (Shepherd 1991). The Care Programme Approach, introduced in England in 1990 and later in Wales (WAG 2002), required that each service user be assigned a care coordinator who would be responsible for arranging and overseeing a package of care. This care could include not just medication or therapy but forms of occupation, housing and social activities, meaning that although patients were not in institutions, the mental health team still intervened in many aspects of their lives. The community mental health centres continued to grow in popularity and now, commonly known as community mental health teams (CMHTs) rather than centres, they comprise the standard arrangement for the provision of mental health services to outpatients in the community. The mental health team and the professionals within it have therefore become powerful in shaping ideas about what constitutes recovery and how it should be achieved. The next section discusses the origins of the main professions usually included in a mental health team and how they came to be a part of the team.

### **3.12 The Community Mental Health Team**

#### **3.12.1 Psychiatrists**

As services for the mentally ill moved into the community, so did psychiatrists who joined the community mental health teams. However, a survey in 1993 by Onyett et al. (1994) found that they were usually the only psychiatrist in a team, often worked part-time and were not present at all in one-fifth of the teams surveyed. Psychiatrists' work

mainly comprised of diagnosis, prescription of psychiatric drugs, running depot clinics, crisis intervention and undertaking Mental Health Act assessments. There was an assumption within the psychiatric profession that psychiatrists would be the managers of the new Community Mental Health Teams (RCP 1977). Harrison (1989) discusses the need for training for psychiatrists in their new management role and refers to the anxiety experienced by psychiatrist when staff in community teams acted 'independently of the consultant' (p.348).

This fits with the findings of Peck and Norman (1999) and Onyett et al. (1997) who found that psychiatrists reported high levels of anxiety due to the high level of responsibility they felt for the outcomes in the CMHTs. However, a survey of 302 CMHTs (Onyett et al. 1994) suggested that psychiatrists actually had very little management responsibility. This survey, along with other research into the functioning of CMHTs, conducted in the 1990s, suggested other mental health professions rejected the authority of the psychiatrists in CMHTs and questioned why they would automatically assume responsibility for leadership (Muijen 1993; Onyett et al. 1994; Peck and Norman 1999).

The impact of community care, multidisciplinary teamwork, and the increasing influence of the psychosocial approaches alongside the continuing challenges to the medical model and its treatments (e.g. Double 2002; Kingdon and Young 2007; Lewis and Leiberman 2008; Moncrieff 2008a, 2008b; Beresford et al. 2016), have led some to question whether psychiatry is in crisis (Pilgrim and Rogers 2009). Although psychiatrists began to take psychological and social factors in mental illness more seriously and developed a more eclectic approach (Ramon 1985; Fawcett and Karban 2005), most commentators in the 2000s agreed that they remained committed to primarily physical causes and treatments (Moncrieff and Crawford 2001; Rogers and Pilgrim 2014). More recently, this belief in organic causes and treatments has been strengthened by the findings of research into neuroscience and genetic/epigenetic factors in mental health (Craddock et al. 2008). However, alongside a continuing commitment to biological causes and treatments, there has been a move toward more person-centred relationships with patients that recognise patient expertise and

attempt to build a more equal doctor–patient relationship, in line with a contemporary recovery approach (Roter 2000; Barry and Edgman-Levitan 2012).

### 3.12.2 Social workers

In the 1930s, the social work approach to mental illness and recovery, strongly influenced by the mental hygiene movement, was focused on psychoanalytic theories along with an awareness of the impact of social conditions, such as unemployment, on people's lives. Social work training took place at the postgraduate level and entrants were required to have a degree in social sciences, reflecting their focus on psychosocial over biological theories. social workers' involvement in adult mental health care slowly grew as mental health legislation in the 1930s and 1940s allowed, encouraged and recognised their role in both hospitals and limited community services (The Mental Treatment Act 1930; The NHS Act 1946). Social work training in the 1930s emphasised their role as providing assistance to psychiatrists (Timms 1964).

Timms (1964) identified a move in social work training towards social medicine and sociological concepts from the mid-1950s. It was in the 1950s that a number of large-scale sociological surveys found evidence of the link between social disadvantage and mental illness (Rogers and Pilgrim 2014). Long (2011) explains the way in which psychiatric social workers at that time developed psychiatric social treatments that enabled patients to function as well as possible in the community, given the disabling impacts of physical treatments. Social workers believed that recovery could not happen without addressing the patient's social and environmental circumstances. They were critical of the way in which physical treatments negatively impacted patients' ability to function in society, but, like psychiatrists, their treatment was aimed at enabling clients to adjust to society and perform the roles expected of them as parents, workers, etc. in a normative manner. However, in the 1960s, drawing on the increasing social science research evidence, social workers began to suggest that poor social and economic conditions were detrimental to people's mental health and that society should also adjust to better support people in difficult circumstances (Long 2011).



Social work practice, policy and training were increasingly influenced by sociology from the 1960s onwards (Jones 2020). The sociological analyses of power, community and equality, along with the civil rights struggles of the 1960s, including the anti-psychiatry movement, contributed to the rise of radical social work. The radical social work approaches were grounded in Marxist analyses of power and class and emphasised being with people who were subject to poverty and oppression (Jones 2020). In this approach, recovery was associated with changes in society that would make people less susceptible to developing mental health problems. In the late 1970s and 1980s, social workers joined the new multidisciplinary mental health teams. The managerialist and marketisation-focused legislation brought in by the Conservative and New Labour governments in the 1990s changed the role of social work, encouraging technical and task-based work (Jones 2020). However, the professional standards of social work still focus on issues of social justice and challenging oppression and disadvantage (Social Work England 2020; International Federation of Social Workers 2021).

### 3.12.3 Community psychiatric nurses (CPNs)

In the 1920s and 30s, the psychiatric profession supported the employment of nurses in mental hospitals as it helped strengthen the opinion that mental health was a respectable branch of medicine like any other. However, the gender- and class-based assumptions about general nursing at the time meant that both men and asylum attendants were excluded from the role of mental health nurse, a policy that was not fully reversed until 1960 (Godin 1986).

After the Seebohm Report in 1968, social work involvement in mental hospitals and patient aftercare decreased substantially for a short time, and this enabled CPNs to increase their numbers significantly in the 1970s (Hargreaves 1979, cited in Sheppard 1991). As mental health care moved into the community, the role of the mental health nurses began to involve work outside of hospitals, initially focused on administering medication to patients in their homes or at community-based clinics. Godin (1996) suggested that this was beneficial to the psychiatric profession as it allowed them to extend their medical authority outside of the hospitals. However, over time and influenced by government policy encouraging a more psychological approach, nurses

began to incorporate psychosocial approaches in their work. Nurses originally worked mainly in primary care under GPs; this gave them a lot of autonomy that they were reluctant to lose by joining the community mental health centres. However, subsequent developments in mental health policy and law meant that CMHCs became the main way in which mental health care would be offered, and therefore, it made sense for CPNs to join these teams (Godin 1996).

#### 3.12.4 Clinical psychologists

By 1974, psychologists were working in child guidance clinics, private practice and in the NHS, although very few in community-based services. The growth of the number of psychologists in NHS mental health services began in 1975 when *Better services for the mentally ill* (DHSS 1975) acknowledged the contribution of psychologists to mental health care and recommended increasing their numbers substantially, including in the developing community mental health centres. Psychologists began to provide support to physicians in primary care as well as to patients who had been discharged from long-stay institutions. Between 1975 and 1999, the membership of the British Psychological Society (BPS) grew by approximately 336% (BPS 2009), and the various special interest groups became involved in conducting research and disseminating evidence-based practice. This contributed significantly to the National Service Framework (DoH 1999) that emphasised the importance of psychological approaches in managing mental illness and introduced specialist community teams, such as assertive outreach, crisis resolution and home treatment teams, which the psychologists became part of.

The increasing access to psychological therapies (IAPT) programme (NHS 2020) was rolled out in England in 2008 and aimed to enable greater access to therapies for people suffering from anxiety and depression. The IAPT programme did not apply in Wales, but there was a similar commitment in Welsh policy and legislation to improving access to psychological therapy. In Wales, the use of psychological therapies was to be broadened so that not only psychologists but all professions should be using psychological techniques delivered through a multidisciplinary team approach (Welsh Government 2012).

Research comparing the outcomes of various forms of psychological therapies, including CBT, humanistic and psychodynamic therapies, has consistently suggested that all are equally effective, a phenomenon known as the dodo bird effect (Beutler 1991; Stiles et al. 2006; Budd and Hughes 2009). However, the NICE guidelines consistently promote cognitive behavioural therapy as the therapy of choice for a wide range of conditions, including depression, anxiety, eating disorders and self-harm. There is a wealth of evidence for cognitive behavioural therapies as they lend themselves more easily to comparison through randomised controlled trial, the gold standard of research (Holmes 2002a). Turner et al. (2015) suggest this situation raises questions about how much the NICE guidelines are 'based on competing professional interests as well as by evidence' (Turner et al. 2015, p. 620). The NICE guidance means that NHS services most frequently offer CBT-based interventions, and this may weaken the claims of person-centred or psychodynamic approaches to enable recovery from mental illness/distress.

#### 3.12.5 Occupational therapists

Although the term occupational therapy was not in use until the early twentieth century, the idea that a suitable occupation contributed to mental health was evident in the moral treatment approach. The moral treatment approach recommended a variety of activities be made available to patients whilst emphasising the need for their willing and active participation (Browne 1837, cited in Paterson 2008). The eventual overcrowding of asylums made supervised activity difficult, but a number of influential individuals, including psychiatrists, nurses and social workers in the USA, continued to develop new initiatives based on beneficial occupation. They were visited by a number of British professionals who went on to develop occupational therapy activities across hospitals in the UK (Paterson 2008).

Occupational therapy in UK mental hospitals was originally given on prescription and was limited to craft activities. However, during the 2<sup>nd</sup> World War, craft materials became difficult to source, and occupational therapists expanded the kinds of activities offered to patients to include those related to real-life occupations. In 1948, most occupational therapists became employees of the NHS. Research on the beneficial

impact of activity from the 1950s onwards helped develop a theoretical basis for the occupational therapists' work, and they eventually moved from being assistants to the psychiatrists to independent professionals (Coia and Joice 1989).

There was initially a struggle for power as the British Medical Association wanted to continue to control the occupational therapy profession. However, the *Professions Supplementary to Medicine Act* (1960) allowed a compromise whereby the medical profession was represented in leadership but did not have sufficient power to override the wishes of the occupational therapists themselves. The Act also formally recognised the need for qualified occupational therapists in the NHS (Paterson 2008). As mental health services moved into the community, so did occupational therapists who eventually joined the community mental health centres.

Social workers, occupational therapists, psychologists and community mental health nurses all originally worked under the supervision of psychiatrists and assisted in the provision of treatment based on a biomedical model of illness and recovery. They were influenced by increasing research in disciplines such as sociology and psychology that allowed them to claim a professional knowledge base separate from that of psychiatry and eventually, to gain independence from psychiatry. The move to community care also enabled them to develop their professional roles as psychosocial approaches became more important in assisting former long-stay hospital patients to integrate into the community.

The gradual move from hospital-based to community-based services contributed to an increasingly multidisciplinary approach to mental health problems as patients began to need assistance with nonmedical issues, such as integrating into society, learning the everyday skills of independent living and finding a meaningful and satisfying occupation. The community mental health team were responsible for overseeing care and as such, liaised with a range of other mental health services. Services, such as day centres, supported housing and employment workshops were set up in the statutory, third and private sectors that were run by a range of mental health professionals alongside unqualified staff. Recovery began to focus less on the end of symptoms and more on the ability to cope independently in the community even with ongoing

symptoms, in line with the contemporary recovery approach. However, in the first decade of community care, there were a number of high-profile and shocking incidents of homicide by people with mental illnesses. The impact of these incidents contributed to a shift in the focus of services, from the integration of patients into the community to the management of risk. This change of emphasis also impacted on practices of recovery as efforts to achieve a good quality of life for patients in the community were surpassed by the focus on the prevention of risk to and from patients in the community.

### 3.13 Community Care and Risk Management

Community care was not initially considered a success. The earlier institutional scandals were replaced by stories of community care failures, such as Jonathan Zito's 1992 murder by Christopher Clunis who was diagnosed with schizophrenia, the 1996 attack on a school teaching assistant and her pupils by Horrett Campbell and Lin and Meg Russell's murder by Michael Stone who was diagnosed with a severe personality disorder. The media picked up on these stories, encouraging what some described as a media-fuelled moral panic (Cutcliffe and Hannigan 2001) and the public concern about the safety of community care grew (Monahan 1992; Reda 1996 cited in Leiba 2000; Davies and Woolgrove 1998). The situation contributed to the 1992 setting up of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness that reported each year on incidents. The reports made a large number of recommendations, many of which focused on improvements in risk assessment and management, better communication between genuinely multidisciplinary teams and increased efforts to maintain patient engagement with services (Appleby 1992; Geddes 1999; Shaw et al. 1999; Appleby et al. 2006; University of Manchester 2016).

The incidents and the resulting inquiries led to a risk minimisation approach in mental health services (Shepherd 1996, cited in Leiba 2000, p. 295). The identification and management of risk became central to mental health services and to each professional. Services began to use the language of risk to describe their work, and the assessment of risk was used to determine the prioritisation of resources (Shepherd 1996; Rose 1998; Leiba 2000). The New Labour government of 1997 responded to the

scandals by producing various new mental health policies (e.g. DOH 1998) and importantly, reviewing the Mental Health Act 1983. Despite significant opposition from stakeholders, including psychiatrists and mental health charities, the proposed reforms recommended increasing coercion in the form of compulsory treatment in the community (DoH 1999a; DoH 2000a; Peay 2000; Pilgrim and Ramon 2009). The Mental Health Act 2007 succeeded in bringing in community treatment orders. Jeremy Laurant, giving the King's Fund Lecture in 2002, described this new focus on public safety as follows:

'Risk avoidance' and 'public safety' became the new watchwords. The switch of emphasis had an enormous impact on the care of people with mental health problems. Concern about the welfare of the many was replaced by fear of the risk posed by the few. (Laurant 2002)

By this time, recovery was strongly associated with safety; mental health services focused on identifying and minimising the risk that patients posed or might pose to others or themselves. The national inquiries highlighted the risks associated with the loss of patient contact with services, and this led to the setting up of assertive outreach services that were designed to address the problem of a group of patients considered to be seriously unwell and prone to avoiding contact with services. Crisis resolution and home treatment teams were also introduced to help offer additional care and protection to/from people outside of normal office hours (DoH 1999). The focus on risk did not just impact the statutory sector but also the third sector and private sector organisations who were providing mental health services on behalf of the local authorities and who therefore were subject to the same risk-focused policies and regulations. Recovery, at least from the professionals' perspective, came to be practised by maintaining engagement with patients and preventing any adverse incidents from happening in the community.

At the same time as the government was responding to the public safety concerns, it also needed to respond to the strength of the growing service user movement (which was supported by many professionals) in their calls for more compassionate, person-centred, substantial and effective mental health services (Laurant 2002). The next

section will outline the growth of the mental health user movement and explain how, despite the context of increasing coercion in the 1990s and early 2000s, the movement appeared to succeed in its aims of increasing user involvement and control in services and eventually, in bringing a recovery approach to mental health services.

### 3.14 The Mental Health User and Survivor Movement

The service user movement started in the early 1970s (Crossley 1998) but became prominent in the UK in the late 1980s and 1990s. It drew on the resources and arguments of the anti-psychiatry movement but also emphasised the crucial role of patients in bringing about change (Crossley 2006). The movement promoted self-help, empowerment and advocacy and protested about various aspects of psychiatry, including the lack of control by patients (Jacobson 2004). By the 1980s, numerous local user-led forums were set up across the UK, many of which involved carers and aimed to provide mutual support and increase user and carer involvement and control in services (Wallcraft and Bryant 2003). Although individual groups varied in their objectives (Roger and Pilgrim 1991), one universal element of the service user movement was its belief in the role of service user expertise in individual recovery and the improvement of mental health services in general.

In the 1990s and 2000s, mental health services were focused on risk management and mental health law was increasingly coercive (Shepherd 1996; Cutcliffe and Hannigan 2001; Laurance 2002). However, in health and social care policy, ideas of consumerism and citizen responsibility meant that the notion of the service user or patient expertise was gaining value. The rise of consumerism from the 1970s meant that service users' concerns began to be listened to as they were now seen as customers whose views mattered, as opposed to patients whose views could be dismissed as mentally unreliable (Rogers and Pilgrim 1993; Pilgrim 2008). The Conservative government, between the 80s and 90s, introduced a range of policies that were influenced by principles of marketisation, including the requirement that services actively seek out user views on the quality of their services.

The NHS and Community Care Act 1990 marked the first time that patient involvement in planning health services became a legal requirement. The New Labour government

of 1997 continued the push towards the recognition of service user expertise: a number of key policy documents built on the idea that mental health service users were not passive patients but key stakeholders or partners whose expertise should be sought in the development and delivery of services as well as in their own personal health care (DoH 1998; DoH 2000b; Health and Social Care Act 2001). In 2001, the expert patient project started in which individual patients were trained and then obliged to train fellow patients in how to manage their illnesses, including mental illnesses (DoH 2001). The notion of personalisation, developed by financial journalist Charles Leadbetter, was a development of the policy of marketisation. The personalisation agenda first introduced the notion of co-production, a new way of delivering services that would gradually increase consumer participation, knowledge and responsibility (Leadbetter 2004). It was believed that by involving service users as co-producers of services, those services would become more efficient (Ferguson 2007). The policy drew on a consumerist ideology: the aim was to ensure that services were more flexible, offered choice and met individual needs better (Askheim et al. 2017). The mental health policy in the 1990s and 2000s supported the notion of the mental health service user as a partner in their care and possessing valuable expertise that should be harnessed to co-produce more efficient mental health services. In addition, service users were seen as able to self-manage, reducing their need for statutory support.

The aims of the majority of service user groups in the 1990s and 2000s were to improve psychiatric services through increased service user involvement and control. In the early 2000s, they began to support the implementation of the recovery approach that appeared to support these aims. The implementation of the recovery approach was therefore supported by health policy at the time. However, the neoliberal, consumerist ideology underlying many of the policy developments was not in line with the humanistic, recovery-focused beliefs of the service user movement.

Some aspects of practice promoted by the recovery approach can also be understood as promoting neoliberal discourses of the responsibilised consumer. Scourfield (2007) argues that direct payments, seen from a recovery perspective as increasing service user control over their care, have effectively shifted the responsibility for the



management of care from the state to the service user who is expected to prudently manage their own care. Similarly, Rose (2014) highlights the fit between the recovery approach's positive endorsement of (return to) paid work and the neoliberal changes to welfare benefits that focus on cuts to benefits and helping disabled people get back to work through punitive sanctions and enforced work experience programmes.

Mental health services are seemingly able to work within a humanistic recovery approach whilst also adhering to neoliberal policy. Butler and Drake (2001) describe social work as 'exploiting the ambiguity' inherent in right-wing libertarian policy, allowing it to 'retain the semblance of loyalty to its own values, while carrying out the bidding of political masters with very different ideas and purposes' (p. 8).

This flexible exploitation of ambiguity can be seen in the way the recovery approach has been put into practice in a policy and practice context of risk minimisation and neoliberal ideology.

Many commentators have highlighted the alignment between recovery concepts of service user control and responsibility and the neoliberal vision of the responsibilised consumer. McWade (2016) goes further than this in her textual analysis of policy, to argue that recovery ideas were *used by* the New Labour government to 'usher in' increasing regulations and coercion in mental health that 'produce and police difference' (p. 64). The current study focuses on the practices of mental health professionals and concludes that in a context of increasing neoliberal health and welfare policy, professionals have been able to draw on the recovery approach to engage individuals in managing their own risks by advocating self-management and responsibility. Pastoral power is exercised by mental health professionals in mental health services who encourage service users to talk openly about their problems and offer emotional support whilst constantly observing and monitoring service users' behaviour and whereabouts. Service users are required to attend appointments, undertake forms of activity considered beneficial to them and sometimes, to live in particular accommodation. In addition, they are encouraged to learn about their illnesses, develop coping strategies, be fully involved in developing plans for their

recovery and ultimately become independent, self-governing citizens who do not require state intervention.

### 3.15 Conclusion

This history of recovery has shown how the policy of community care brought professionals with different underlying understandings of recovery together with the aim of enabling patients to reintegrate safely into the community. Physical treatments aimed at keeping patients calm in overcrowded hospitals became less important, and psychosocial approaches were increasingly valued to assist patients to function in the community. Multidisciplinary teams, based in the community mental health centres and a variety of third and private sector services, became accepted as the best way to provide care, although they sometimes experienced conflicts due to their different underlying models of mental illness or distress (Columbo et al. 2003). The recovery approach, as promoted by service user activists, was accepting of all models of mental distress, advocating that the service user should choose which approach they found most helpful. The approach was therefore relevant to all professionals. It focused on the nature of the relationship between the professional and service user and encouraged a focus on respect, equality and empowerment. In the context of risk-averse and increasingly neoliberal mental health policy, the recovery approach became a resource on which professionals could draw to engage service users in the management of their own risks and to advocate self-management and responsabilisation whilst ostensibly adhering to the humanistic values inherent in the original, emancipatory version of the recovery approach.

Taking a Foucauldian informed approach to the history enables the identification of the multiple assumptions underlying current and historical practices of recovery. It facilitates multiple ways of seeing (Roberts 2016) in order to move away from an acceptance of the self-evident (Foucault 1994b). Instead of asking *what* recovery was in the past, a genealogical approach asks *how* it was practised which enables an understanding of 'its complex interaction with a multiplicity of historical processes, many of them of recent date' (Foucault 2002 p. 225 cited in Roberts 2016, p.49). Through attempting to produce a history of the present, I could see threads of past

approaches reflected in the current approach and I was able to contextualise current practices both historically and sociologically.

## Chapter 4: Methodology

### 4.1 Introduction

This study analyses the recovery approach through a focus on practices of power by mental health professionals and the service users they interact with. Drawing on a Foucauldian conceptualisation of power, I combined historical study, ethnography and discursive analysis to answer my research questions. I aimed to identify the conditions of possibility for the development of different understandings and practices of recovery in the UK, to investigate how mental health professionals and service users practise recovery in mental health services and to identify challenges, dilemmas or tensions encountered in the practice of recovery by staff and service users.

I begin this chapter with a consideration of the Foucauldian ideas relating to power that informed my study. I then discuss my use of ethnography and discourse analysis that combined aspects of Foucauldian approaches and discursive psychology. I briefly introduce my three research sites before outlining the ethical approval procedure I completed and the main ethical issues relevant to my research. I explain how I gained access to each site and the recruitment procedures I used to gain participants. This is followed by an exploration of the way in which my identity impacted the research. I then explain how I analysed my data and organised my findings before ending with a more detailed description of each research site. This chapter will begin with a discussion of Foucault's understanding of power.

### 4.2 Foucauldian Ideas of Power

The work of Foucault has been recognised as useful for the analysis of power in institutional settings (Hill 2009). Foucault was interested in the relationship between knowledge and power: how knowledge regulates the discursive practices in specific institutions that shape people's behaviour (Hall 2001).

A Foucauldian understanding considers any practice that aims to shape the behaviour of the self or others as a practice of power (Foucault 1994a), which enabled me to consider the practices of service users, carers and others as well as professionals and

service managers. From a Foucauldian perspective, power is seen as productive and not necessarily repressive, and it cannot be exercised without discourses of truth (Hall 2001). The body of knowledge supporting the recovery approach has authority and power in that it has become accepted as true, at least at the level of policy that directs the expected actions and approaches of mental health services. I was interested in how this more recent truth in the field of mental health shapes behaviour and expectations in contemporary mental health services. Recent studies in the field of governmentality have suggested that the recovery approach is a new iteration of neoliberalism with a focus on responsabilisation and self-management (Harper and Speed 2012; Braslow 2013; Rose 2014). I wanted to explore how this new discourse of recovery had become possible, and I chose to undertake a Foucauldian-inspired exploration of the meaning and practice of recovery before embarking on an ethnography of current practices.

My historical analysis drew on the concept of problematisation to produce a history of the present (Foucault 1977/1991). I drew on both historical materials and contemporary analyses of past approaches to consider how particular truths came into being at certain points in history and how these impacted the responses to people in mental distress. I considered how social, economic, political and other circumstances impacted the power of different discourses to define how mental illness/distress should be understood and addressed. I aimed to use history to help me 'shake off the self-evidence' (Foucault 1994b, p. 225) of the current recovery practices. As a recent mental health practitioner, this was important as I initially found myself fighting familiarity (Delamont and Atkinson 1995) when thinking about current practices in mental health services. The historical study showed how the transitions in the understanding and approaches to recovery did not portray a 'triumphal procession towards liberty and enlightenment' (Middleton 1998, p. 5, cited in Hill 2009, p. 312) but instead reflected numerous historical processes impacted by combinations of seemingly unrelated factors, such as war, charismatic personalities and government policy related to budgetary constraints. In addition, there were constant attempts by the proponents of rival theories in mental health to achieve dominance.

The history suggests that the current recovery approach draws on a number of historical threads in approaches to mental health, including biological, psychological and social. The approach reflects the humanistic principles of equality and mutual respect in relation to appropriate professional–client relationships. However, the more recent neoliberal policy context has led to the recruitment of the recovery approach as a resource for professionals to engage individuals in managing their own risks and advocating self-management and responsabilisation.

My study was informed by Foucault’s work on modes of power throughout history. Foucault identified a number of forms of power, each of which was dominant at different times in history but none of which has completely receded. In medieval times, the sovereign exercised complete control over his subjects through the threat of or actual violence. Also known as juridical power, this form of power continues to exist in mental health services in the form of the Mental Health Act, which allows for the forced incarceration of people considered to be mentally ill and at risk. Disciplinary power, emerging in the seventeenth and eighteenth centuries, was visible in the growth of institutions in which people were trained to behave in ways desired by the various authorities, such as schools, prisons and asylums. Central to this form of power is the idea of the panopticon, a prison design (Foucault 1977/91) that illustrates how people will moderate their own behaviour if they believe they may be observed at any time. In his lectures given between 1978 and 1979, Foucault discussed another form of power that he argued ‘most uniquely characterises the exercise of power in the Western world’ (Foucault 2004, cited in O’Farrell, p. 47). This notion of pastoral power is particularly important to my study.

Pastoral power originated in the Christian church in the role of the priest who cared for his flock by monitoring their behaviour and attempting to bring them back into line if their behaviour were to stray from what was acceptable to the church. Foucault explains how the function of pastoral power has moved from the church to secular institutions and how its aim has changed from salvation in the next world to health, wealth and security in this world (Foucault 1994a). Recent work has drawn on Foucault’s notion of pastoral power to explore the role of health and social care professionals in shaping individuals’ behaviour to the desired norm of self-

management and acceptance of responsibility. Early in my analysis, I noticed how professionals' interactions with service users were in line with the notion of pastoral power, and this led me to focus on how mental health professionals practised the recovery approach by exercising pastoral power.

In order to focus on power in the recovery approach, I adopted a poststructuralist, social constructionist position (Burr 2003) that recognised the important role of language not just in reflecting reality but in creating it, including the reproduction of power relations. Juhila et al. (2003) suggest that the tools of social constructionist research can be used to make visible the tacit, practical knowledge used by social workers and others in human service professions. They suggest that expertise in these professions is not just about theories, empirically evidenced methods or legislation but about 'local negotiations' using 'different narratives' to 'organise and articulate messy issues' with service users and other professionals (Juhila et al. 2003, p. 18).

This approach is especially relevant to the study of mental health services in which many phenomena, such as diagnoses, are produced within language (Harper 1995). Drawing on Foucault, Ringer and Holen (2016, p.162) argue that concepts in mental health, such as recovery, are not objective and unchanging but are constantly 'negotiated between people in specific institutional and historical contexts'. My research explored how recovery was constructed, negotiated and practised through language. In line with a social constructionist approach, I was interested in how participants talked about and practised recovery, rather than seeking to identify how it should be practised or what it really means.

### 4.3 Ethnography

The literature on recovery discussed in Chapter 2 has suggested that there are many versions of recovery and an ongoing debate as to the meaning of a recovery approach. Pilgrim (2009) argues that context-dependent, practice-near research is required in order to prevent continuing confusion and vagueness. He suggests that this 'can only be generated by ethnographic research' (Pilgrim 2009, p. 477). An ethnographic approach is in line with Foucault's understanding of power as practised in specific local contexts.

Hammersley and Atkinson (2019) explain that ethnography does not have a simple definition due to its complex history across different disciplines; however, some core features can be identified. Ethnographers study people's actions and accounts in everyday settings and do not attempt to manipulate the environment in any way. They typically spend extended periods of time in the field (the location or situation they are studying) and collect a range of data that usually includes participant observations but may also include formal and informal interviews, documents and artefacts. The data collection is unstructured and in-depth; the orientation is exploratory, although the researcher may have some relevant issues or foreshadowed problems in mind (Malinowski 1922; Hammersley and Atkinson 2019). The analysis of ethnographic data involves the interpretation of the 'meanings, sources, functions and consequences of human actions and institutional practices' (Hammersley and Atkinson 2019, p. 3).

Ethnography is a useful way of looking at the impact of initiatives and policies in health and social care and can be drawn on to analyse the relationship between power, knowledge and practice in these settings (Kielman 2012). Recovery, as discussed in Chapter 2, is a complex and polyvalent concept. It is understood differently by different people, at different times and in different contexts (Davidson and Roe 2007; Hopper 2007; Pilgrim 2008; Shepherd, 2017). Research methods that collect data at one point in time may fail to capture this complexity and variation in meaning across different contexts. Mental health practitioners who appear to understand the theory of recovery-oriented practice often struggle to put that into practice (Waldermar et al. 2016; Zuaboni et al. 2017). Osborne and Stein (2017) interviewed mental health practitioners and found that, although they were able to articulate the values of the recovery approach clearly, including giving control to service users, they also described a very directive (controlling) practice without showing any awareness of the tensions between these two approaches.

An ethnographic approach enabled me to explore how recovery was practised in specific institutional contexts, and I also believed it would help me identify, in line with the literature, any potentially different versions of recovery in use that may have been contributing to the difficulties in the relationships between staff and/or clients (Pilgrim 2009). An ethnographic approach can help explore the gap between rhetoric and



reality in the practice of the recovery approach (Kielman 2012) and identify differences between what participants say about recovery and what they do in daily practice (Liberati et al. 2015).

I decided to use a case study approach to illustrate my findings. This approach is a way of describing and understanding rich, complex meanings and understandings. Mitchell (1983 in Perry 2011, p. 223) described the case study as:

‘a detailed examination of an event (or series of events) which the analyst believes exhibits (or exhibit) the operation of some identified general principle’

I have used case studies to show how practitioners and service users across the three research sites employed specific discursive strategies to induce, align with or reject recovery discourse.

I chose to combine an ethnographic approach to data collection with a discursive psychological analysis in line with my social constructionist approach and my Foucauldian understanding of power as enacted through discursive practices.

#### 4.4 Discourse Analysis

The use of more than one approach to discourse analysis within the same study raises tensions related to the different assumptions and foci of the different styles of analysis, an issue that will be discussed following an introduction to discursive psychological analysis.

Discursive psychology (DP) developed out of conversation analysis, studies of rhetoric and a strand of discourse analysis developed by Potter and Wetherell (1987). It can be described as a theoretical and analytical approach (Wiggins, 2017) rather than a method, and as such, there is no one correct way of doing it. The kind of analysis I carried out follows the work of Edwards and Potter most closely (Edwards and Potter 1992; Potter 2003). Discursive psychology moves away from the recent assumptions in psychology that what people say represents their thoughts and that behaviour is based on prior cognitive processes. Instead, it understands concepts such as mind and reality as resources that people can use in interactions to perform certain actions, such as being in recovery or doing the recovery approach.

Discursive psychology analysis involves identifying the use of discursive devices which help to achieve social action (Wiggins 2017). My analysis draws on a number of these discursive devices, the most frequent of which are described below.

Hedging is used when an utterance is: 'marked as provisional, tentative or conditional' (Wiggins 2017 p.152) and is often used in relation to a delicate issue in conversation. It can be shown in various ways such as through the use of 'um' or 'well' at the start of an utterance, or by the phrases 'I think' or 'I guess'. Hedging enables the speaker to reduce their accountability; they avoid making a certain or definite claim, enabling the claim to be retracted or softened if there is disagreement.

The examination of pronoun use and shifts in footing originates in the work of Goffman (1979) and enables a consideration of the participant roles that are produced in talk. In my research, staff participants often talked about themselves as 'we', producing themselves as a team member and as the author and/or animator, but not necessarily the principal of the words they were saying (Goffman 1981).

Extreme case formulations (Pomerantz 1986) refer to the use of semantically extreme language, which must be heard as going to extremes within the interaction. They are often used to justify or strengthen an argument or add credibility. In my data, for example, staff used extreme case formulations to strengthen their arguments that some service users did not engage with them, and to justify their decisions to discharge these service users from the service.

Lists can be used as a rhetorical device in interaction. The 'three -part list' identified by Jefferson (1990) is a normative pattern used by speakers in all types of communication and was used regularly by staff and service user participants in my data. It is used to emphasise points and present them as more factual.

In analysing interactions between professionals, service users and/or myself, I paid attention to the situatedness of the interaction, considering the context, such as a care planning meeting (involving a professional performing their job in meeting with a client), an informal chat between colleagues in the lunchroom or an interview with the researcher. I considered the rhetorical framework; how the interactants constructed

versions of events or situations. I also focused on the indexicality of utterances, interpreting the meaning of talk through considering what came before and after. I concentrated my analysis on what actions the participants accomplished through their talk (Wiggins 2017). I combined my use of discursive psychology with the use of a Foucauldian approach that considers people as both shaped by and creating discourses.

Approaches to discourse analysis are often discussed in terms of different forms, such as conversation analysis, discursive psychology and Foucauldian discourse analysis, and researchers are advised that they must be undertaken separately (e.g. Wiggins 2017). They may also be distinguished in terms of whether they focus on the action-orientation of talk in interaction (e.g. discursive psychology) or whether they are concerned with discourse at a broader level, considering issues of discourse, power and subjectification (e.g. Foucauldian discourse analysis) (Wetherell 1998). However, a body of work has emerged that supports a synthesis of or an eclectic approach to these different forms of analysis (Miller and Silverman 1995; Wetherell 1998; Edley and Wetherell 2001; Brownlie 2004; Riley et al. 2010; Korobov 2011). The use of both fine-grained analysis and broader approaches offers the possibility of an analysis that places the identification of the action accomplishments in talk within a broader socio-historical context. Edley and Wetherell (2001) explain how, studying talk as a social action in its local organisational context, they assumed that:

talk ... assumes regular patterns that reveal the shared sense-making resources of a sample or which may be specific to a site, institution or characteristic of a broader social context and historical period. (2001, p. 441)

Brownlie (2004, p. 521) argues for the need

‘to link Foucault’s conceptualisation of power and resistance to perspectives which allow for an analysis of how programmes of conduct are translated – or not – into verbal and non-verbal moments/moves of power and resistance’.

I, therefore, combined a focus on the micro-processes of interaction with a consideration of wider ideological patterns of discourse (Weltman and Billig 2001). The

discursive approach that looks at the 'interactional business of talk' can be used to explore how speakers use broad discourses as resources in particular contexts (Weltman and Billig 2001, p. 371). I noted how some service users drew on other discourses, such as biomedical, to assist them in rejecting a recovery approach. The use of these approaches enabled me to consider how recovery is constructed and practised through individual interactions between service users and staff and how those service users and staff draw on, and are constructed by, wider societal discourses concerning mental illness/distress. I chose to use the term discourse rather than interpretive repertoire, which is commonly used in discursive psychology, as my understanding of discourse was a Foucauldian one, including material practices, buildings, professions and laws as well as the 'building blocks used by speakers for constructing versions of actions' (Wetherell and Potter 1988, p.172).

My discursive psychological analysis, alongside my Foucauldian ideas about power, enabled me to recognise staff talk as a form of pastoral power, and I began to notice staff using particular discursive strategies in their attempts to shape clients' behaviour, induce responsibility and encourage self-management. I also recognised some service users' responses as resistance (Foucault 1990). My ethnographic approach enabled me to look at discourse in a broader, Foucauldian sense as encompassing both language and practice (Hall 2001).

Some recent studies of recovery in Danish mental health services have begun to employ discourse analysis, sometimes with ethnography, to explore the role of language in recovery. Ringer and Holen (2016) undertook an ethnographic study of inpatient and outpatient settings in Denmark. Using notes from participant observations and interviews, they identified three discourses used in the institutions: 'really ill', 'instability' and 'lack of insight'. The patients' use of these discourses in their interactions with staff had an impact on how they were perceived by staff, including whether or not they were ill and how unwell they were. The discourses, therefore, had implications for how the patients were able to understand themselves and be understandable to professionals (Ringer and Holen 2016, p. 161).

Waldemar et al. (2019) studied the practice of recovery in an ethnographic study of two inpatient mental health wards in Denmark. They took written notes of interactions observed between patients and staff and used the Recovery Self-Assessment Scale to carry out both deductive and inductive analyses. They concluded that some aspects of recovery practice, such as offering choice and integrating patients' preferences, were enacted rhetorically in interactions, but in reality, the professionals made the decisions. These ethnographies of recovery point to the role of specific discourses (or interpretative repertoires) used in institutions in enabling or precluding certain understandings of mental distress and responses to it. Waldemar et al.'s (2019) study suggests that recovery is something that is enacted rhetorically in speech.

More recently Jorgensen et al. (2020) conducted a Fairclough inspired critical discourse analysis of the conditions of possibility for recovery practice in Danish mental health care. The study focussed on nursing practice and drew on interviews and medical notes to identify the discourses within which recovery was articulated. They conclude that nurses use of discourses of paternalism, biomedicine, self-care and holism were all encompassed by a discourse of neoliberalism focussing on the responsibility of the service user to self-care and achieve recovery. They argue that recovery has become professionalised and synonymous with treatments that nurses believed would lead to recovery. The studies discussed above demonstrate that a focus on language in recovery is useful in showing how recovery is constructed, negotiated and practised in specific institutions.

#### 4.5 The Present Study

In contrast to the ethnographic studies discussed above, I made audio recordings of meetings between staff and service users, and their individual interviews with me. This meant I was able to undertake a fine-grained analysis, including consideration of the features of interactions, such as pauses, hesitations, laughter, etc. and rely on what was actually said instead of my recollection of the conversation. I was, therefore, able to explore how professionals and services users enacted recovery in their moment-to-moment interactions.

My ethnographic study included several methods of data collection: I observed and recorded meetings between staff and service users, I recorded one-to-one interviews with them, and I also made field notes in which I noted some speech but also recorded aspects of the environment and the physical actions of people. In addition, I collected some materials from the settings, such as leaflets, and I took photos of posters, notices and some of the rooms in the various institutional buildings. I collected data for approximately one year and aimed to spend four months at each site. In practice, data collection periods overlapped, and I spent about 6 months visiting each site during 2017-2018.

There is an ongoing debate as to the relative value of researcher-generated data, such as interviews in DP analysis (Wiggins 2017). I attempted to mitigate the problems in using interview data (Potter and Hepburn 2005) by approaching the interviews as context-specific interactions in which the interviewees gave accounts that were not representative of an external reality but of their construction of reality. I was careful not to delete myself from the interviews, ignoring my role in the construction of recovery, but instead, I considered the actions performed in language by myself and the interviewees.

#### 4.6 Research Settings

I chose to conduct my ethnography in three separate mental health services: a statutory community mental health team, a third sector supported housing organisation and an inpatient unit run by a third sector organisation. I have given each site a pseudonym: site one is Llan castell CMHT, site two is Cartref Hapus Housing and site three is Forest View Recovery Centre. All three services reported that they worked within a recovery ethos and provided ongoing support and/or treatment to enable the service users' recovery journey. Study at these sites would therefore allow ongoing and multiple observations of the production and practice of the recovery approach across varied contexts. I decided to observe these services rather than specific recovery focussed initiatives such as a recovery college as I wanted to study how professionals induced recovery in service users who experienced serious mental health problems which impacted their ability to function in their everyday lives. Also, many

specific recovery projects such as peer support schemes involve less of the one-to-one contact between service users and staff that I wanted to observe. I chose to focus on three sites as I believed this would allow me to collect a sufficient amount and depth of data whilst also enabling me to identify possible differences between the statutory and third sector and inpatient and outpatient settings.

Sites one and two (Llan castell CMHT and Cartref Hapus Housing) were chosen partly based on pragmatic reasons. I had personal contacts who were able to assist me in making initial contact, I was able to travel to the sites relatively easily, and I had been made aware that they were likely to welcome the opportunity to take part in my research on recovery. Despite being chosen on mainly pragmatic grounds, they also met my criteria in terms of providing a statutory and a third sector service. I chose to approach the Forest View Recovery Centre as I was aware it had been set up recently with the explicit purpose of providing a recovery-focused inpatient service. I was keen to find out if there were differences between the practices of recovery at this site and the other sites, which, although ostensibly committed to a recovery-oriented approach, had not, like Forest View, originally been set up with this purpose.

The Llan castell CMHT and Forest View Recovery Centre had as their main aim to support and enable service users' recovery. Although service users received a range of interventions, including those related to housing or finance, the aim was always to contribute to their mental health recovery. Cartref Hapus Housing was different from the other two sites in that although it was run by a mental health charity, it was funded to enable service users to maintain their tenancies. Therefore, all mental health-related support was provided (or seen to be provided) to support this central aim of tenancy maintenance. This difference in funding streams and the resulting priorities impacted the way in which each service interacted with service users and practised the recovery approach.

## 4.7 Ethics

### 4.7.1 Gaining ethical permissions

In the UK, research that involves human participants or uses NHS facilities requires ethical permission from the Research Ethics Committee (REC). The purpose of the REC is to protect the rights and wellbeing of the participants and researchers whilst ensuring that the research is beneficial to the participants, science and society (Health Research Authority, 2017). Research must also be approved by the relevant Trust Research and Development department, and both permissions must be obtained via the online application system known as the Integrated Research Application System (IRAS). The process involves submitting a full research protocol (approx. 900 words) along with all research documentation, including consent forms, information sheets and interview schedules (see Appendices 1–7).

In addition, any research project in Wales involving the NHS or social services must, in line with the Research Governance Framework (Welsh Assembly Government 2009), have a sponsor who is responsible for confirming the proper management of the project and its adherence to ethical standards. The sponsor for my research was Cardiff University, and therefore, the protocol and documents had to be approved by the University Research and Innovation Service prior to the completion of the IRAS form.

Following the completion of the IRAS form and the approval of the University, an appointment was made for a meeting via phone conference with the Research Ethics Committee on 17 August 2017. Approximately 12 members of the Committee attended the meeting and asked a small number of questions about the recruitment, methodological approach and expected outcomes. Following the meeting, the Committee gave a favourable opinion with additional conditions (see Appendix 8). The conditions involved minor additions to or changes in the wording of the information sheet and also giving an independent point of contact in case of complaints about the research. After making the changes and sending them to the Committee, I was given permission to commence the research.



#### 4.7.2 Ethical issues relevant to my research

My research protocol, which was approved by the Ethics Committee, set out the process I would undertake to ensure informed consent. Consent in ethnographic research is not a one-off contractual agreement but an ongoing process in which it is negotiated and renegotiated, and it depends to a large degree on the relationship of the researcher with the host organisation and the individuals within it (Murphy and Dingwall 2007). In line with this conception of consent in ethnographic research, I sought consent at the start of the research at each site with each participant but also before each meeting or activity that was due to be recorded and observed. Following the Economic and Social Research Council (ESRC) guidelines, I attempted to discuss the issues of consent regularly and informally as well as through more formal consent procedures (ESRC 2015). However, I found that neither staff nor service users wanted to engage in the thorough consent procedure I had set out. Those staff and service users who showed an initial interest in taking part agreed to all aspects of the research without asking questions or raising any concerns. They did not appear to want to engage in discussions about any ethical issues I raised, such as confidentiality, but were keen to get on with the research. Therefore, although all my participants signed a consent form, I could not be sure that either the service user or staff participants had given fully informed consent.

Explaining the nature of qualitative research can be difficult, especially to people who do not have previous knowledge of this form of research (Brewster-Smith 1979; Glazier 1993, cited in Murphy and Dingwall 2001). Despite trying to explain my role as a researcher several times, one potential service user participant repeatedly explained that he did not need any more help as the organisation supporting him were already doing such a good job. A number of the service user participants who had given consent told me about situations or treatments they were unhappy with, and I got the impression that they believed I could help them change their situation or advocate for them against the organisation or staff. I had to make clear that this was not my role, although I usually advised them to speak to staff or a volunteer.

I found it difficult to explain the discourse analytic framework of understanding for my research in layperson's terms, and I am not sure that the participants understood my

social constructionist approach. Given that positivism is the dominant and more widely understood form of research, despite my explanations to the contrary, many of the participants may have been expecting me to find out about the 'reality' of recovery (Josselson 1996a, cited in Murray and Dingwall 2001). In addition, given my critical lens in the analysis, there may be differences between the way I have represented some participants and situations and the way the participants understood them (Josselson 2007). Some participants may be upset or angry because they might feel that they have not been fairly represented, and this is an issue I will need to address if it comes up during the dissemination process.

In explaining my research to (potential) participants, I was aware of the ethical issues relating to the exploitation of the participants for the researcher's benefit (Dubisch 1995, cited in Murphy and Dingwall 2001). I was clear with the participants that my research was unlikely to produce quick or tangible benefits but was aiming instead to contribute to a wider research literature on recovery. Clemens and Tierney (2020) point out how ethnography is in a precarious position with regard to informing policy due to the current valuation of positivist forms of research (p. 389). Even if my research was to influence mental health policy, it may not be in a way that my participants would approve of, and of course, participants may differ in their views about appropriate policy development in mental health. I intend to produce some academic articles following the completion of my PhD that I hope will contribute to the academic literature and increase understanding of neoliberalism in mental health care. I agreed at the start of the research to return to the research sites to share my findings. I had also intended to work with the three research sites to find ways in which the findings could inform their practice. However, the reality of my full-time senior lecturer role alongside the pressure to produce academic publications will not leave me significant time to develop this dissemination work, and this aspect of the PhD will not be as substantial as I hoped it would be. In addition, many of the service user and staff participants may have moved on from the organisations in the time since I finished my fieldwork, and those remaining are unlikely to remember much about the research and may not be interested in my findings (Patai 1991). I therefore, feel that I have personally benefitted from the participants' contributions and not fully

counterbalanced that benefit with reciprocal acts (Murray and Dingwall 2001). This situation has left me with an 'ethical hangover' that Lofland and Lofland (1995, p. 28) refer to as a: 'feeling of persistent guilt or unease over what is viewed as a betrayal of the people under study'.

Harm to participants in qualitative research can be subtle and tends to happen in the interactions between the participant and researcher (Guillemin and Gillam 2004). My research related to a sensitive topic, especially for service user participants but also for staff, who may have felt under pressure to say the right thing and represent their organisation appropriately. There was potential, therefore, for emotional harm to occur both in the interviews and meetings with the staff or service user participants. I did not ask directly about service users' experiences of mental health problems or traumatic events, but these inevitably arose in response to my questions about their experiences of recovery. I was expecting that some service users would become upset when talking about their experiences, but this was not the case. I was careful to end the interviews with a 'phase of emergence' (Corbin and Morse 2003) by asking questions about their plans for activities over the next day or so, their hobbies or an upcoming family visit. I also left service user participants with a list of support organisations that I attached to the information sheet.

Maintaining anonymity was an important and challenging aspect of the study. I did not have a large number of participants and within this group there were often few representatives of any particular profession. The descriptions of the participants' occupations in the thesis are therefore sometimes deliberately vague, using terms such as care coordinator or practitioner in order to avoid specifying a profession. Sometimes, I also avoid specifying at which research site a participant is based in order to protect their anonymity.

## 4.8 Access and Recruitment of Participants

### 4.8.1 Site one: LLancastell CMHT

During the first six months of my PhD, I attended a seminar on ethnography in health settings and had the opportunity to discuss my PhD plans with a senior research

manager based in a South Wales university health board. She assisted me in contacting a senior manager of mental health in the health board, who in turn, put me in touch with a local team manager who he believed may be supportive of my research. I met with the Llan castell CMHT manager, a social worker, who was keen for her team to be involved in the research and agreed to all of my planned data collection methods. After gaining ethical approval, I contacted the team manager and arranged to attend a multidisciplinary team meeting to tell the staff about the research and ask them to consider taking part. Following this meeting, three members of the staff were interested. I met with them again to discuss the research in more detail, and they were all keen to be involved. As none of them were medical staff, they all agreed to try to persuade some of their medical colleagues to volunteer, but this was not successful. I attended another team meeting where I discussed the research again, but this did not result in any more volunteers. I decided to go ahead in the hope that after getting to know me, more members of the staff would be happy to take part.

Two of the three staff members who had volunteered were able to recruit one or more of their clients for the study, and I soon started to undertake audio-recorded visits with a social worker and another practitioner. A few weeks later, having not been successful in recruiting any medical staff, I approached one of the consultant psychiatrists and explained my need for data from meetings between clients and the medical staff. She agreed to her patients being sent letters inviting them to be recorded in their meetings with her, and this resulted in three recordings, some of which also included nursing and social work staff. I also attended a dialectical behaviour therapy consult meeting of the psychology staff<sup>16</sup> and several multidisciplinary team meetings. I later interviewed nine staff members and five service users (see Appendix 10 for a table outlining data collection at each site).

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<sup>16</sup> Dialectical behaviour therapy (DBT) is a form of group and individual therapy offered to clients that requires that staff meet regularly to discuss the therapy. These meetings are known in Llan castell CMHT as consult meetings.

#### 4.8.2 Site two: Cartref Hapus Housing

A friend who had worked in mental health care for many years suggested that the manager of this site might be interested in research on recovery. I called the manager and explained my research, and she was very keen that her organisation be involved. She put me in touch with the relevant team managers<sup>17</sup> who suggested I come along to a team meeting to talk to staff. Following a short talk at the staff meeting, several staff members said they would ask some of their clients about taking part. This resulted in introductory meetings with seven service users. Two of them agreed to participate and be recorded in meetings, and I subsequently observed and attended eight meetings between the two service users and four support workers as there were staff changes during my fieldwork period. I also attended two supported house meetings and spent some time in the office observing and chatting to the workers. I later interviewed nine staff members and two service users.

#### 4.8.3 Site three: Forest View Recovery Centre

I was aware of this service from my previous work in the mental health field and was keen to study it due to its particular focus on the recovery approach. I contacted one of the directors via email and arranged to meet with her and a colleague. They were both keen to be involved. Again, I spoke at a team meeting and a service user meeting about the research. I left flyers<sup>18</sup> in the lounge area, explaining who I was and what my research was about. Staff were happy for me to spend time at Forest View conversing with them and the patients, but no staff member felt comfortable with me recording individual meetings with service users due to the personal and often traumatic nature of the material discussed. Most of the service users were also happy to talk to me, and over time, even the more reticent of them began to engage with me. I took part in activities, such as food shopping, gardening, stacking the dishwasher and playing pool, and spent a lot of time in the lounge area talking to service users and staff. I regularly

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<sup>17</sup> This section is lacking some details about the site and staff titles in order to maintain anonymity.

<sup>18</sup> I have not included these in the appendices in order to maintain the anonymity of the research site.

attended handover meetings that took place at lunch time every day when members of the staff ended or started their shifts and spent some time in the offices talking to the staff or listening to the goings-on in the administrative corridor as well as collecting various documents. I also talked to the director in her car when she gave me a lift to and from Forest View on several occasions.

#### 4.8.4 Participant characteristics

31 staff and 13 service users across the three research sites were interviewed and/or observed in meetings. Approximately an additional 10 staff and two service users were observed in general activities at the research sites. The analysis also draws on data relating to two further service users who I did not meet but who were discussed by staff. Of the 13 service users who were interviewed and/or observed in meetings, seven were female and six male. Their ages ranged from early twenties to late forties. Service user participant diagnoses included anxiety and/or depression (5), bipolar disorder (2), personality disorder (3) schizophrenia/psychosis (4) and one participant who had not been given any particular diagnosis. Some participants had more than one diagnosis. Of the 31 staff who were interviewed and/or observed in meetings, seven were male and 24 were female. The staff participants included psychiatrists, psychiatric nurses, social workers, occupational therapists, support workers, recovery practitioners, peer support workers, volunteers, team or service managers, directors, and housing officers. All of my participants were White British reflecting the ethnic makeup of the areas in which my research sites were situated. Census data from 2011 shows that in the three relevant local authority areas the population is approximately 97% White British (Office for National Statistics 2011). For reasons of anonymity the research site or job title of staff participants is not always stated.

#### 4.9 Researcher Identity

Qualitative research involves a particular understanding of the role of the researcher. Following the recognition of the problem of 'ethnographic authority' in the 1980s, qualitative researchers are now required to acknowledge and explore the impact of power relations within the research and consider how they choose to represent the people they study (Gilmore and Kenny 2018, p. 56). Rather than being seen as neutral

and objective, there is an acknowledgement of the relationship between the researcher and the researched, and the findings are considered as negotiated or co-constructed between the researcher and the participants (Rogers et al. 2018). This recognition requires that the qualitative researcher take a reflexive stance by interrogating his/her identities and considering how they might impact the research process and findings (Gilmore and Kenny 2015; Rogers et al. 2018).

My personal and professional background meant that my perception of myself as an insider or outsider changed with different participants in different contexts. As a former mental health support worker and social worker, it was easy for me to identify with the staff at all settings; I had an awareness of the responsibilities, rewards and frustrations associated with the work of mental health professionals. My professional background also includes working in user-led mental health projects focused on increasing user involvement to challenge the dominant paternal or medical approaches and practices in mental health care. My involvement in these projects, alongside my work in statutory mental health care, has given me an understanding of the sometimes extremely opposing views about how mental health issues should be addressed, the quality of current mental health services, treatments and staff and the rights and responsibilities of the service users. This varied professional background led to my decision to take a curious stance on the recovery approach, avoiding any assumptions about its usefulness or appropriateness as an approach in mental health care as much as possible.

Although I attempted to make it clear during recruitment that I was not there to evaluate their practice, some staff participants still appeared to assume that I was pro-recovery. On a few occasions, staff apologised to me for a particular action or statement not being recovery-oriented, and I analysed these as part of my data. It is possible that the current policy and practice requirements for a recovery approach mean that they automatically assume that any perceived deviation from this approach is liable to criticism.

As well as being a former mental health professional, I also identify myself as someone who has experienced mental distress, and I believe that this enabled me to have a

deeper empathy for and understanding of the service users' experiences than if I had never experienced a mental health problem. However, I have never experienced an ongoing psychotic illness, nor have I used a secondary statutory mental health service or been forced to receive any kind of treatment, meaning my experiences have been very different from many of the service user participants in my study. In addition, although I consider myself working class, I have never experienced the level of relentless, extreme poverty experienced by many of them. As a white, educated woman, I was in a privileged position, and despite my experience of mental distress, I did not feel that I had much in common with most of the service user participants. I often mentioned to potential service user respondents that I had personal experience of mental health problems. However, I felt slightly uncomfortable about suggesting that I was in a similar position to them and usually also mentioned that I had not been under the care of statutory services. As Grove (2017) points out, having an aspect of shared experience can potentially increase insight into another's life experience, but other major differences, such as class, gender or sexuality, can prevent a more nuanced understanding.

My professional social work background gave me a number of advantages in the field. I drew on my social work experience to recruit staff participants, taking a sympathetic tone that suggested I understood the challenges of their work (Berger 2015). Although not all staff at the three sites were keen to be involved, a substantial number were, and these staff members appeared to be very open about their thoughts and experiences as well as allowing me to audio record them doing their work. I also had relevant cultural knowledge; I was aware of relevant issues and familiar with the language and processes used in the various services. I was not shocked by talk of suicide plans or the sight of severe self-harm scars, nor was I unsettled by behaviour or talk that might be labelled as psychotic. I also understood the nuanced and sometimes contradictory responses of the participants to my questions as I had experienced the complex discursive landscape in which they practised.

However, there were also some disadvantages to being an insider. I sometimes found it hard to separate my role as a researcher from my former role as a social worker. I had intended to have minimal involvement during the meetings other than general,



polite conversation to help participants feel comfortable with my presence. However, on more than one occasion, I was drawn into a conversation in which I became more of a second practitioner than a researcher. On one occasion, in which I made a significant contribution to the meeting, the service user's distress was tangible and profound. I was aware from previous discussions with his case manager that this service user would be discharged if he did not begin to engage with the service, and this knowledge may have contributed to my need to join in the attempt to persuade him to engage in some kind of activity considered (by myself and the worker) to be helpful to his recovery. In addition, the worker was a student social worker who was much younger than me; I felt protective of her and wanted to support her attempts to work with a client considered 'difficult to engage'. Gair (2012) suggests that researchers should be taught skills in empathy. However, as a former social worker trained in counselling skills who has personal experience of mental distress, my ability to empathise, along with the factors noted above, led me to blur the boundaries between my roles and become overinvolved in the interaction. The extent of my involvement in some of the meetings became apparent during the analysis, and I, therefore, chose to analyse my role alongside the participants' as I had clearly contributed to the construction and practice of recovery in those meetings.

Staff and service user participants have sometimes treated me as if I were a practitioner, which made it difficult to maintain a researcher role. At the inpatient unit, after regularly visiting for a couple of months, the manager asked me if I could hold the main keys and 'keep an eye on' the service users while they had their staff meeting. Although I felt uncomfortable about the situation, I found myself agreeing; it was difficult to refuse her request when they had been so helpful in allowing me constant access to the unit. Walking into the lounge, holding a large, jangling set of keys, I felt like I had somehow betrayed the service users: rather than being a neutral observer, I was now actively involved in restricting their freedom. Possibly in order to deal with my own discomfort, I made a joke about feeling like a jailer. This backfired as two of the service users became concerned that I had been put in this position and suggested that they would complain on my behalf. I reassured them that I did not mind, and the afternoon passed without incident.

I found that most service user participants shared personal information and experiences with me and sometimes asked for advice. I hoped that encouraging and enabling them to explore their situations or experiences might be helpful, but I was generally very careful to avoid giving advice and usually restricted my comments to suggesting that they speak to a member of staff about the issue. However, on a few occasions, I found myself in a position where I was able to give useful information and/or reassurance to a service user, and I felt it would have been unethical not to share this with them.

My familiarity with mental health services and their processes, procedures, cultures and language that had been so useful during my fieldwork became a hurdle as I started the analysis. Initially, I struggled to notice anything interesting or unusual in my data, seeing it as reflective of normal mental health practice. The reactions and guidance of my two (non-mental health professional) supervisors, along with studying methods of discourse analysis and using theory to explore my data, eventually enabled me to start seeing it through fresh eyes and make the familiar strange (Delamont and Atkinson 1995).

#### 4.10 Data Analysis

On finishing my fieldwork, I had collected 23 audio-recorded meetings between staff and/or service users, 28 audio-recorded staff interviews, 10 audio-recorded service user interviews, two unrecorded interviews, one with a staff member and one with a service user, on which I had made thorough notes, and 134 handwritten pages of field notes as well as a small collection of documents and photos of leaflets and posters (see Appendix 10 for a table showing the data collection across the three research sites). Throughout the period of data collection, I made reflective notes that highlighted the issues I thought were interesting, the features of communication I had noticed and the concepts or issues I thought might be relevant to the analysis. These notes informed my ongoing data collection, and I sometimes asked specific interview questions related to my reflections or focused on a particular theme in my observations.

I transcribed almost all<sup>19</sup> the recorded interviews and meetings, which enabled me to start to become familiar with the data. However, the large volume of data made it hard to gain an overview. After transcribing each recording, I read through all of the interviews, meetings and fieldnotes, noting anything I thought was particularly interesting or unexpected. I also drew on my reflective notes to help identify any patterns or characteristics in the data relevant to my research questions. I then went through each meeting transcript line by line and noted any issues coming up in terms of the content of the discussion and features of the interaction. Based on my literature review, I expected that I would find different understandings and practices of recovery expressed by different professions and individuals. However, the initial analyses of the interviews and meetings suggested that this was not the case, at least in terms of staff: they all appeared to talk about and enact recovery in very similar ways, both with me and with service users.

However, despite the staff's recovery practices' seeming homogenous, their interactions with service users were sometimes very different in terms of the nature and outcomes of the meetings and the emotions expressed by the participants and felt by me as an observer. I identified two different categories of interaction. With those service users considered by themselves and the staff to be in recovery, the practitioners and service users smoothly co-constructed a narrative of current and future anticipated recovery. They agreed with each other's suggestions and added more details to the narrative. With other service users not considered to be in recovery, co-constructing the recovery narrative took more work for both the professional and the patient. There were disagreements and negotiations sometimes resulting in a compromise, but sometimes, co-constructing a recovery narrative did not seem possible. The patient and the professionals disagreed about what the patient could or should do to recover or if recovery was even possible. These interactions were

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<sup>19</sup> I paid for two of the meetings to be transcribed by a professional as I have a minor hearing impairment, and I struggled to hear the service user who spoke very quietly and quickly.

characterised by conflict and sometimes criticism of the service user by the staff or of the professional, team or service by the patient.

Following this initial analysis, I selected a number of extracts from the recorded meetings that appeared to characterise these different kinds of interactions and performed a more fine-grained analysis, noticing how the participants constructed subjects and objects, how they managed the issues of accountability and how they used various discursive strategies to perform actions within the interactions. I discussed my ideas with my supervisors and refined and revised my analyses until I was satisfied that they were adequately evidenced in the data. At the same time, I was reading about Foucauldian ideas of power, and I began to recognise what I was seeing in the interactions as the practice of pastoral power. I found that this provided a useful way to conceptualise the exercise of power in the interactions.

Having analysed the transcripts of the meetings with various service users, I looked at the relevant extracts of the interviews with or about the same service users as well as any relevant field notes. This was particularly important for service users based at site three, Forest View Recovery Centre, where I was not able to record the meetings for ethical reasons. In line with my discursive psychological approach, I was careful to consider the interviews as interactions (Potter and Hepburn 2005) in the context of me being a recovery researcher and not as factual accounts of how they did recovery.

The final stage of the analysis was to organise my findings into a coherent structure, which I did by organising them into three chapters. The first chapter starts with an outline of some of the broad findings about recovery across the three sites. The remainder of this chapter considers the practice of recovery with service users who were considered to be in recovery. The second chapter considers the practice of recovery with service users who were not considered to be in recovery. And the third focuses on instances where the consistent use of a recovery practice was considered by staff and/or the patients to have failed to enable them to achieve recovery and looks at what happened in these circumstances. The next section will offer an extended description of each research site.

#### 4.11 Llan castell Community Mental Health Team

The Llan castell community mental health team (CMHT) is situated close to a small-town centre in South Wales. It forms part of the secondary mental health services serving a region of approximately 90,000 people across both urban and rural areas. The team is multidisciplinary and houses a variety of mental health professionals, including psychiatrists, community psychiatric nurses (CPNs), social workers, psychologists, occupational therapists and administrative staff. Several student social workers and CPNs also came and went over the course of my study. Patients are referred to the mental health team when their mental health problems are considered too severe or risky for primary care, GP-based services to deal with, but they do not need inpatient care. The patients have a variety of diagnoses, including depression, anxiety, bipolar disorder, schizophrenia and personality disorders. A significant proportion of them also had co-occurring substance misuse problems. The team does not take on people with eating disorders as there is a separate team for this. The team is housed in a large, single-storey office building that contains an outer and inner reception area, a kitchen, two large communal offices and six smaller offices/meeting rooms as well as corridor areas and toilets.

All newly referred patients attend an initial assessment with two members of the staff. Their assessment is discussed at the weekly multidisciplinary team meeting where a decision is made as to whether they should be taken on and which professional(s) should be allocated to them. New patients are allocated to workers depending on their needs, although they all see a psychiatrist who will usually diagnose them and often, but not always, prescribe medication. The team offers a number of services, including medication review and monitoring, depot clinics (weekly or fortnightly injections of antipsychotic medication), help with social problems, such as benefits, debt, relationships or housing, along with emotional support and psychological therapies. Each patient has a care plan that sets out what help they will receive in order to achieve certain goals identified by them and their care coordinator<sup>20</sup>. Most patients

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<sup>20</sup> To have a care coordinator is a legal requirement for patients in secondary care under care and treatment planning legislation. The care coordinators in Llan castell CMHT were community psychiatric

have a weekly or fortnightly visit from their care coordinator, and some also receive help from a separate local team who provide unqualified support workers to assist people with getting out into the community, overcoming anxiety, etc. If the patient is considered to need more than one visit per week from their primary worker due to their level of distress and/or risk, they are referred to the home treatment team who visit them every day until they are either taken into hospital or discharged back to the CMHT.

An administrative staff member is always the first to arrive at the office at about 8.30 am. They unlock the front door that is only used by patients and visitors and turn off the burglar alarms. Staff begin to drift in from 9 am onwards, using the back door that has a code entry system. During the day, staff come and go, attending meetings with clients or other agencies or working at their desks, catching up on case notes, making phone calls or writing up assessments and care plans.

The team appears to have few shared routines other than the multidisciplinary team meeting that takes place every Thursday morning. The meeting takes place at another local social service building in a large meeting room as the CMHT does not have enough room. The meeting is regularly attended by staff from other local services – the hospital, the eating disorder team and the home treatment team as well as visiting speakers from other related services – and lasts for about three hours. The staff discuss new assessments and some current clients about whom they wish to get advice and suggestions from the team. Joint decisions are made about which new clients to take on and what kind of service they need, who to discharge, who might need to be sectioned, how to help various non-engaging clients, how to manage risk and who should undertake these various tasks.

The psychology team hold a meeting once per week, also in the other building, that tends to go on for at least two hours. Referral meetings are held once per week, led by

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nurses, social workers or OTs. Occasionally, a psychiatrist or psychologist would be the allocated coordinator if the patient did not have contact with any other professionals.

the social work-qualified team manager and attended by only one or two staff members, usually a senior social worker and/or a CPN.

#### 4.12 Cartref Hapus Supported Housing

Cartref Hapus is a third sector organisation based in a small South Wales town that provides a range of services to adults with mental health problems, including housing support, which my study is focused on. The organisation rents six properties in the local area that are shared by two to four clients, and it also provides floating support to other clients who live in council or housing association properties. Clients are referred to the service through a central, council-run referral scheme.

There are two housing teams, one focusing on the supported housing clients and one on the floating support clients, although in practice, some staff members work across both types of housing. Each team has a manager and is staffed by approximately six support workers. There is also a housing officer for the supported housing team whose role focuses on property maintenance and enforcing the tenancy agreements and house rules as well as an administrative worker and several additional housing workers who focus on homelessness and provide a drop-in advice service.

The organisation is funded by Supporting People<sup>21</sup> to provide housing-related support and, therefore, prioritises helping clients to sustain their tenancies. Each client is allocated to a particular support worker. The support workers in Cartref Hapus were mainly unqualified, although one had a social work diploma, and several had a first degree in a relevant subject, such as psychology. Some had significant previous experience in social care work whereas, for others, it was their first job in the sector. The support offered covered a wide range of issues from securing suitable accommodation, managing money, bills, benefits and debts, assisting clients to develop a meaningful occupation and providing emotional support. Once referred, a client attends an assessment with their allocated support worker, and sometimes a

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<sup>21</sup> Supporting People is a Welsh government programme that gives funding via local authorities to organisations that provide housing and/or housing support.

manager, during which they produce a support plan. The plan sets out the client's goals and the help that Cartref Hapus will provide. Support can be offered for up to two years but will be ended once the goals have been met or the client disengages with the service. The staff are office-based, and the support workers manage a caseload of clients who they tend to visit on a weekly basis other than in times of crisis when visits increase as needed. The staff attend team meetings once a month, but other than that, they tend to work individually, organising their own work, setting up visits to clients and accompanying them to meetings at job centres or with other agencies. House meetings are held monthly at each supported property, run by a senior member of staff who checks the fire alarms and raises any issues relating to health and safety as well as encouraging tenants to keep the house clean and share the chores equally. Support workers often attend the meetings.

Clients in supported housing sign up to standard tenancy agreements that they are expected to adhere to. The approach is more lenient than it might be outside of a charity setting, and clients are supported to keep to the agreement. However, clients are occasionally evicted for consistently breaking the agreement. Many of the clients have complex social problems as well as mental health problems, and co-occurring substance misuse is common. Some clients have regular contact with their local community mental health team and have a diagnosis of a particular mental health condition, while others have no contact with mental health services. The staff were often unsure if clients had a formal mental health diagnosis.

The charity's office base covers four floors; the housing teams are both on the first floor of the main building. The building is old and probably used to be housing. Although well maintained, it is a little creaky and the soundproofing is lacking in some areas, making it a rather noisy space. The housing department has two large communal offices shared by support staff, housing officers and managers, a smaller office shared by three staff members, a tiny kitchen, and toilets. The office is often very quiet, with only the sound of hurried typing and an air of urgency and busyness. Sometimes, staff are on the phone, organising client visits or talking with other agencies about support for their clients. Every so often, the staff stop for a chat, and the atmosphere is comfortable and jovial. There is regular tea/coffee making in the



kitchen down the corridor. The kitchen is the size of a large cupboard and can only fit in one person at a time. There is a small fridge that contains milk and various packed lunch items. There are various drinks and crockery items on a tiny section of the worktop as well as a kettle in a stand, a sink and a cupboard above, leaving hardly enough room to make a drink without knocking something off the worktop or draining stand.

#### 4.13 Forest View Recovery Centre

The Forest View Recovery Centre is an inpatient unit set up and run by a third sector organisation and overseen by an advisory committee that includes service users and carers. The unit is funded by '*Invest to Save*' Welsh government funding and a grant from the National Lottery. It adheres to the requirements of Health Inspectorate Wales (HIW) and the local health board. It is situated in a quiet residential area in the countryside but not far from a small town in South Wales. The service was set up and designed specifically to adhere to a recovery approach. It can accommodate up to 16 patients, but at the time of my study, only had five. During the six months I spent visiting Forest View, one patient left and a new one arrived. Patients are accepted from anywhere in the UK and are usually funded by their local health board. To have a funded place at Forest View, patients must require 24-hour care but also be well enough to understand the concept of their recovery and commit to it. The current patients have been given diagnoses of psychotic disorders, personality disorders, anxiety and depression. Several of them self-harm regularly and have substance misuse issues. All of them have multiple diagnoses. The staff includes a management consultant, a director, a manager, qualified nurses, a student nurse, recovery practitioners, peer support workers and several administrative and maintenance staff as well as a psychiatrist and psychologist who visit weekly.

The peer support workers and a high proportion of the staff have personal experience of mental health difficulties. There are often agency health care support workers covering shifts when there are not enough permanent staff to meet the staffing requirements. Often, these staff are training to be mental health nurses or have

considerable experience in mental health work; a few have very little experience in the mental health field.

The Forest View Recovery Centre is all on one floor. Entry is by a glass door at the front of the building. As some of the patients are not permitted to leave the building without an escort, it is always necessary to ring the bell and be let in by a member of the staff. The door opens onto a corridor that runs along the front of the building and has glass windows all the way along, making the space light and airy.

The building has three main sections: the administrative corridor, the patient bedrooms and the communal areas. The administrative corridor contains staff offices and meeting rooms as well as the staff room and the caretaker's room. It has not been refurbished to the standard of the rest of the hospital and looks rather tired in comparison, with dull magnolia walls and old-looking office furniture. Opposite the administrative corridor is another small office that is fitted with several monitors showing pictures of all the areas of the building. This room is used for overnight shifts and is also where the medication is stored. Only staff are allowed access, and the door is always locked.

The patients' bedroom area is on the right of the building. The bedrooms are arranged in four separate corridors, each of which has its own name and colour scheme. To the side of each corridor is a lounge area with comfortable chairs and a small, low table. Each corridor has four bedrooms. They are small but pleasant – they reminded me of hotel bedrooms: well equipped, clean and colour-coordinated. There is a single bed, a bedside cabinet, a chest of drawers and a wardrobe in each room as well as a television set into the wall. Each room has its own en-suite bathroom with a toilet and shower.

To the left of the building, at the other end of the front corridor, are the communal areas: a large lounge, a kitchen and an activity room. Like the bedrooms, the lounge area reminded me of a hotel – clean, comfortable and well-designed, not luxurious but with lots of touches aimed at making it homely rather than institutional. There are large windows along two walls, making the space very light. At one end is the seating area with about ten comfortable chairs arranged in a wide horseshoe shape around

two large, low tables. There is a television and a wood-burning stove. There are plenty of throws and cushions and pictures on the wall. A large dresser contains a collection of ornamental tea pots. At the other end of the lounge are some large, round wooden dining tables and chairs, used for meals and other activities. In the lounge, above one of the tables, there is a large notice board for the activity plan. The plan covers three weeks and is usually kept up-to-date. Activities include gardening and art sessions which service users can choose to attend.

To the left of the lounge, there is a door that leads through a small lobby to the kitchen. The kitchen is the least homely part of the communal areas. It is a large, square room fitted with industrial-style stainless steel worktops, a sink, a cooker with six hobs and a sizable oven. The floor is hard, and there are numerous notices on the walls relating to health and safety. To the back of the kitchen is the pantry where the food, crockery and cutlery, including knives, are kept. The door is kept locked, and the patients can only enter with the staff.

Another door leads out the back of the lounge, past the television, to the activity room. This room has large windows covering three of the four walls and has the feel of a conservatory. There is a large, plastic-coated table with plastic chairs. Around the outside edge of the room is a wide worktop covered in arts and crafts equipment, including paints, chalks, brushes, pots and some pieces of artwork completed by the residents and staff.

The doors from the activity room lead to the garden that is quite large and has a tall wooden fence all the way around. To the right is a separate area known as the tranquillity garden where patients can choose to spend quiet time with the staff when they are feeling distressed. In the main garden is the smoking shelter that resembles a wooden bus shelter where both the patients and the staff spend much time. The garden also doubles as a tennis and badminton court and a space for kickabouts as well as time out of the building for patients who have limited leave.

Most staff, excluding the administrative staff, work a mix of shifts, including weekends. The morning shifts run from 7 am to 1.30 pm, the afternoon shifts from 1 pm to 8.30 pm, the day shifts from 9 am to 5 pm and the night shifts from 8 pm to 8 am. Often,

the staff work long days from 9 am to 9 pm to cover staff shortages. The unit aims to be as homely as possible, and therefore, although the patients are encouraged to develop a daily routine as part of their recovery, there is no set routine for them other than the therapeutic community meeting (see below).

Handover meetings happen at each shift change at 7 am, 1 pm and 8 pm. Qualified staff are required to attend the handover, but other staff also often attend. The leading qualified psychiatric nurse usually enquires when the staff taking over were last on shift and will then report on each patient's mood and activities since the staff last saw them. Every morning at 9.30 am, there is a therapeutic community meeting. All patients are expected to attend this meeting; however, generally, only one or two of them attend it, with the rest staying in bed. The qualified nurse on duty leads the meeting in which the participants discuss what activities the patients have to or want to do during the day and which staff will support them with these.

The patients get up at various times from early morning to early afternoon and sometimes choose to go back to bed during the day. The majority of them go out most days either to health-related appointments, leisure activities or college. Some are escorted by staff, others come and go alone or with other patients, depending on their current leave permission. While I was there, some patients had their leave reduced after absconding or inappropriate behaviour whilst on leave. Many of them spend a lot of time at the unit either drinking tea in the communal areas or smoking in the garden.

These descriptions of the research sites set the context for the next chapter that will explore the practice of recovery across the three sites with service users who were considered by themselves and staff to be in recovery.

## Chapter 5: Recovery Practice with ‘Recovering’ Service Users

### 5.1 Introduction

Recovery in the three research sites was a complex and heterogenous assemblage (Rose, 1999) of professionals, patients and carers; bodies of knowledge; statutory, private and third sector organisations; and law, policy and practice, in which no network of expertise was dominant, but in which multi-disciplinary groups of professionals drew on similar recovery discourses in a pragmatic way with a focus on ‘what works’. Recovery is a historically distinct approach which differs from previous approaches to mental distress. It involves a new regime of practices which draw on a number of bodies of knowledge within a neoliberal model which requires patients to take responsibility for their recovery. The recovery approach took place within a context of scarce resources across all three sites and this was sometimes drawn on in discourse to justify responses to service users’ lack of engagement with services.

This chapter will begin with an outline of the theoretical framework that underpinned the analysis. I then present an analysis of practitioners’ talk about the causes of and treatments for mental health problems. Staff in all three research sites drew on discourses of complexity and adverse childhood experiences which justified the need for a multi-disciplinary team of professionals to facilitate service users’ recovery. The multi-disciplinary nature of mental health services meant that hope could circulate between types of treatments and this enabled the maintenance of hope for recovery. The majority of the chapter focuses on how the recovery approach is practised by professionals and service users in cases where the service user is considered to be in recovery. All the service users discussed in this chapter had been using one of the three fieldwork services for between nine months and 20 years. Their mental health diagnoses (formal and informal) were agreed and accepted by the service user and staff working with them, and all of them had a care and/or support plan which set out the nature of their proposed treatment and support from the relevant organisation. The broad purpose of all the meetings was to provide support to the service user to help them work toward recovery; however, as all of the service user’s problems,

challenges and recovery goals were unique, each meeting addresses different issues pertinent to the particular service user and their circumstances. In addition, the staff members varied in profession, qualification and role.

Through an in-depth analysis of four cases, I argue that the professionals exercise pastoral power to enact recovery through the use of discursive strategies. The discursive strategies I identified were practiced by staff and service users across all three research sites. These four meeting extracts were selected because they best represent and illustrate the discursive strategies used by staff and services users in meetings where the service user was considered to be in recovery. I also observed meetings between staff and an additional three service users who were considered to be in recovery (Sue and Pete at Llan castell, and Liz at Cartref Hapus). In these meetings, staff and service users drew on very similar discursive strategies to the ones described in this chapter but the transcripts were less suitable in terms of providing extracts to illustrate those strategies<sup>22</sup>. The exercise of pastoral power is illustrated through the interactions that involved the practitioners showing care for the service users and monitoring their thoughts and behaviours whilst also encouraging self-management and independence. The staff used tactics of encouragement, persuasion and praise and presented objects and subjects in particular ways in order to mould the service users' subjectivities in line with a recovery discourse. For example, they constructed the service users as capable and motivated to do recovery-oriented tasks. Previous research has suggested that professionals may retreat to a more paternal illness management style of working when faced with high levels of risk. I did not find consistent evidence of this in my study. Instead, I show how the practitioners discussed in this chapter continued to act as modern pastors in using the same

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<sup>22</sup> In both Sue and Liz's meetings, the examples of discursive strategies were widely dispersed across very long transcripts making it hard to select a suitable shorter extract. (This issue also applied to Aiden, but I chose to include an analysis of one of his meetings as it provided a particularly clear illustration of the way in which staff minimised and hid their power). In Pete's meeting the sound quality of the recording was very poor and it was not possible to transcribe the meeting. I wrote notes after the meeting but they were limited and the other fully transcribed meetings provided stronger evidence of the discursive strategies used.

discursive strategies with clients considered to be both in recovery and at a high level of risk.

## 5.2 Theoretical Framework

In the chapters discussing my findings, I will draw on the Foucauldian concepts of governmentality and modes of power to explore how power operates through a recovery discourse to constitute the subjectivities of service users and professionals. I will show how other discourses compete in shaping professional practice and how the recovery discourse is sometimes resisted, challenged and adapted.

Foucault has identified a number of regimes of power that have been dominant at different times in history. Pastoral power moved from being a tradition of the Christian church to a form of power exercised over the whole state by the multiplication of its agents and aims. Rather than offering a focus on salvation after death, the state form of pastoral power promised salvation in this life, and salvation took on a broader meaning to include health, wealth and security. Pastoral power is exercised by organisations that aim to care for and support individuals and, by doing so, save them from suffering or living life wrongly (Foucault et al. 1994a).

Foucault's concept of governmentality refers to the way in which, in contemporary democracies, individuals are ruled through, rather than over, their freedom. Rather than being above individual subjects, the modern state, by the use of pastoral power, integrates them whilst shaping their subjectivity in ways desired by the government (Martin and Waring 2018).

Pastoral power aims to produce self-disciplined and self-managing subjects. The modern agents of pastoral power, such as health care professionals, oversee and monitor individuals' behaviour with the aim of inducing them to monitor and manage themselves. They, therefore, come to exercise pastoral power over themselves as well as others. The exercise of pastoral power is a 'conduct of conduct' (Foucault et al. 1994a, p. 341) that aligns very closely with the recovery discourse: mental health professionals work to constitute the patients' subjectivities within a recovery discourse, seeking to creating motivated, responsible citizens keen to manage their

own mental health. Previous studies using the concept of modern pastors have focused on the work of health care professionals, such as pharmacists. This chapter shows that mental health professionals also exercise pastoral power and illustrates the discursive strategies they use to align service users within recovery discourse.

### 5.3 Staff Talk About the Causes of and Treatments for Mental Health Problems

Staff drew on discourses of complexity and adverse childhood experiences in their interviews about causes and approaches to treatment. They frequently pointed out the limitations of their own discipline and the potential of other approaches to help patients. Patients who had experienced trauma were understood to need intense psychological therapy to enable them to develop resilience. The discourse of resilience was individualised and rested on the ability of the individuals to develop emotional management skills by working on themselves. These understandings justified the need for a multidisciplinary team of staff and prevented any one team member from having to take sole responsibility for a patient's recovery. The existence of the different theories of causation and associated treatment approaches meant that hope could circulate between the different approaches. Hope often settled on the psychological therapies where the ever-deepening nature of therapy meant that it could be sustained indefinitely, despite the ongoing failure of psychological approaches to achieve recovery in some patients.

In their one-to-one interviews, I asked staff what they thought caused mental health problems, if anything, as well as what kinds of treatments they thought were effective. The participants' initial responses to the question about causes implied that they recognised this as a big and/or difficult question:

R: 'What do you think causes mental health problems, if anything?'

J: 'Right, have you got ten hours?' (both laugh) (June, nurse, Forest View Recovery Centre, interview)

H: 'Wow!' (laughs) 'Ooh!' (Hayley, practitioner, Llancastell CMHT, interview)

H: 'Oh, God!' (Helen, support worker, Cartref Hapus, interview)



Z: 'Mmm...' (draws in breath and sighs) (Zoe, social worker, Llan castell CMHT, interview)

Nurse Becky's response was typical of the answers offered to the question 'What do you think causes mental health problems, if anything?'

B: 'Genetic disposition; a lot of the patients that I've nursed, historically, it's drugs and alcohol, um, and the world that we live in; it's stressful. There's expectations, high expectations, especially on children to achieve in school... It is a cruel world, and some people have been unfortunate in the fact that they've had abuse and trauma in their past, and they've carried it through their life, and some people have been very unlucky too, so there's lots of factors, lots and lots of factors.' (Becky, nurse, Forest View, interview)

Other factors mentioned included pressure from social media, bullying, stress through studying, stress in the womb, attachment problems, current abusive relationships, a lack of support networks, discrimination, poverty and unemployment. Most of the participants talked about how these factors interacted with each other to result in mental distress. Their answers suggested that one factor alone could not cause mental health problems, but that it rather required the interaction of two or more factors:

Z: 'So I'm wondering if everyone's got different brains and if you have that perfect storm of that type of brain, that structural brain or whatever, along with those experiences, you will develop something psychological later on or some sort of illness.' (Zoe, social worker, Llan castell CMHT, interview)

J: 'So I think there's loads of different factors that can interact on those different domains, and that is enough possibly to interact enough that it reaches somebody on that continuum that it gets to a point that it really impacts on their wellbeing, that it causes them to not be able to work, to not be able to function as well, to cause them symptoms, that they might go and see their GP.' (Joe, psychologist, Llan castell CMHT, interview)

Practitioners' responses reflected the multi-factorial approach of the power threat meaning framework proposed by the British Psychological Society (Johnstone et al. 2018). The framework allows for the identification of patterns of distress and troubling behaviour which are understood as coping and survival mechanisms in response to

past and/or present conflict and adversity. It does not support the notion of biologically based disorders, although it allows for the influence of biological factors in mediating or enabling these patterns of responses.

Within the framework, distress or troubling behaviours are understood as responses to threat which occur as a response to the negative operation of power. The framework allows for a wide conception of the negative exercise of power which may cause a threat to a person, group or community. Threat is interpreted through meanings which are produced in social and cultural discourses. Meaning impacts on the response to threat and results in a threat response aimed at ensuring survival.

Using the framework, a practitioner must investigate the origins and maintenance of distress in the persons' experience of power and threat, the meaning they made of those experiences and how they survived. Drawing on psychological research the framework proposes that 'symptoms' are more usefully understood as strategies for survival. Biological, social and psychological factors are seen as inseparable, as existing through their constant interaction.

Although all participants were able to offer a list of potential contributing factors to mental health problems, there was a sense that this was a difficult area of knowledge that was still in flux. Some participants referred to research and what had or had not been proven yet. Some of them talked about a lack of understanding of the biological elements:

R: 'What do you think about the idea that some things are caused by chemical imbalances in the brain? Do you think there's any truth in that?'

L: '... I don't look into that side of things; that's way too intelligent over my head, and, we don't have to deal with things like that. That's what we got psychiatrists and all for, so I think it probably could be true, yeah.' (Leah, support worker, Cartref Hapus, interview)

It was not just unqualified practitioners who struggled to understand biological explanations, though:

R: 'Do you think there's any genetic factors involved in mental illness?'

S: 'Um, (pauses for three seconds) yes, probably, but I wouldn't say I would know enough about it to have an idea as to why. Obviously, every assessment that we take always talks about family history, and it's always made very obvious that maybe a maternal great grandfather has schizophrenia, and there's a very definite link there but how that happens, I don't know. It's a bit baffling.' (Sheila, senior nurse, Forest View Recovery Centre, interview)

Gordon, a psychiatrist, suggested that researchers in different fields, including both psychology and neuroscience, sometimes made arguments that were not fully thought through:

G: 'People used to be very critical of psychological approaches, and you'd hear people talking about "oh that's just psychobabble". Now, you get "neurobabble" where people give unfalsifiable, overdetermined explanations based on poorly understood neuroscience, which they haven't really thought about. But there's some really good stuff coming from both directions.' (Gordon, psychiatrist, Forest View Recovery Centre, interview)

Social worker Andrew put it this way:

A: 'So, it does work what we're doing, but I think the reasons are really complex, and obviously, at the moment, generally, it's agreed and accepted that it's a combination of factors that are the causes of mental distress, so your biological, the medicalised version, your biological predispositions... chemical imbalances... But then, obviously, life events impact on you, so your social circumstances, and then maybe make—accelerate the likelihood of you experiencing that as well as psychological trauma and all things like that, so biopsychosocial, which I do agree with. I gotta be honest, you know, I just think the whole mental health system and mental health generally is just historically been a case of trial and error, really, and no one really knows what they're doing, including psychiatrists. But for the last 150 years, people have just been winging it.' (Andrew, social worker, Llan castell CMHT, interview)

The different factors causing mental health problems were associated with different treatments in the participants' answers. Genetic or chemical imbalance theories were associated with medication, whereas the experience of trauma was associated with forms of therapy and help with social circumstances. This understanding, therefore,

justified the need for a multidisciplinary team of professionals to help patients. It also positioned practitioners as members of a team who did not have all the knowledge or expertise needed to help patients recover but could call on their colleagues to make up for what they lacked. Many practitioners referred directly or implicitly to the limitations of what they could do from their professional perspective and pointed to the strengths of other professions.

Nonmedical practitioners saw the medical approaches as helpful and sometimes necessary. Many talked about the importance of medication for people with serious mental illness, by which they generally meant schizophrenia, bipolar disorder and clinical depression.

H: 'I think that some of those more biologically rooted disorders or diagnoses like pharmacological intervention is always going to play a big part in that. For example, if someone is actively psychotic, then they need—medication has to play a part in that, and some medication, antipsychotic medication, is really effective. People who are really clinically depressed, um, like they need an SSRI, like that they need that medication, and that's one of the things that's going to help, and I would say be more of a mainstay intervention in those kinds of patients, in addition to psychosocial or psychological other interventions and other input. But I think you definitely need the medication part of it.' (Hayley, non-medical practitioner, LLancastell CMHT, interview)

Zoe, a social worker also talked about the importance of medical treatments:

R: 'Do you see medication as being part of recovery or not really?'

Z: 'I do, because if people are in a lot of distress, no amount of cwtching<sup>23</sup> in and talking is going to do anything if they're in so much distress, so I think PRN medication is really good for that situation. Um, antidepressants do work hand in hand with all the other stuff as well. It builds up resilience so they can then tolerate the challenging discussions that we have. Um, and also, I've seen people medicated

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<sup>23</sup> Cwtch is a Welsh word for cuddle

for psychosis, and people left unmedicated and you can see a definite difference.’  
(Zoe, social worker, Llancastell CMHT, interview)

However, some psychiatrists talked about the limitations of medication. Louise, a psychiatrist, talked about a patient with severe anxiety and intrusive thoughts and explained that the medications she had tried so far were not helpful:

L: ‘We’ve tried a couple of different medications, but actually, the last one we tried probably made him worse.’

R: ‘Oh, no.’

L: ‘Which is obviously the opposite of what we’re here for and to try to do but in terms of his intrusive thoughts have improved, so it’s treated what it’s meant to treat, but it’s left him really deflated and demotivated... So we’ve had to change his medication again, which may mean that the intrusive thoughts become worse, but hopefully, he’ll have more motivation and his mood will improve.’ (Louise, psychiatrist, Llancastell CMHT, interview)

Louise went on to talk about the importance of psychological therapy for patients who had experienced trauma and again referred to the limitations of medication:

L: ‘We know that actually, medication is only going to play a small part in somebody with a really horrendous background of trauma, and what they need is psychological input.’ (Louise, psychiatrist, Llancastell CMHT, interview)

Practitioners saw other professions as being able to offer something that they could not, that, in combination with their own input, would lead to the patient’s recovery. This meant that no one discipline or practitioner saw themselves as wholly responsible for a patient’s recovery. Recovery depended on the input of a team of professionals.

Although all participants proposed multiple, interacting factors as causing mental health problems, many of them, including the more medically trained, emphasised the importance of trauma, including adverse childhood experiences:

J: ‘Um, (pauses for three seconds) I honestly believe, I think in my ten years of working with a whole variety of different people and seeing lots of different presentations, one of the things that I see time and time again is that there is—mental health

problems do emerge from something different, so mental health, in particular, I think there's always an underlying trauma of some sort.' (Julia, psychologist, Llancafell CMHT, interview)

The experience of childhood trauma was thought to have prevented patients from learning skills in childhood that would enable them to be resilient to mental health problems in adulthood.

R: 'What do you think causes mental health problems, if anything?'

M: 'I think a lot of it is to do with life experiences and whether that individual has been able to learn emotional skills during their lifestyle. I think far more than genetics, which is quite controversial, but I think looking at the people that we see and um, you're just so much more vulnerable if you've had a very—a childhood full of quite negative life events to be able to develop skills that will make you more resilient. I think that's the biggest thing.' (Margaret, psychiatrist, Llancafell CMHT, interview)

Margaret had mentioned earlier in the interview that many psychiatrists understand mental illness as purely biological, and therefore, her view that mental illness is mainly caused by life experiences might be seen as controversial. She draws on empirical evidence ('looking at the people we see') to justify her different opinion. This use of evidence from experience was used by a number of practitioners, including Julia (above) and Zoe, a social worker, who explained that she also thought people who used mental health services had less resilience because of childhood trauma:

Z: 'I think things happen when you're young, which have an effect on your resilience as you grow up. So, you might have two people who have depression, say... If they had depression, one might have had a shitty upbringing, so the resilience to dealing with that and being creative in how to manage that is impaired whereas somebody who's had a really good upbringing with little trauma, and they've been nurtured to help themselves a bit more, perhaps they cope with it... A lot of people who come through our doors, regardless of the diagnosis, it's surprising how many people have experienced abuse, especially sexual abuse and rape... It's really shocking; you don't get many people that come through that've had a lovely childhood.' (Zoe, social worker, Llancafell CMHT, interview)

The participants used different terms to refer to adverse childhood experiences. Some talked about abuse or attachment problems while others talked about childhood trauma and a lack of love experienced as a child. The discourse of adverse childhood events has emerged from epidemiological studies, showing an association between childhood maltreatment and a range of adverse outcomes (Kesller et al. 2010). The explanations of this link have been both psychological and biological. The psychological explanations have focused on the development of unrealistic and unhelpful cognitive schemas in childhood (Garety et al. 2001; Birchwood et al. 2004). The biological explanations argue that maltreated individuals have higher stress reactivity and cortisol dysfunction (Aas et al. 2012; Janssen et al. 2012). Some biological theorists have turned to neurobiology, and particularly brain scan research, to support their claims that the maltreated child's brain suffers early and irreparable damage. However, these theories have been heavily criticised. Wastell and White (2012, p. 402) draw attention to the numerous problems with the methodology and interpretation of the results, an issue recognised by psychiatrist Gordon (quoted earlier) in his reference to 'neurobabble'. The irreparable damage theory, used to argue for early state intervention in troubled families (Wastell and White 2012), could potentially lead to a sense of hopelessness in adult survivors of abuse, and not surprisingly, it was not mentioned by any practitioner in this study. Instead, staff constructed traumatised patients as having experienced deficits in early learning that could be corrected by psychological therapy.

In the current data, patients with a history of trauma were understood by staff to need intense and sustained therapy; ordinary emotional support was not considered enough to help them overcome their difficulties. However, their problems were not seen as irreparable; a lot of hope was attributed to psychological therapies. Helen, a support worker at Cartref Hapus, described working hard to get psychological therapy for her client:

H: 'There was a whole history of trauma and abuse and I felt myself, I'm not a psychiatric nurse and that things she was saying... She needed a more deeper intervention than just my emotional support, but it's been a struggle to get people in the mental health... to listen to that, you know, she is struggling ... Anyway, I said

she needs psychological intervention; she's suffered severe traumas in her life... Anyway, eventually, she did get an appointment, and we met with this person from (the hospital) yesterday; she was a psychologist, therapist, and she did an intense assessment.' (Helen, support worker, Cartref Hapus, interview)

Helen constructs psychological therapy as something that is more intense than emotional support and would be offered by someone qualified. She has put a lot of effort into advocating for psychological therapy for her client as it is seen as the solution to this patient's ongoing difficulties. Zoe talked about a patient who has recently been recognised as having a severe learning disability. The patient had been raped at the age of five and had gone on to develop mental health and alcohol problems. Zoe explained:

Z: 'So now we're looking at getting him over to learning disability. They could perhaps do some specialist psychological therapy with him, which is gonna take years.' (Zoe, social worker, Llancastell CMHT, interview)

This patient's recovery is understood as possible but requiring years of 'specialist' therapy.

Medical practitioners also talked about the importance of psychological input and stressed the limits of their profession in treating certain kinds of problems. Louise talked about the difficulties involved in trying to maintain the patients' hope for recovery whilst waiting for psychological therapy and also being realistic about the limitations of medication.

R: 'Have you got another patient you can tell me about who's maybe not progressing as well as you'd hoped?'

L: 'Um, well, I suppose... I see lots of patients that have got like a background of adverse events, so sort of a trauma background, and whether that's in childhood or more as an adult or usually combination of both... They're often found to be too complex for the primary care support service to work with, and our psychology waiting list is very long, very long, and I guess we know that actually, medication is only going to play a small part in somebody with a really horrendous background of trauma, and what they need is psychological input. But often, I think I'm left holding a patient who is distressed and struggling and trying different medication



options and almost, you know, having that sort of strong hope, I think, rather than a reality. I think they know the reality is the medication's not going to make much difference.' (Louise, psychiatrist, LLancastell CMHT, interview)

The practitioners' talk about what treatments were helpful suggests that the therapeutic hope for recovery tended to shift between the various professions and their associated techniques. Medication was expected to help some patients, particularly those with psychotic illnesses, and when it did not, hope was maintained by making changes to the dose or type of the medication or by adding a psychological therapy to work in combination with the medication. Non-psychological practitioners often believed that psychological therapies, in particular DBT and CBT, would enable recovery for their clients. However, despite the hope attached to psychological therapies by most practitioners, they were not always successful. The psychologist participants talked about the limits of psychological therapy in helping people. Some patients engaged with the therapy, but this did not seem to reduce their distress or problems. Paul, a DBT session facilitator, commented on the progress of a particular service user who was engaging with the therapy:

P: 'Her needs are really high; it's hard to see how she can break away from that if I'm honest. I've had my moments where I've been feeling totally hopeless about it, and it's my fault I'm unable to see how you can move away from that total reliance on people... She enjoys the DBT skills; I do think they help her 'coz she's quite reactive, and that's the first step... But yes, progress is slow, and I do struggle sometimes to think about where we're going.' (Paul, DBT practitioner, interview<sup>24</sup>)

Paul's talk about his struggles to maintain hope for a patient is presented as a confession ('if I'm honest') and reflects the discourse of recovery in which hope is a necessary element. Within the recovery discourse, the practitioner is responsible for maintaining hope for the patient, especially when the patient is not able to feel hopeful themselves. Paul takes on this responsibility by accepting the blame ('it's my fault') for his inability to remain constantly hopeful for this patient.

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<sup>24</sup> Research site omitted to maintain anonymity

However, if patients did not engage with the therapy, then the responsibility for their lack of recovery was placed with the patient:

J: 'I think, yeah, I think that everybody is responsible for their own actions, really... They're out there living their life, and it's there in that time outside of the session that the change happens. So I do feel like there is a huge responsibility on the client to be able to implement the stuff that we're talking about and the work that we're doing, and that does put the responsibility on them.' (Joe, psychologist, Llancafell CMHT, interview)

For patients who were discharged for not attending or engaging, hope was deferred by the possibility that they might come back when they felt ready. Motivation was something that could come and go, and therefore, hope was never completely lost:

K: 'I think with people with BPD [borderline personality disorder], there's a lot of conflict, like internal conflict, so that motivation sometimes gets lost, but it's not gone. Does that make sense?' (Kyle, psychologist, Llancafell CMHT, interview)

If a patient was engaging with the therapy, the staff referred to the need to push on despite the challenges with the expectation of eventual change. There was an acceptance that some patients might need to engage with therapy for long periods of time:

K: 'I think people with BPD [borderline personality disorder] are notorious for staying in service forever, um, which people find frustrating but then also, if that's why they need them, that comes back to comparing patients against patients... Like how people with depression leave so everyone wants people with depression, to then make their case it looks like they've cured.'

R: 'So, you think some people with BPD might need to have the support of services?'

K: 'For a long time, and I think that's OK, like some of the therapists are brilliant, they're clearly amazing, and then they've got the same patients for years, and it doesn't reflect on them as psychologists or therapists. It's just that they're very challenging and complex caseload who just need longer.' (Kyle, psychologist, Llancafell CMHT, interview)

Some patients were discharged from therapy for not attending or in one case, for sleeping through the group sessions. However, for those who were attending but not seen to be making any effort to change, their lack of motivation became a topic for therapy to address:

J: 'Sometimes you get some resistance, and you can work with that by naming it.'

(Julia, psychologist, Llan castell CMHT, interview)

Some patients attended therapy but regularly continued to engage in risky or inappropriate behaviour. Rather than this being seen only as a consequence of their failure to make changes, it became an issue to explore in therapy. Psychologist Kyle described a particular patient diagnosed with borderline personality disorder who would (in the staff's opinion) deliberately appear to be as ill and at-risk as possible. He explained that his approach was to ask why she would engage in that behaviour:

K: 'This has come up a few times recently, and my sort of approach to that is why that might be the case? Why do they want to be as ill as possible? Are they worried you're going to leave them? What is triggering that "I need to be ill, so you'll help me", and that's the issue.'

R: 'So, you'd try and look at the underlying reasons why.'

K: 'Yeah, so there's a function to that. I'm thinking of a lady in particular who lies constantly to different members of staff, what other staff are saying and could get people in trouble... Why is she lying; what function does that serve? I think it's more important than if they're ill. They're ill; they're in services anyway. Why are they trying to show you how ill they are; what does that mean? You're not helping them enough like what—what else could be done?' (Kyle, psychologist, Llan castell CMHT, interview)

Senior nurse Sheila explained how the Forest View Recovery Centre responded to inappropriate or risky behaviours:

S: 'I think a better way to look at behaviour is probably a need. So somebody acts perhaps something out because there is an unmet need somewhere in their care. But until we can work out what that unmet need is, we've got to focus on what

they're doing to try and gain some understanding.' (Sheila, senior nurse, Forest View Recovery Centre, interview)

Again, the response to the patients' failure to change their behaviour was to question the function of the behaviour in order to gain an understanding of the patient.

If the patient was physically present in a therapy session, then useful work could be done. The lack of engagement, motivation or change became topics to discuss in therapy that were believed to lead to a better understanding of the patient's needs. For example, senior nurse Paul explained how a patient, Bethany, was doing very well but was not able to talk about plans for moving on:

P: 'I think that she could live independently. ... However, it's difficult to say that because if you were to ask her in the room, she would get quite angry... It's quite triggering; it's quite problematic for her because the idea of change prompts some really maladaptive behaviour... So we're only at a stage at the moment whereby we've agreed to work on strategies to help her talk about where we go next rather than actually where we go next.' (laughs) (Paul, senior nurse, Forest View, interview)

There was an assumption that with enough effort the patients' behaviour could be understood and presumably changed. In this way, the therapy was potentially limitless; the patients' lack of motivation to change could be discussed continually, and understanding could be endlessly improved.

All the practitioners drew on a discourse of complexity. They constructed mental health problems as caused by multiple, interacting biological, psychological and social factors that were unique for each individual. In addition, the knowledge about these causes and their interactions was understood as complicated, not always possible to understand and constantly changing with ongoing research. A discourse of trauma was also evident in the participants' responses: adverse childhood events (ACE's) were frequently identified as the most important factor in causing a person's mental health problems. The existence of multiple, interacting factors of causation justified the need for a multidisciplinary approach to work with patients and meant that a lone practitioner could not be expected to facilitate recovery. There was no evidence of

competition or disagreement between professions in the practitioners' responses: most of them pointed out the limits of their own discipline and the possibilities of other kinds of techniques to help the patient. In this way, hope was maintained within the team by being constantly attributed to the next form of treatment. Often, hope was referred to psychological approaches, particularly dialectical behaviour therapy (DBT), for patients who had experienced trauma. However, the psychologists also talked about the limitations of their treatments and their struggle to maintain hope. The nature of psychological therapy meant that the patients' failures to motivate themselves or make changes became issues to be addressed in therapy. Therapy initially aimed to teach the patients skills to become aware of and manage their emotions and behaviour. However, if the patient was not able or willing to do this, then the therapy focused instead on the reasons for their lack of engagement. Therapy became an ever-deepening search for understanding the patient, which was potentially limitless. There was no clear end point at which it could be declared as unsuccessful, and therefore, it could maintain hope in patients for whom all previous treatments (including psychological) had failed to result in recovery.

Practitioners often drew on a discourse of resilience, particularly in relation to patients who had experienced trauma in childhood. Garrett (2016, p. 1910) has described resilience as a 'convincing conceptual framework' that has become 'common sense' in social work; the present data suggest that it is accepted across all the mental health professions in the services I studied. Resilience was understood as created by stable social relationships in childhood that conferred psychological benefits, which enabled resilience in adulthood. Those patients who had suffered adverse experiences, therefore, needed to learn skills for resilience by engaging with therapy as adults. The practitioners drew on an individualised discourse of resilience focusing on the development of individual attributes: individuals were expected to learn to manage their emotions and behavioural responses to enable them to function safely and independently in society. This neoliberal conceptualisation of resilience aligned with the recovery approach in promoting the responsibilised, independent subject but did not consider the cultural contexts, social structures or political processes (Bottrell 2013) that many of the practitioners had mentioned when initially asked about the

causes of mental health problems. When talking about specific patients, the route to recovery was an individualised one, dependent on the individual's motivation and commitment to work on themselves. In the remainder of this chapter, we will see how some patients appeared to 'freely, actively and enthusiastically embrace resilience' (Gill and Orgad 2018, p. 491) and, hence, recovery. They were keen to work on themselves and welcomed the professionals' guidance in this task. However, subsequent chapters show how some patients rejected recovery and a resilience discourse; they were not willing or able to undertake the work on themselves to develop the required skills for resilience.

## 5.4 Charlotte

Charlotte is a patient of the LLancastell Community Mental Health Team and has a care coordinator, Hayley, who visits her approximately every fortnight. The extract below is taken from a recorded meeting on 10 January 2018, between Hayley and Charlotte, that was the first of three meetings I attended. Charlotte is in her early twenties and lives with her parents. She was previously attending college but is not currently in education or employed. Hayley told me that Charlotte has been given a diagnosis of anxiety, depression and mild obsessive-compulsive disorder and also occasionally experiences minor auditory hallucinations. Later, in a one-to-one interview with Charlotte, she also listed these diagnoses and said that she was in agreement with them. For Charlotte, recovery means being able to manage her symptoms well enough to live independently, go back into education and have a social life. She currently finds it difficult to go out of the house alone and sometimes suffers from panic attacks both in and outside the house. However, both Charlotte and Hayley believe that Charlotte is in recovery. They have agreed on a recovery plan that includes her long-term goals as mentioned above and a number of smaller, interim goals, one of which is to regularly go outside of the house on her own to the local shops, park, friends' houses, etc. The following extract started at approximately six and a half minutes into a meeting between Hayley and Charlotte and follows a discussion about the activities Charlotte has been doing inside the house to manage her emotions.

H: Hayley, care coordinator

C: Charlotte, service user

- 1 H: 'How's it been going? 'coz the last time I came, I was having a look through our notes,  
2 and that was mid-December. You'd walked down to the pharmacy, hadn't you, by  
3 yourself and picked up meds. Have you been anywhere else on your own? Been out of  
4 the house on your own?'
- 5 C: 'Um, not on my own, but when I go out with my parents, when we go shopping and  
6 that, I'll kind of just wander around on my own. Like not wander 'round, but I'll do my  
7 own stuff.'
- 8 H: 'So, kind of go off by yourself for a little bit.'
- 9 C: 'Yeah.'
- 10 H: 'That's good.'
- 11 C: 'Like, I think we went shopping about two days ago, and I did all of my shopping on my  
12 own, and then like, instead of just ringing up my mum, I just went to go and find her.'
- 13 H: 'In (town)?'
- 14 C: 'Yes.'
- 15 H: 'That's good. But you haven't been down to the pharmacy or shop or anything?'
- 16 C: (nods head)
- 17 H: 'No, that's OK.'
- 18 C: 'Hopefully, by the end of this week 'coz like 'coz we need more meds 'coz my dad's got  
19 tablets as well.'
- 20 H: 'Yeah, so would that be a little thing for you to do: go down by yourself?'
- 21 C: 'Yeah.'
- 22 H: 'Cool.'
- 23 C: 'Like I haven't really been going down the path much because of the weather.'
- 24 H: 'Yeah, it's not the nicest time of year to go outside.'
- 25 C: 'You've got to go like up and down a mountain to get to the park.' (laughs)
- 26 H: 'I want you to go outside, but I don't want you to compromise your safety.' (both laugh)

- 27 C: 'I slipped on a step once, and I was like oh, God. I was looking around to see if anyone  
28 saw.' (laughing) 'Luckily, no one was there.'
- 29 H: 'But going down to the chemist, that's a good goal, and we've talked about maybe  
30 going down to the shop just to pick up little bits and pieces, haven't we?'
- 31 C: 'Mm, my mum went to our friends, which is like a little bit past the chemist and up a  
32 small mountain thing, and she went there, and I met her up there.'
- 33 H: 'Yeah, that's good. That was by yourself?'
- 34 C: 'Yeah.'
- 35 H: 'Cool, well done. So, there's been some bits of going out by yourself.'

During the interaction, Hayley consistently constructs Charlotte as able to do the recovery-oriented behaviour she is aiming towards: going outside on her own to local places. Hayley constructs the required behaviours as desirable and praiseworthy but also easy to do. By the end of the interaction, Charlotte has agreed to go to the pharmacy on her own, but at no point does Hayley tell her what to do. Instead, she uses various subtle discursive strategies that result in Charlotte suggesting and confirming relevant goals to achieve before Hayley's next visit. Charlotte appears to play an active role in this process, using her own discursive strategies to present herself as keen and able to do these desired activities. In the first part of the extract, Hayley offers a formulation (Heritage and Watson 1979), drawing on her previous notes to summarise Charlotte's previous achievements in going outside on her own. Hayley's formulation includes two second-order functions (Edwards 1997, p. 99): the inclusion of the date of the last meeting highlights that Charlotte has had several weeks to go out on her own and the utterance 'you'd walked down to the pharmacy' confirms that going out of the house on her own is something that she is capable of doing. The formulation constructs Charlotte as someone who is capable of the recovery-oriented behaviour of going outside alone, and who, perhaps, given the time that has elapsed since their last meeting, should have done more of this behaviour.

Hayley constructs the going outside alone behaviour as admirable and valued by praising Charlotte every time she gives an account of autonomous activity outside of the home. Charlotte presents herself as trying hard to achieve autonomous activity,



giving various examples of this kind of behaviour. In line 5, Charlotte admits that she has not been out alone again for several weeks. However, demonstrating her hearing of going out on one's own as a praiseworthy activity that she should have done more of, she immediately qualifies her initial answer with an account of 'doing her own stuff' whilst out with her parents, which has the effect of presenting her as someone who has partly achieved the desired behaviour. She corrects herself (line 6) where she explains that she does not just 'wander 'round' but 'does her own stuff'. 'Wander 'round' suggests an unplanned, unmotivated behaviour, whereas 'do my own stuff' constitutes Charlotte as someone who has things to do and who gets on with it on her own. Hayley praises her for this in line 10. In lines 11-12 and 31-32, Charlotte gives further examples of when she has undertaken autonomous activity, and Hayley praises her again (lines 15, 33 and 35). In line 15, Hayley offers the formulation 'you haven't been down to the pharmacy or shop or anything?', which is presented as a question, and invites Charlotte to confirm that she has not actually been anywhere on her own since the last time she met with Hayley. Three-part lists are used to signal the special comprehensiveness of what the speaker is saying (Atkinson 1984, cited in Antaki 1994, p. 133) and in conjunction with the extreme case formulation (or anything?) (Pomerantz 1986; Edwards 2000), the effect is to make it plain that Charlotte has not fully achieved the desired behaviour of going out on her own. Charlotte is forced to admit that she has not done so (line 16). Immediately following this (lines 18-19), Charlotte offers a palliative: an account aimed at softening the undesirable responses she has given (Kitzinger and Frith 1999) by proposing that she will 'hopefully' be undertaking this desired behaviour of going out on her own by the end of the week. Hayley's agreement with Charlotte's proposal is presented as a question (line 20). The effect of this is that Charlotte agrees and confirms to Hayley that she will do this activity: it has now become an agreed-on recovery-focused goal for this week rather than something that Charlotte will 'hopefully' do. Hayley responds with 'cool' (line 22), a casual, light-hearted comment that, together with her earlier minimising in line 20 ('a little thing'), sets up the agreed-on activity as something easy, quick and not serious or challenging. By the use of 'we've' and 'haven't we' (lines 29 -30), Hayley attempts to enrol Charlotte in a joint project: going out alone is presented as something they are working on together rather than something that Charlotte has to achieve by herself.

In this extract, Hayley can be shown to exercise pastoral power. She monitors Charlotte's behaviours and thoughts and shows care for Charlotte. Her response to Charlotte's failures to go out alone is not punitive but accepting and encouraging of Charlotte's efforts. The tone of the whole extract is one of care and support, rather than instructions and discipline. Through her consistent praise and encouragement and by setting up opportunities for Charlotte to create behavioural goals, she also works to shape Charlotte into someone who strives for autonomy and independence in line with both the recovery approach and the neoliberal ideology of the responsibilised citizen. Through their interaction, both Hayley and Charlotte constitute Charlotte as someone who is committed to recovery and will achieve this by her own determined and consistent efforts at doing recovery-oriented behaviours.

## 5.5 David

David is in his forties and has been attending the CMHT for approximately nine years. He was originally referred to the team in 2004 and again in 2007 but other than attending a managing anxiety course that year, he chose not to stay in contact. David has been given a diagnosis of anxiety and depression and finds it very difficult to leave the house alone. He lives with his parents who shop and cook for him and provide company and reassurance. David sees Zoe, his care coordinator, every three to four weeks. Zoe (a social worker) coordinates his support, which includes weekly therapy sessions with Joe, a trainee psychologist, and attending a local social group for men with mental health difficulties. David is considered to be in recovery by himself and the staff at the CMHT.

Over the last year, David has been more open about his experiences of bullying at school, work and home, and the staff believe that his bullying experience amounts to severe trauma, which is a major contributing factor in his mental health difficulties. David is seeing Joe for therapy aimed at helping him manage his emotions. He is due to

start eye movement desensitisation and reprocessing (EMDR)<sup>25</sup> treatment with one of the psychologists shortly.

Zoe met with David approximately every fortnight to discuss his progress and monitor his wellbeing. I attended and recorded two of these meetings. This extract is taken from the second meeting that took place on 12 February 2018 at David's home. In the few lines before this extract starts, David and Zoe have been discussing how hard David finds it to process his emotions and how this has resulted in him self-harming. In this extract, they talk about the EMDR treatment David is due to have.

Z: Zoe, social worker

D: David, service user

- 1        Z: 'So, you're working with Joe; does that help you to process the emotions a bit more
- 2        readily or you become aware of them a lot sooner?'
- 3        D: 'I think, at the moment, it's just making me aware 'coz hopefully, we're going to dissect
- 4        it in a further session. You know, how to deal with these, you know, the anxiety and—'
- 5        Z: "Coz you need to be aware of them before you can do anything with them.'
- 6        D: 'Yeah.'
- 7        Z: 'Sounds like he's working wonders with you. It's been a long time coming, hasn't it?
- 8        Waiting for this...'
- 9        D: 'Yes.'
- 10       Z: 'Mm.'
- 11       D: 'Can't wait for the EMDR now to see if that will make a difference.'
- 12       Z: 'I know, yeah.'

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<sup>25</sup> EMDR (eye movement desensitisation and reprocessing) is a form of psychotherapy in which the client recalls distressing images whilst simultaneously focusing on an external stimulus, usually therapist-directed bilateral eye movements. It is thought that EMDR facilitates the accessing and processing of traumatic memories to bring these to adaptive resolution (NHS 2018).

13 D: “Coz like I say, it didn’t with Des<sup>26</sup> but then he’s—it was only with a finger rather than  
14 light.’

15 Z: ‘And it was years ago, wasn’t it? Must have been.’

16 D: ‘It was 2011.’

17 Z: ‘Yeah, I was gonna say it must be coming up to ten years, nearly; it’s seven years since  
18 you’ve done it.’

19 D: ‘Yeah and he said it’s come on since then, haven’t it?’

20 Z: ‘Yeah, I think emotionally, you’ve matured a lot, and you’re able to express your  
21 emotions in a more constructive way now.’

22 D: ‘Mm yeah.’

23 Z: “Coz when I first met you, you were still at risk of self-harming and things like that,  
24 weren’t you?’

25 D: ‘Yeah, like I say, I do still get these thoughts; I had these thoughts the other day quite  
26 strongly. I think the reason why... I don’t know... is ‘coz I’m thinking of my parents. So,  
27 I’m not doing anything daft because of that, I think.’

28 Z: ‘Yeah.’

29 D: ‘It is ‘coz I see what it does to my parents, and obviously, I don’t want that happening  
30 so...’

31 Z: ‘And also what it does to you as well ‘coz it only solves things in the immediate term,  
32 doesn’t it? But in the long term, you’re still at risk of experiencing those emotions and  
33 becoming overwhelmed, so you’re working really hard to manage those emotions and  
34 live with them more comfortably.’

35 D: ‘Yeah, yeah, I’m trying, yeah.

In this extract, Zoe and David create an optimistic narrative about David’s mental health, jointly constructing the current and future treatments as effective. They also co-construct David as motivated to undertake the required recovery-oriented

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<sup>26</sup> Des is David’s former EMDR therapist

behaviours and developing and maturing in a way that will help him better manage his mental health. David also shows some subtle resistance to a recovery discourse, downgrading Zoe's assessment of his improvement.

Zoe starts by asking about David's work with Joe, the trainee psychologist. The structure of the question has the function of encouraging David to make a choice between two options, both of which require him to confirm that working with Joe has helped him with his emotions in some way and thus constructing the therapy as effective.

David selects the second option (line 3), that the work with Joe has made him more aware of his emotions. He then uses the temporal marker 'at the moment' twice to emphasise that they will be going on to do something more substantial with his emotions in the future. David's use of the word 'hopefully' indicates his willingness to go on to this next part of their work in processing his emotions. His response constitutes him as someone who is actively working on managing his emotions, wants to recover and is keen to do further work on himself to achieve this.

In line 7, Zoe makes a very positive evaluation of the work that the psychologist is doing with David, suggesting that he is 'working wonders.' This description constructs David as someone for whom psychological therapy is very successful and who is making progress because of it. David is not given a slot to respond to this, meaning it cannot be challenged.

David had EMDR therapy several years previously, but it was ineffective. In lines 11–19, both Zoe and David suggest reasons why the EMDR treatment may be effective this time, for example, the use of a light as a stimulus this time rather than the therapist's finger (David, line 13) or because presumed advances in the technique will render it more effective (Zoe, line 15, David, line 19). David and Zoe construct EMDR as something that can be affected by different external factors and that is more likely to work this time than previously. The 'he' referred to in line 19 is Joe, the trainee psychologist, who has been talking to David about EMDR.

Zoe constructs David as having experienced personal growth. She suggests that he has emotionally matured and developed the abilities to better manage his emotions (lines 20–21). Zoe continues to emphasise how David has improved and ends her utterance in line 24 with ‘weren’t you?’, inviting David to agree that he used to self-harm but does not now. This utterance works to enrol David into her argument that he has developed, matured and improved and also to link maturity and development to stopping self-harm. Risk-taking behaviour, such as self-harm, is constructed (lines 20–21) as something that people do when they are not emotionally mature enough to express their emotions constructively.

David’s response to this suggests some resistance to the notion that he has made the significant improvement suggested by Zoe: he initially replies with ‘Mm, yeah’ (line 22) in an unanimated, low tone of voice<sup>27</sup>. His response that he still thinks about self-harming (lines 25–27) enables him to make clear that it is still an issue for him without suggesting that he may do this behaviour again in the future, that, following the last part of their conversation, would amount to him saying that he is not emotionally mature. David’s response positions him as someone who has developed emotional maturity: even though he has had strong thoughts about it recently, he has not self-harmed, and hence is someone who is able to self-manage their thoughts and actions.

David suggests (line 26) that he does not self-harm due to his worries about his parents, but in line 31, Zoe corrects his reasoning, suggesting that the impact on David is the most important factor to consider. This works to change David’s reason for not self-harming from his parents’ reaction, an external factor, to his own emotional self-management, something that he is assumed to be able to control, albeit with great effort. At the end of the extract, Zoe works to construct David as someone who is still at risk of being unable to manage his emotions but who is ‘working really hard’ (line 33) to manage this risk. In line 35, David continues to present himself as making a concentrated effort to manage his emotions.

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<sup>27</sup> It may also reflect the conflict experienced in responding to a compliment (Pomerantz 1984).

Throughout the interaction, both David and Zoe use a number of strategies to construct David as in recovery and developing the ability to self-manage and cope independently. They co-construct the current and future therapy as successful, and David as able to develop and mature in his ability to manage his own emotions. David shows a low level of resistance to Zoe's optimistic evaluation of his progress, but in general, he presents himself as engaged and proactive in his recovery.

## 5.6 Aiden

Aiden is in his early twenties and has been living in one of Cartref Hapus' supported houses for just under a year. Aiden's childhood was very unstable with some time spent in care and numerous moves of home and school. Aiden told me he does not have a formal medical diagnosis of mental illness but suffers from anxiety and depression. I attended five meetings with him, of which this is the fifth and the second with Ben, who had recently become Aiden's support worker. Aiden has previously expressed concern about his poor diet that he thinks is partly due to his problems with budgeting. In this meeting, Ben and Aiden are, therefore, discussing budgeting.

The meeting, recorded on 28 June 2018, lasted just over 51 minutes. Due to the length of the transcription, it is not included in full in this chapter, but a full version can be found in Appendix 9. In the meeting, Ben induces Aiden to give him information about his finances and his troubles with budgeting. Through the course of the meeting, Ben persuades Aiden to make various decisions to better manage his finances and diet, however, at no point in the interaction is there any obvious power imbalance between them. The exercise of power in this scenario is subtle and seeks to mould Aiden into a more self-managing person in regard to his finances and diet whilst carefully managing the relationship to ensure that at no point is the exercise of power explicit or intrusive.

Towards the beginning of the extract, Ben tries to find out about Aiden's problems with budgeting:

B: Ben, support worker

A: Aiden service user

- 61 A: 'You see, I've always tried to budget, but I've never been able to.'
- 62 B: 'Yeah. Why do you think you haven't been able to budget? You don't mind me asking
- 63 these questions, do you?'
- 64 A: 'Well...'
- 65 B: 'It's just getting me... understanding it better.'

Ben uses various softeners in his question (line 62) to reduce its directness. For example, he uses the phrases 'do you think' and 'haven't been able to' rather than the more direct wording, such as 'why can't you budget?'. However, despite this, the question could still be understood as intrusive: it states Aiden is failing and asks for reasons for his failure. Ben's following question ( line 62-63) possibly attempts to prevent any rupture in the relationship resulting from his pointing out Aiden's potential failure. As he has not left a slot for Aiden to respond, Aiden cannot reply with offence or anger, and Ben's subsequent utterances make it difficult for him to say that he does mind Ben's inquiries. Ben's final utterance in this section (line 65) presents him as someone who cares for Aiden and wants to understand rather than judge, which takes away the potential negative implications of the question. It would be difficult for Aiden to disagree with Ben wanting to understand him better, and this paves the way for Ben to elicit more information from Aiden.

Ben uses various methods to persuade Aiden to budget better: he talks about the benefits of budgeting, such as being able to treat oneself (lines 283–292, 776) and being better prepared for the future (lines 85–91):

- B: 'Yeah. Well, this is one of the... good ideas about budgeting, yeah? So, you can budget, and you can save for like going away and treats and... like you said, you want to buy stuff.' (lines 283–286)

He sometimes talks about how 'other people' choose to do a particular action (such as saving) and the benefits it has for them (lines 126–128, 407–408, 465–467). On one occasion, he points out the negative consequences of Aiden not budgeting well (lines 785–787). Budgeting is presented as bringing significant benefits related to a better quality of life: not just surviving but living (lines 91, 166):



B: 'Yeah. Erm... yeah, looking to your future, and... so, you've got money and not – like you said – I think you said a couple of minutes ago here – you said, you can survive on... but... like living isn't about surviving.' (lines 89–91)

Ben uses a number of strategies to induce Aiden to better manage his money, without giving him instructions. He uses the phrase 'you could' (lines 314, 322, 434, 439–440, 443, 474, 481, 847, 857, 866), presenting the suggestions as options rather than instructions. He also uses questions such as 'do you want?', 'are you interested in?' and 'do you think it's a good idea?' to gain Aiden's agreement in a way that constructs the decisions as Aiden's rather than his (lines 174, 259, 380–381, 781–783, 846–847):

B: 'Do you want to... do you want to put some money away for... just in case you need to go to like [town] or [town]? So... like £2 a week?' (lines 380–381)

Some suggestions are made in the form of statements about what 'other people' do (lines 126–128, 407–408, 465–467) that serves as a device for indirectly offering recommendations:

B: 'Ok. So, you pay enough to... well, obviously, to cover your rent, so you... erm... because something that other people might sort of do is they pay their rent and they pay a slightly... a little bit more?' (lines 126–128)

Ben uses the pronoun 'we' repeatedly (e.g. lines 252, 320, 333, 361–362, 621, 806), especially when agreeing on plans and ensuring they appear jointly constructed and mutually agreed on. Ben's language positions Aiden as in control: plans are made on the basis of Aiden 'wanting' to do them. Even when a plan has been agreed on, Ben makes it clear that Aiden could choose to change it:

B: 'Yeah, but this... this... this menu... this budgeting can... can change. So, if you find you want to spend more money on food, then we can change that.' (lines 332–333)

At one point, Ben appears to lack information. Yet, later on, it becomes apparent that he knows more than he has previously suggested. In discussing Aiden's service charge arrears, he initially appears to have just found out that Aiden has arrears and is paying them off:

B: 'Yeah!' (laughs) 'So, you've got... you've got rent arrears, but you're paying a little bit extra, to pay them off?' (lines 148–149)

The pitch of Ben's voice is raised at the end of this utterance, making it a question rather than a statement. Aiden responds to this without disclosing how much he owes but later on in the conversation, having agreed to inform Sarah, the housing manager, of the situation and for Aiden to keep paying a little extra, Ben says:

B: 'Yeah? Oh, that's fair enough. Because I think you were like about £120 in arrears, I think.' (lines 157–158)

This suggests Ben had already looked into Aiden's finances and was aware not only that he was in arrears but how much he owed. Ben uses several lexical hedges ('I think', 'like', 'about') to appear tentative in this sensitive part of the interaction (Wiggins 2017). Showing that he had been able to access information about Aiden's finances in advance of their meeting would have been an obvious sign of his power in the situation, and hence Ben avoids doing this before they have agreed on various actions relating to Aiden's debt.

Throughout the conversation, Aiden presents himself as keen to budget well and tries hard to do this:

A: 'You see, I've always tried to budget...' (line 61)

A: 'I do try... I do try to stick to it...' (line 72)

He also casts himself as someone who takes responsibility for his finances. For example, he talks about his service charge debt and how he is paying this off by paying extra rent (lines 150–163).

In lines 508–514, Aiden describes how he used up the very last scrapings of his tobacco so as not to waste any and uses the phrase *waste not, want not*.

A: 'The other day, when I had it... like... [? A quarter] was lasting me a month and a half, and I was like that – the little bits, down at the bottom, I was like... I opened up the packet, got my key out to scrape it off the sides, because it sticks to the sides, well, waste not – want not.' (lines 511–514)

Aiden's narrative about saving his tobacco demonstrates that he is capable of being the kind of person that Ben is encouraging him to be, someone who is careful with resources and not wasteful. As well as presenting himself as generally managing his finances well and trying to budget, Aiden also talks about occasions in which he did not manage his money well. However, these are presented as occasional failures, and he also offers a number of excuses to explain this behaviour. For example, between lines 262 and 306, Aiden explains how, recently, he spent more than he could afford on fast food, buying kebabs for himself and some friends. He then offers a number of accounts (Scott and Lyman 1968) for his behaviour: he was 'really, really hungry' (line 263), he did not have his bank card so could not go to a shop and (presumably) buy something cheaper (295–298), he bought food for his friends out of politeness (267–269) and finally, that it was very easy to buy the food online (lines 297, 298, 301) and perhaps, therefore, it was a behaviour that many people would have succumbed to in those circumstances.

Throughout the extract, Aiden presents himself as generally capable of self-management but prone to occasional mistakes or lapses. Ben does not directly construct Aiden as someone who is self-managing and capable but as someone who could manage if he followed advice (lines 785–786). However, the interaction as a whole positions Aiden as someone who is managing his finances: during the interaction, Aiden makes decisions to take various steps to manage his money, the kind of decisions that a responsible, self-managing person would do. Ben's efforts to minimise the obvious power imbalances in the interaction work to hide his role in the decision-making and instead produce Aiden as a self-managing person who is capable of controlling his finances.

## 5.7 Geraint

Geraint is in his forties and has been a patient of the CMHT for 16 years. He explained to me that he is a university graduate whose career was cut short after being diagnosed with manic depression (bipolar disorder) in his early twenties. Geraint described several periods of mania and depression which resulted in some chaotic and troubled times in his life, but said he has now been stable for many years. He currently

sees a psychiatrist from the team once every six months; this is his only contact with the service. Geraint told me that he lives alone and spends his time playing sports, socialising with friends and doing voluntary work.

This extract is from a meeting between Geraint and a psychiatrist, Margaret, that takes place in the CMHT office building. The extract occurs 38 minutes into the discussion that lasts for just over an hour. In the extract, Margaret consistently evaluates Geraint as responsible and self-managing and constructs his proactive approach to his problems as praiseworthy. Geraint responds by avoiding self-praise whilst also agreeing with and supporting Margaret's positive evaluations with the evidence of his ability to self-manage and take responsibility for his behaviour.

- 1 M: 'There's just a form that we need to fill out as ever. The NHS are really good at forms.  
2 It's actually quite useful, though, I think it will be really useful for you. It's looking at all  
3 areas of your life and how we could support you. Sounds like you're incredibly self-  
4 sufficient, and you've actually gone ahead and looked for the support yourself but just  
5 seeing if there's anything that we can support you with... You've already done a lot of  
6 the work that we would probably do already, but it's seeing if there's any gaps so it  
7 would be looking at um...'
- 8 G: 'I've been a manic depressive for more than half my life.'
- 9 M: 'Right, it is a lifelong, unfortunately, yeah.'
- 10 G: 'Yeah, but I haven't had a manic episode for, um, a while, which is good because they  
11 always end in tears.'
- 12 M: 'And you, you've done very well, incredibly well to stay out.'
- 13 G: 'I coach myself, you know. I say, well, you're doing alright; you haven't earned a million  
14 pounds or anything, but you're doing alright; you're OK.'
- 15 M: 'And there's lots of people who haven't got manic depression, who haven't, who are in  
16 a situation, which is, who haven't had maybe the same motivation to deal with some  
17 of their stuff, which you're dealing with, which is actually going to get some help  
18 regarding the debt and actually trying to find a way through it, so all credit to you;  
19 that's not an easy situation to have to deal with, but you've been very appropriate.'

20 G: 'Well, it was my responsibility in the first place 'coz I spent money I didn't have on  
21 things I didn't need for too many years.'

In lines 3–6, Margaret offers a very positive evaluation of Geraint: that he is self-sufficient and has already done work that professionals normally expect to do for someone. In line 8, Geraint's response to Margaret's positive evaluation enables him to accept the praise from Margaret whilst also not engaging in self-praise (Pomerantz 1978). His statement suggests that he has been manic depressive for so long that he has had a lot of time to learn to be self-sufficient and find support outside of formal mental health services.

In lines 10-11, Geraint explains that although he still has manic depression, he has not been very unwell for a while. The second part of the utterance is an understatement that emphasises how positive this is. The use of the moderate 'good' (rather than fantastic or brilliant) and the idiomatic phrase 'end in tears' work to gloss over the severe suffering caused by his manic episodes (previously discussed in this meeting). As much as he expresses how positive it is not to have manic episodes, he is also presenting himself as stoic and not wanting to complain or go into detail about his past suffering.

In line 12, Margaret attributes his ongoing wellness to his own efforts by another very positive evaluation of Geraint. 'Stay out' in this context refers to staying out of hospital, a topic that has come up previously in this meeting.

12 G: 'I coach myself, you know, I say, well, you're doing alright; you haven't earned a million  
13 pounds or anything, but you're doing alright; you're OK.'

Geraint's response in lines 12–13 is a scaled-down agreement (Pomerantz 1978): he is 'doing alright' rather than 'incredibly well', which Margaret proposed. Geraint uses active voicing (Wiggins 2017 p. 246) to describe his inner dialogue or self-talk. Through describing his self-coaching behaviour Geraint presents himself as someone who is able to independently work on his development, a behaviour clearly demonstrating self-management. Margaret responds by reasserting her positive evaluation, this time comparing Geraint favourably to other people (lines 15–19).

The comparison to people without manic depression works to emphasise how motivated Geraint has been and how much of an achievement this is given his illness. Being highly motivated, getting appropriate help and dealing with problems are all presented as praiseworthy qualities.

In lines 20–21, Geraint responds to Margaret's praise with a qualifier: he takes personal responsibility for the situation that caused his problems. There is no attempt at providing excuses, eliciting sympathy for his situation or references to his bipolar disorder as a reason for overspending. Geraint presents himself as able to take responsibility for his behaviour, including past failures, to self-manage.

In this extract, Margaret offers three very positive assessments of Geraint that construct Geraint as a person who is motivated, can self-manage and deal with problems appropriately. Geraint's responses are typical in that they reflect a balance between agreeing with the praise whilst avoiding self-praise (Pomerantz 1978). However, at the same time, they work to present Geraint as uncomplaining, self-managing and taking responsibility for his behaviour and its consequences in line with the recovery approach.

## 5.8 Conclusion

In this chapter, I have shown how mental health professionals exercised pastoral power in their interactions with service users in order to align their subjectivities with a recovery discourse. Through a combination of hope and subtle exhortation, they persuaded the service users to undertake various activities and decisions aimed at transforming them from passive patients to independent, self-managing citizens. The professionals demonstrated care for the service users in asking about their feelings and empathising with their difficult experiences. They consistently monitored the service users' thoughts, feelings and behaviours, asking frequent questions about these as well as their future plans. They worked to induce self-management, using a number of discursive strategies. They presented recovery-oriented behaviours as positive, praiseworthy and not too difficult. They constructed the service users as responsible, capable and motivated and as making efforts to recover. They consistently praised their past and present efforts to be independent and self-managing. They

frequently painted a very optimistic picture of their situations, treatments and future prognoses in an attempt to build up their hope that things would improve for them. Their requests for the service users' actions were focused on aspects of the situations that the service users could control, for example, their response to difficult feelings. By focusing on their internal locus of control rather than outside influences, they emphasised the service users' control over their situations and their abilities to resolve their problems without waiting for external changes. They worked to foster a sense of self-initiated self-development in the clients that, in combination with the treatments, would lead to a reduction in mental distress, rather than constructing the service users as passively waiting for treatments to work.

The practitioners worked hard to minimise the visibility of power in the interactions. This was demonstrated most obviously in the case of Ben and Aiden. However, all the professionals generally refrained from giving straightforward advice or instructions that would make obvious an assumed superior level of expertise to the service users. For example, Hayley facilitated the conversation with Charlotte in a way that encouraged Charlotte to suggest what recovery-oriented actions she could take. Hayley then agreed with the suggestions and got Charlotte to confirm she would do the actions, producing it as a jointly agreed goal. All the interactions were managed by the professionals in a way that constructed the service user as having jointly agreed to the plans for treatment and/or their recovery-oriented activities.

The service users also exercised pastoral power over themselves. They presented themselves as capable and motivated to self-manage as well as agreeing to take on various recovery-focused goals. There were occasional signs of subtle resistance through minimal or passive responses to staff suggestions or formulations. However, in general, they were compliant with the staff's suggestions, willing to undertake the recommended activities, and minor problems were overcome easily in the interactions.

The service users discussed in this chapter were all considered to be in recovery by themselves and the staff. For these service users, the exercise of pastoral power appeared to be an effective way to work toward recovery. The professionals' efforts to

induce self-managing behaviours were usually successful, and the service users accepted the responsibility for their recovery and the efforts needed to achieve it. The regime of practices involved in recovery appeared to be successful in that the service users came to accept themselves as responsible, self-managing subjects or at least as subjects who ought to strive towards these ends (Dean 2010, p. 44). However, these service users comprised a subsection of the service users I observed, and there were others who responded differently to the professionals' attempts to mould them into responsibilised and self-managing citizens. The following chapter will consider these non-recovering service users who rejected the professional use of strategies and tactics, and resisted attempts to mould and shape their behaviour and thoughts.



## Chapter 6: Recovery Practice with ‘Non-Recovering’ Service Users

### 6.1 Introduction

In this chapter, I will present three case studies of service users who were not considered by themselves or staff to be in recovery. A case study approach allows for the exploration of the complexity of recovery in real-life mental health practice (Simons 2009; Crowe et al. 2011) in order to illustrate dilemmas and contradictions in ways that a broad discussion of staff or service user accounts cannot. I will show how staff draw on a model of pastoral power enacted by various discursive strategies in order to try to help service users achieve recovery. The interactions involve participants managing issues of accountability, stake and responsibility. The staff’s strategies mainly align with a recovery discourse in constructing the service users as responsible partners in recovery and encouraging them to take control over their lives. Some service users rejected these constructions and presented instead as unable or unwilling to take responsibility. In the following section, I analyse extracts from data relating to Kate and Rob, both patients of Llan castell CMHT, and Emily, a patient at Forest View Recovery Centre. These three cases were selected as they best represent the discursive strategies used by staff and service users across the three research sites when a service user is not considered to be in recovery.<sup>28</sup>

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<sup>28</sup> I was only able to record meetings with two service users not considered to be in recovery (Rob and Kate). I draw on extracts from these as they illustrate the discursive strategies used in staff - service user interactions. I observed the same strategies in unrecorded conversations between staff and four additional ‘non-recovering’ service users at Forest View. I also observed staff talk at Cartref Hapus which aligned with these strategies in focussing on responsabilisation. Emily is discussed in this chapter because the data relating to her most clearly demonstrated the strategies used to accept or reject responsabilisation, which my findings suggest is a key aspect of the practice of recovery.

## 6.2 Kate

Kate is a young woman who has been given a diagnosis of emotionally unstable personality disorder by the psychiatrist at Llan castell. Zoe, Kate's social worker has told me that Kate lives with her grandparents who brought her up, as her mother, who has drug problems, was unable to provide for her either physically or emotionally. Kate's grandparents told me that they find it difficult to cope with some of her behaviours, and their relationship is obviously strained. Kate and her grandmother argued in both the meetings I attended. Zoe explained to me that Kate has received support from Llan castell CMHT on and off over several years. Her most recent period of contact has been for the last two years. She currently has a care coordinator, Zoe (a social worker), and sees a psychologist, Cath, once a week for dialectical behaviour therapy (Lineham 1993). Kate experiences extremely low moods, regularly self-harms and has suicidal thoughts. She is not considered by herself or the staff to be in recovery at the current time.

The extract on the following page is taken from the first of two meetings I attended with Kate and Zoe and occurs about halfway through the meeting which took place on 8 December 2017. Before this extract, Zoe and Kate have had a long discussion about the kind of supported housing placement that might be right for Kate.

My analysis of the extract below shows how Zoe consistently draws on a recovery approach and uses pastoral strategies in the interaction; she monitors Kate's thoughts and behaviour whilst also encouraging her to take responsibility for managing her behaviour. Kate rejects Zoe's approach. She presents herself as very unwell and draws on a biomedical discourse to support her claim that she is unable to take responsibility for her behaviour. Like in the previous extracts in Chapter 5, Zoe downplays the power associated with her professional role. Zoe and Kate draw on various linguistic strategies to manage the issues of accountability and responsibility for Kate's behaviour and wellbeing.

Z: Zoe, social worker

K: Kate, service user

- 1        Z: 'But we're looking at some sort of long-term, well, not long-term but perhaps a year or  
2        so of you living somewhere safe where you can access the right therapies and have the  
3        right sort of graded exposure and rehab on practical stuff as well. That's what I'd be  
4        looking at in supported living.'
- 5        K: 'OK.'
- 6        Z: 'Does that sound alright with you? (Pauses for three seconds) You're going to need to  
7        work at it.'
- 8        K: 'Yeah, you're talking to me now, and you know my plans for the next few weeks.'
- 9        Z: 'Yeah, that's the next thing we'll talk about.'
- 10       K: 'Yeah, so that's what I'm like, everything's going over my head at the moment.'
- 11       Z: 'Mm-mm.'
- 12       K: 'Yeah.'
- 13       Z: 'OK, 'coz that's the next thing I wanted to talk about was this suicide plan you've got. Is  
14       it New Year's Eve you said, wasn't it?'
- 15       K: 'I'm not stupid. I know you can section people.'
- 16       Z: 'Well, I'm not going to do that now.'
- 17       K: 'I don't know what you'll do. I might start saying stuff, and you'll be like actually, I am  
18       going to section her.'
- 19       Z: 'I can't. I need a couple of doctors with me first.'
- 20       K: 'But you'll come back.'
- 21       Z: 'And the authorisation of a manager. I'm not going to section you because you're saying  
22       you have a plan to kill yourself in three weeks' time.'
- 23       K: 'I thought you wanted me to talk to Cath [psychologist] about it?'
- 24       Z: 'It would be helpful 'coz it would be nice for you to do something other than kill  
25       yourself.'
- 26       K: 'I explained to Cath, it's like somebody else inside my body doing it, so it's not me.'

27           Z: 'I think you can survive it because when it was the anniversary of your father's death,  
 28           alright, you had a plan to kill yourself, but you got through that.'

29           K: 'It's nothing like that.'

30           Z: 'It's different to that again, is it?'

31           K: 'I'm a completely different person to how I was back in the summer.'

32           Z: 'Mm.'

33           K: 'I'm a completely different person to how I was.'

34           Z: 'OK, yeah, so, I would like to talk to Cath about that because if we need to keep you  
 35           safe because you can't keep yourself safe, then, you know, we will have a plan in place.  
 36           But it's New Year's Eve, is the date, is it?'

37           K: 'I'm not saying the date.'

In lines 1–3 and 6–7, Zoe tries to engage Kate in a recovery-oriented discourse focused on her future, involving progress, support and improvement, achieved with effort by Kate, but Kate's response in line 8 rejects this trajectory. She treats Zoe's formulation as irrelevant, questioning why they are even talking about this topic when she is planning to kill herself in the next few weeks<sup>29</sup> ('you know my plans', line 8). In line 9, having failed to engage Kate in a discussion about her longer-term future, Zoe addresses Kate's plan and requests confirmation of the date for her planned suicide.

In lines 15 and 17, Kate positions Zoe as a powerful mental health professional, sanctioned by law to take control of her fate, and positions herself as a powerless patient, unable to predict what action Zoe will take. Kate's refusal to give specific details, such as dates, portrays her as concerned about the possibility of being sectioned. However, she does not suggest at any point that she does not need to be sectioned but instead suggests that Zoe might decide to section her if she were to say more, thus presenting herself as very unwell and at-risk.

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<sup>29</sup> Zoe is aware of Kate's plan as she has been informed by the psychologist who Kate has already told.

In response to Kate's positioning, Zoe plays down her power in the situation, emphasising that she would need agreement from her colleagues in order to section Kate and reassuring her that she will not be sectioned today if she talks about her plan (lines 19, 21, 22).

In lines 27–28, Zoe draws on a strengths-based recovery discourse ('you can survive it because when it was the anniversary of your father's death, you had a plan to kill yourself, but you got through that'). She constructs Kate as someone strong and resilient and able to overcome suicidal feelings by referring to a past situation as evidence of Kate's abilities and strength. In lines 29, 31, and 33 Kate again refuses to take responsibility by explaining that she is now a 'completely different person'. As a different person, presumably, she cannot be assumed to have the same strengths or resilience as she had at the previous time, which invalidates Zoe's claim that she will be able to get through this difficult period. It also functions more broadly to ensure that Zoe cannot rely on any of Kate's past behaviours as guidance for how she might behave now as she is a different person who is, therefore, unknown, unpredictable and at-risk.

In lines 34–35, Zoe responds to the risk presented by Kate by setting out what she will do in response to that risk ('you know we will have a plan in place'). Unlike in lines 27–28, where Zoe positioned Kate as strong and capable of managing the situation safely, in this statement, she positions herself and her colleague (Cath) as responsible for managing the risk and taking control of the situation. Having explained that they will have a plan in place, she asks Kate to confirm the date she plans to take her own life (line 36), giving Kate the opportunity to collaborate with Zoe and Cath to put in place a plan to keep her safe. Kate again refuses to confirm the date.

In this extract, Zoe attempts to give Kate the responsibility for her plans and behaviour, but she rejects this, first by claiming that there is someone else inside her head who is making the plans for her (line 26) and then, when this is ignored by Zoe, by presenting herself as a 'completely different person' who is not able to cope. At the end of the extract, Zoe accepts that Kate cannot or will not take responsibility and positions herself and her colleague as responsible for protecting Kate.

In the second extract, Zoe and Kate continue to manage the issues of accountability and responsibility. Zoe draws on a recovery approach, suggesting that Kate could and should take actions to look after herself at home. Kate uses a number of strategies to construct herself as unable but not unwilling to take responsibility.

Prior to this extract, Kate has explained that ‘the person inside her’ has been doing various suicide-related activities, such as watching documentaries about how people kill themselves and looking at pharmacy websites for medications which do not need a prescription.

- 39           Z: ‘What would you choose to do instead of doing that stuff, if it was you in control and  
40           not this thing using your body? What would you be doing with the time?’
- 41           K: ‘I dunno.’
- 42           Z: ‘Mm, have you been shutting yourself away since you’ve moved back in with gran?’
- 43           K: ‘Yeah.’
- 44           Z: ‘Yeah, have you been doing anything to pass the time?’
- 45           K: ‘Um, taking tablets to go to sleep.’
- 46           Z: ‘Right, OK, so sleeping is the only thing you’ve been doing to pass the time?’
- 47           K: ‘Yeah, or like, um, if I feel safe enough, I see [friends], but, yeah, even that’s gone out  
48           the window.’
- 49           Z: ‘Mm, yeah, is there anything you can do? Even if you’re shutting yourself away, is there  
50           anything you can do in the house?’
- 51           K: ‘No, I just lie here, and then that other person takes over.’

In lines 39–40, Zoe changes the topic (‘instead’) from Kate’s description of ‘the person inside’ her to Kate’s ‘choice’ of how to spend her time. Zoe attempts to counter Kate’s argument that she is not in control of her actions by constructing Kate as a separate being who has her own agency apart from the ‘thing’ inside her (‘if it was you in control and not this thing’). This question poses a problem for Kate in terms of managing her responsibility (or the lack of it). Giving a suggestion of what she would choose to do would demonstrate her ability to make choices. This would imply she is

able to do things independently of the 'person inside her' and would, therefore, position her as being at least partly responsible for her actions. Her response ('I dunno') enables her to avoid accepting the responsibility either for making suicidal plans or doing any other kind of activity whilst not explicitly refusing responsibility that might make her appear a difficult patient. In this way, Kate manages her interest (Potter 1997) in presenting herself as unable, rather than unwilling, to take responsibility for her actions.

In lines 42–51, there is a discussion of the activities that Kate has been undertaking in the house. Kate's response in line 45 ('taking tablets to go to sleep') is completely out of line with a recovery discourse in that it suggests a lack of any positive action toward recovery and involves a level of risk (taking tablets contrary to prescription advice). Deliberately going to sleep by using tablets could be seen as intentionally avoiding doing anything that might help her toward recovery. In line 47, Kate refers to an activity she used to do (seeing friends) and gives an excuse (Scott and Lyman 1968) for why she is unable to do this anymore (she no longer feels 'safe enough'). This presents Kate as wanting to do recovery-oriented activities, such as seeing friends, but unable to do so, rather than as deliberately choosing not to do appropriate activities. Zoe acknowledges this in line 49 ('Mm, yeah.') and uses an extreme case formulation ('anything') to emphasise the choice that Kate has in terms of the activities she could do in the house. In line 51, despite Zoe's invitation for her to do 'anything' in the house, Kate rejects the suggestion ('No, I just lie here, and then that other person takes over.'). Her response suggests a passive acceptance of 'the other person' taking over that, again, is incongruent with a recovery approach in that she is not presenting as willing to take responsibility for trying to retain control and autonomy but instead appears to allow the other person to take over.

In the second meeting I attended with Kate, she was not happy for me to record or take notes. Immediately after the meeting, I recorded verbal notes with a recorder and then wrote them up. In this meeting, Kate was claiming to be experiencing psychosis (hearing voices), but the professionals considered this unlikely and believed she was using this claim to appear more severely ill. Kate asked for antipsychotics for her symptoms:

Zoe asked Kate if there was anything else that would help rather than antipsychotic medication, but Kate said no, it was just the medication; she says she couldn't cooperate with therapy while she had psychosis. (extract from notes taken after the meeting between Zoe and Kate, 8.3.2018)

Zoe draws on a discourse of service user expertise, in line with the recovery approach, asking Kate what she thinks would help her, but Kate presents her psychosis as being resistant to any treatment other than medication. In this way, she constructs herself as powerless to do anything about the symptoms and reliant on medication to manage them. The strategies used by Zoe reflect a pastoral power model: they act at the 'nexus of discipline and subjectification' (Martin and Waring 2018, p. 1304), both monitoring and recording Kate's behaviour and attitude whilst, at the same time, inducing her to take on board the expectation that she will make efforts to self-manage and reduce the risk she poses to herself. Zoe's strategies attempt to prioritise the need for Kate to self-manage and take responsibility for her behaviour. Even when she takes responsibility for Kate's wellbeing in response to perceived risk ('we will have a plan in place'), she invites and encourages Kate to collaborate with her by sharing information that will help protect her from harm. Kate's responses reject the construction of her as able to self-manage or reduce her risk of harm. She sometimes presents herself as wanting to be able to self-manage but being unable to by virtue of the severity of her illness and the inability of treatments or actions (other than medication) to lessen her symptoms. At other times, she presents as simply choosing not to take control of her behaviours ('no, I just lie here'), directly resisting any responsibility for her recovery.

### 6.3 Rob

Rob is a middle-aged man who has had contact with Llan castell CMHT for many years. His current contact with the team is in relation to severe depression and anxiety experienced since the death of his wife approximately two years ago. Rob is anxious about leaving the house, and coupled with his lack of motivation, has rarely done so in the last two years other than to collect his medication from the local pharmacy and do essential food shopping. Rob drinks alone at home, regularly self-harms and has very



little social contact. Both Rob and the CMHT staff agree that depression and anxiety are normal responses to his situation. However, it has now been nearly two years since his wife passed away, and the CMHT staff feel that he needs to be working towards some kind of change in his life. Neither the staff nor Rob believe that he is currently in recovery.

In the analysed extracts, Jan, a social work student working with Rob, exercises pastoral power and uses various discursive strategies in her interaction with Rob. She monitors Rob's thoughts and behaviours by constantly asking questions and takes notes throughout the meeting. She uses various strategies to induce and persuade Rob to self-manage, pointing out the benefits of various activities and holding Rob responsible for taking action toward his recovery. Rob consistently rejects her attempts to engage him in self-managing behaviours, sometimes refuting the claims that various activities will have positive outcomes for him and also rejecting responsibility by constructing his problems as either unsolvable or medical and, therefore, needing medication to resolve them rather than other activities that he could undertake. He also presents himself as at-risk. The extracts in this section raise the dilemma of authority versus equality (Billig 1987), and Jan can be seen to manage this through her language, maintaining an 'authoritatively friendly manner' (Billig 1987, p. 77).

The extracts are taken from the two meetings I attended with Rob and Jan, a student social worker who had been asked to work with Rob. In the first extract, which is at the very start of the first meeting on 7 February 2018, Rob talks about his feelings about his situation and recovery.

J: Jan, social worker

R: Rob, service user

- 1 J: 'I think recovery is particularly relevant for you, which is why we're speaking to Rachel
- 2 in the first place. Because I think we're trying to work out what you define recovery as
- 3 and where you want to see yourself.'

- 4 R: 'But I'm still entrenched in that view that my life doesn't matter so, you know, um,  
5 (pauses for five seconds), so what's the point?'
- 6 J: 'So, do you think you're finding it difficult at the moment to think, to even have the  
7 thought as to what you want different in your life?'
- 8 R: 'Yeah, yeah, 'coz—and as much as I want to move on, it's still that thing, well, wait a  
9 sec. This is huge; it's ever-present in my life, and it won't go away.'

In lines 1–3, Jan starts with a formulation oriented to my presence as a researcher. Her description of what she and Rob are trying to do functions to set out the expected (recovery-focused) kind of work to be done in this meeting and justifies why I have been invited to meet with them (because 'recovery is particularly relevant' to Rob)<sup>30</sup>. In lines 4–5, Rob gives an immediate undesirable answer ('but') that questions the relevance of the concept of recovery in his life. He explains that as his life does not matter, and there is no point in thinking about recovery. He constructs himself as keen to move on but prevented from doing so by the ongoing presence of 'that thing'<sup>31</sup> in his life. He wants to recover but has no control over this due to his personal circumstances ('it won't go away', lines 8–9).

In the second meeting on 8 March 2018, Jan suggests that Rob might like to attend a local social activity group and asks Rob if this is something he would consider. This is followed by a long silence and then the extract below:

- 18 R: 'Do I really need to answer that? I think everybody knows the answer.'
- 19 J: 'It looks like you're thinking about it.'
- 20 R: 'No, you know what I'm going to say. This is only the second time Rachel's met me, and  
21 she knows what I'm going to say. It goes back to that point you can't do—there's only  
22 so much you can do.' (sighs) (pauses for five seconds) (sighs) 'Um...'

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<sup>30</sup> Both Rob and Jan have completed the informed consent procedure and are, therefore, aware that my research is focused on recovery.

<sup>31</sup> 'That thing' refers to the loss of his wife.

23 J: 'Is it really something that doesn't interest you, or is it something that seems like a big  
24 thing to do for you?'

25 R: 'A bit of both, you know. (pauses for six seconds) I'm going to change tac slightly; I  
26 think that I do need to see, er, the psychiatrist. I've been thinking about that last week.

Rob's response attempts to enrol Jan and me into the perspective that there is very little we can do for him and possibly, that there is little he can do for himself too. He attempts to make this argument stronger by suggesting that we already know it is the case: it is so obvious that even I know it, and I have only met him twice (lines 20 -22). In lines 23–24, Jan challenges this perspective by offering two options regarding the reasons for him not wanting to attend a group: his lack of interest or the fact that it will be difficult for him. This response works to change the point of debate from whether there is anything that can be done to the issue of Rob's choice (or readiness) to undertake a potentially helpful but difficult action. It makes Rob responsible for taking actions that may help his recovery and rejects the notion that Rob cannot do anything to help himself. Rob concedes that he both lacks the interest in attending a group and that it is a big and presumably challenging thing for him to do. Rather than going on to talk about why this might be challenging, Rob instead states that he needs to see a psychiatrist (line 26) and goes on to talk about the possible changes to his medication after this extract. He constructs his problems as requiring medication to enable change rather than as something he can influence by his own efforts to undertake various therapeutic activities. He implies his problems are biological rather than psychological or social. Jan clarifies that he would like to see a psychiatrist and then continues the discussion about Rob's recovery.

27 J: 'Well, I was speaking to Zoe, and she said coz obviously, I've only got like a month left  
28 now, but if you do think you are ready to commit to some sort of recovery approach  
29 and staying within the services, then she was suggesting I come out maybe every week  
30 now until I leave to look at specifically what—to try and put some sort of...'

31 R: 'Plan to action.'

32 J: 'Yeah.'

33 R: 'I'm... (pauses for five seconds) The self-harm, it's gone from like just a, you know, to  
34 the tops of my thighs are just in bits...'  
35 J: 'Is that since the last time I've seen you?'  
36 (14 lines omitted)  
37 J: 'Mmm, do you think it's progressing to a point where you might?'  
38 R: 'Yeah, that's what I wanna, yeah.'  
39 J: 'So, do you want to stop self-harming at the moment?'  
40 R: 'There is a point between when it stops being helpful and it stops being routine, and I  
41 know I'm not cutting that deep 'coz I'll always, from my experience, I know that I  
42 actually cut a vein because they just keep going back; they're like elastic but, um...'  
43 J: 'Have you tried to cut that deep before?'  
44 R: 'Yeah, I've tried committing suicide before, yeah, three times.'  
45 J: 'Do you have any thoughts of doing that again?'  
46 R: 'Yeah.'  
47 J: 'Mmm, and how are you managing those?'  
48 R: 'Drinking.'

(Recorded meeting between Rob [service user] and Jan [student social worker],  
8.03.2018)

In lines 27–30, Jan puts Rob in control of his future relationship with Jan and the CMHT, making it dependent on his choosing to 'commit to a recovery approach' and 'staying in services', constructing Rob as able to make a choice of whether to engage with the service and his recovery. She also suggests that failure to engage with recovery-oriented activities may result in him being discharged from the service.

Rob responds to this statement by telling Jan that his self-harming has recently become worse (lines 33 – 34). This initiates a discussion in which Jan asks Rob about his self-harming, and Rob presents himself as at greater risk than previously: 'there is a point between when it stops being helpful and it stops being routine' (line 40). When

Jan asks how he is managing his suicidal thoughts, he replies that he is 'drinking' (line 48), adding to the factors presented that might increase his risk.

Jan's interactions with Rob demonstrate the tensions between the authority and equality inherent in modern relations between experts and non-experts (Billig et al. 1988). Jan works to minimize her power and tries to convey an egalitarian partnership that is particularly visible in the following extract:

- 10        Ra: 'So maybe just recap what you've been talking about, just so I can—'
- 11        J: 'So, do you want to?' (to Rob)
- 12        R: 'No, you can.'
- 13        J: 'OK, so we were talking about, we were looking again at Rob's barriers to recovery, I
- 14            guess and what he's been thinking about. We're still kind of struggling as to what his,
- 15            what he thinks would be best to change or to move forwards, um, and whether he's at
- 16            a point where he's ready to do that. Would you say that's fair?

I had arrived a little late and asked if they could recap their conversation. Jan offered Rob the opportunity to recap (line 11), suggesting that either of them would be equally capable of offering me a summary of their meeting so far. Then she presented her and Rob as working (and struggling) together towards shared goals. The use of 'I guess' (line 13-14) can be seen as a stake inoculation (Potter 1996) in that it suggests uncertainty and a level of casualness to her thoughts about Rob's barriers to recovery. The issue of Rob's barriers to recovery is a delicate one as it raises the issue of his level of accountability for these barriers. By presenting herself as 'wondering' about them, she downplays her potential interest in attributing the responsibility to him.

Throughout the discussion, Jan exercises pastoral power: she speaks in a friendly tone, showing care for Rob, and she monitors Rob's behaviour and risk, asking questions about his self-harming behaviours and his thoughts about them. In line with the recovery approach, she constructs Rob as being able to make a choice about whether to continue to self-harm ('do you want to stop self-harming at the moment?') and being able to manage his thoughts about harming ('how are you managing those?'). She also attributes responsibility for his recovery to Rob, suggesting that it is he who

needs to be ready for recovery and decide what it is he wants for his recovery. In contrast, Rob sometimes presents his problems as unsolvable. At other times, he constructs them as the results of medical illness and needing medication to achieve recovery rather than actions that require significant effort from him, such as attending a social group. Rob wanted to continue to have regular visits from Llan castell staff, but without engaging with any of the suggested activities. However, this was not an option and he was made aware that continued failure to engage could result in discharge from the service. Rob's talk about self-harm and suicide functions to present him as someone who is at significant risk and perhaps, therefore, who cannot be discharged from the service despite not engaging with any recovery-oriented activities.

#### 6.4 Emily

Emily is in her late thirties and has been at the inpatient unit of the Forest View Recovery Centre for a few months. She told me she has had mental health problems since childhood and has used mental health services for about 20 years. Emily has a history of multiple and complex traumas, and she also has a mild learning disability. Before she came to Forest View, she was in another inpatient unit that was more restrictive. She is subject to the Mental Health Act 1983, and therefore, her ability to leave the hospital is controlled by the visiting psychiatrist who decides how much escorted (accompanied by staff) and unescorted leave she is allowed. Emily tells me she has been given diagnoses of complex trauma, personality disorder, obsessive-compulsive disorder and depression. She is not in agreement with the personality disorder but does agree that she displays some of the symptoms associated with this diagnosis. Emily is very talkative; she talks to me the most out of all the patients at the unit. Her family is important to her; they visit every few weeks. She enjoys sports, has recently joined a gym and also likes to go to the library sometimes. She tells me that recovery for her means getting out into the community, learning about yourself and 'how to deal with your behaviour' as well as 'working out what it is you want as a person' (interview with Emily, 11.7.2018). Despite her verbally expressed engagement with her recovery, her behaviour was often assessed by the staff as not in line with a recovery approach. In addition, although she talked a lot about taking part in various activities, I came to realise after spending more time at Forest View that these

happened much more rarely than her talk would suggest. Emily sometimes became very angry with the staff and/or the other patients, and during my few months at the unit, there were several incidents in which she shouted and swore, threw objects or slammed doors. Emily described these incidents as 'a bit intense'; she feels she is not in control, and that makes her feel vulnerable and frightened (interview with Emily, 11.7.2018). Emily and the staff were not happy for me to observe or record one-to-one meetings with her due to the sensitivity of the material discussed. The following analysis, therefore, draws on ethnographic field notes, recorded interviews with the staff<sup>32</sup>, informal conversations with Emily and a one-to-one recorded interview with her.

The analysis focuses on the ways in which the staff used various strategies to try to persuade Emily to self-manage her emotions and behaviours and the ways in which Emily often resisted or was unable to comply with these efforts. The staff's strategies appeared to have two main aims: to enable Emily to manage her emotions and resulting behaviour and to induce her to take responsibility for her behaviour and its consequences. Emily drew on various strategies to manage the issues of responsibility and blame in her interactions with me, and her talk about responsibility was inconsistent, suggesting an ambivalence around this issue.

The main strategy promoted to Emily to help her manage her emotions and behaviours was dialectical behaviour therapy (Linehan 2015; Grace 2017). Emily attended regular DBT group sessions and was encouraged to practise the STOP skill, a technique aimed at enabling distress tolerance. The skill involves stopping, taking a step back, observing the self and others, and proceeding mindfully, balancing emotions with reason to work out the best response in the circumstance (Linehan 2015). The staff understood DBT as a way of giving Emily the skills she needed to manage her emotions and control her behaviour:

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<sup>32</sup> One staff member preferred not to be recorded in their interview; I took thorough notes and wrote them up immediately.

P: 'I guess it's about managing emotions for him. She enjoys the DBT skills; I do think they help her 'coz she's quite reactive.' (Paul, senior nurse, Forest View Recovery Centre, interview)

G: 'We've given her all the tools not to do that [angry reactions] and things to use, adaptive coping mechanisms.' (Gemma, nurse, Forest View Recovery Centre, interview)

Emily expressed different thoughts about DBT during my time at the unit. Early on, she expressed resentment at being advised on how to respond in certain kinds of situations:

Emily tells me that she doesn't like mindfulness or DBT. She said, 'if I wanted to be trained like a dog, I'd go to Battersea.' I ask her why she dislikes DBT so much, and she said, 'I have a voice, I can use it correctly or incorrectly, it's my choice'. (Forest View Recovery Centre, field notes)

Emily resists the use of pastoral power through DBT to help her control her emotional responses and contrasts the passivity implied in the training with making active choices about how to express her emotions. She talks about her voice and her choice, two concepts central to humanistic, person-centred approaches and also promoted by the recovery movement as essential to service user empowerment. Through this, she constructs DBT and the idea of controlling one's emotional responses as in opposition to choice and being heard. DBT focusses on the control and appropriate expression of emotion; outbursts of emotion can be implied as irrational, but it is possible that Emily might see her emotional responses as actively resisting something she disagrees with.

At a later date, Emily told me she found DBT enjoyable: 'I do like DBT because it's challenging and I like answering questions' (interview with Emily, 11.7.2018). However, later in the same interview, she expressed doubts about whether she would be able to master all the skills:

E: 'Um, they try to make you think about it and all that, and how the hell can you think about it and actually put it into practice? It's not that easy, once you've gone and tried dealing with your emotions. You've got like different sectors of everything in DBT; it's not just like one part of it. There's like a whole load of it, and I'm thinking,



frigging hell, what are we supposed to be, Albert Einstein?' (R laughs) 'So I can't do it all.'

In this extract, Emily presents DBT as very difficult to put into practice and overwhelming in volume. She uses an extreme case formulation ('Albert Einstein') (Pomerantz 1986) to upgrade her justification for not being able to practice DBT skills. Emily's response resists the cognitive paradigm suggesting that she does not act as a 'naïve scientist', constantly engaging in a process of testing and refining her understanding of herself and the world as proposed by learning theorists such as Kelly (1955).

A 'behaviour' that the staff believed Emily needed to change was absconding from the unit. Emily had left Forest View unescorted on a few occasions when she did not have permission, and the staff wanted her to accept the responsibility for this and learn to control her urges to abscond. Paul (senior nurse) explained how he used a strategy of disinterest to put the responsibility onto Emily when she suggested that her absconding was his problem:

P: 'My response has been "Actually, this is not my problem; your disappearance is very much your problem and is going to interfere with your daily routine or the things that you want to achieve. It is your problem, not mine; all I have to do is fill in the paperwork and phone the police, so it ain't really my problem." So that sounds very disinterested, but that disinterest has a function, I think, 'coz it pushes ownership back onto the person whose behaviour it is: they own the behaviour, they need to manage it.' (Paul, senior nurse, Forest Green Recovery Centre, interview)

Paul's disinterest is not presented as a lack of care but a deliberate tactic to encourage Emily to take responsibility for the consequences of her behaviour. By taking a disinterested stance, he avoids confrontation with Emily and adopts instead a bureaucratic approach of documenting and reporting the problem so that the consequences of her behaviour are addressed by other agencies, such as the police.

Emily's response to being encouraged to take responsibility could be characterised as ambivalent. This was particularly apparent in her talk about absconding. The following

field notes were taken after a conversation with Emily shortly after an incident in which she absconded with a fellow patient.

Emily is not happy today. She told me she has had her leave revoked because she absconded for three hours last week... Emily tells me that it was the staff's 'fault for leaving the front door unlocked.' She pointed out that she did not sneak out the back door and go over the fence ('they can look for my DNA on the fence, they won't find any'). Later on, she says 'I take full responsibility,' which seems to contradict what she said earlier about it being the staff's fault. (Forest View Recovery Centre, field notes)

In the conversation referred to in the extract above, Emily initially manages the issue of responsibility by presenting her absconding in a way that constructs her as blameless and allocates the blame to the staff (Edwards and Potter 1992, cited in Abell and Stokoe 1999). Within the context of inpatient mental health services and the Mental Health Act, absconding is not legally permitted. However, Emily's version of the events appeals to an everyday understanding of reasonable behaviour: leaving a building through an unlocked front door without trying to hide one's leaving is considered normal and morally acceptable behaviour in the everyday context. She uses a contrast device (Smith 1978) to present this version of the events in comparison to another possible scenario in which she 'sneaked out the back door and went over the fence'. Her version of the events works to present her as honest and reasonable and is made more credible by her suggestion that she is open to the (hypothetical) possibility of the staff checking for her DNA on the fence. Emily's later statement that she 'takes full responsibility' appears to be in direct opposition to what she initially claimed. The further analysis of Emily's talk about her behaviour and responsibility shows additional examples of inconsistency.

In Emily's one-to-one interview that took place approximately two months before this more recent absconding incident, Emily talked about previously having leave cancelled:

E: 'I haven't actually had any leave for myself since March 'coz I took a drug overdose when I was in [previous hospital], and for some reason, the doctor took back my leave... I had to be escorted everywhere, and it didn't change. It wasn't his fault; they were worried about my safety 'coz they knew I could be a little shit, and I have

absconded from here, I'm not saying I haven't. I've walked away from here as well.'  
(interview with Emily, 11.07.2018)

Emily states that the decision to revoke her leave was not the doctor's fault, and her reference to safety concerns and her being a 'little shit' suggests that she recognises her role in bringing about these consequences. In this interview, she presents herself as honest ('I'm not saying I haven't') and aware of her faults.

Emily is faced with a dilemma in that if she accepts responsibility, she also accepts some level of blame for the actions considered wrong (in the context of an inpatient setting). However, within the same context, admitting responsibility for her actions and their consequences is seen as praiseworthy and contributing to her recovery. This may help explain Emily's seemingly inconsistent strategies with regard to managing the issues of accountability and blame.

Emily sometimes expressed a wish for more direct instructions and consequences for her behaviour:

Later on, Emily comes to talk to me again. She tells me that the staff here are not helping her. I ask what they should do to help. Emily replies 'I don't know, but they keep asking how they can support me – I don't know, they should, they're the professionals.' Gemma (nurse) had told her 'We've given you the tools to help yourself', but Emily said that doesn't help. (Forest Green Recovery Centre, field notes)

Emily's account of the staff asking her how they can support her suggests that the staff tried to work in line with a recovery discourse by valuing Emily's knowledge about what is helpful. However, Emily constructs the professionals as experts who should know how to help her. She rejects the idea (key to the recovery approach) that she might have the tools to help herself or that she can take actions to reduce her risks, but instead holds others responsible and presents herself as at-risk and needing to be kept safe by others.

In line with Emily's expressed belief in professionals as experts who should tell her what to do, she sometimes asked for a more disciplining response to her inappropriate behaviour, an approach that was rejected as unhelpful to her recovery by the inpatient unit:

Another incident had happened the day before when Emily called Daniel (another patient) a 'raving lunatic'. They had an argument, and Emily had kicked a chair in anger. Gemma (nurse) reports that Emily has said she is leaving. Amelia (nurse) said that Emily had told her that she needs structure and discipline; she wanted to be grounded. Amelia explained to her that 'We don't do that here.' (Forest Green Recovery Centre, field notes)

Amelia's statement ('we don't do that here') is in line with Forest View's recovery-focused aims of encouraging self-management and responsibility and explains why Emily's appeal to be submitted to a disciplinary approach was rejected. Sheila (senior nurse) explained why they tried not to respond in a disciplinary way to Emily's aggressive behaviour and refusal to apologise:

S: 'She's waiting for us to call rank maybe or revoke leave or ground her. She asked me to ground her the other day, and that takes responsibility away from her. It doesn't teach her anything, you know. If she was to abscond today, I could quite happily revoke her leave, but then I'm putting a punishment in, I'm not enabling her to take responsibility or look at the consequences.' (Sheila, senior nurse, Forest Green Recovery Centre, interview)

Sheila presents the unit as promoting the importance of learning, self-development and responsibility in line with a recovery discourse and as rejecting the notion of punishment as unhelpful to Emily. This is in line with a progressive ideology of learning in which people are thought to learn best through self-discovery (Billig et al. 1988). Although the staff spoke of Forest View as avoiding actions such as revoking leave or grounding patients, this did happen and was usually justified on the grounds of risk to the service user's safety (see Chapter 7 for further discussion of this issue).

A final strategy used by Emily to reject responsibility for her behaviour was to construct mental illness as unpredictable and uncontrollable. In her interview, I asked Emily whether she thought there were any things she could do to help manage her mental health:

E: 'Sometimes, but then again, sometimes people can relapse just like that (clicks fingers). It happens to anybody. I've gone and relapsed about four times, I have, so I can't say anything different. Honestly, it's not—sometimes you can, but sometimes

you can't always. You try to, it's just—I'm saying 'coz I have done that.' (interview with Emily, 11.07.2018)

Emily casts herself as trying to manage her mental health but not always being able to due to the nature of the mental illness. She uses shifts in footing (Goffman 1981) to construct mental illness in general as unpredictable ('people can relapse just like that', 'sometimes you can, sometimes you can't) and, therefore, something that no one could control all the time. She presents herself as honest ('I can't say anything different') that increases the credibility of her argument that mental illness cannot always be controlled, no matter how hard one might try to manage it. This construction of mental illness as capricious or uncontrollable is not compatible with the notion of taking responsibility for changing one's behaviour, and this dilemma was reflected in Emily's talk throughout my time at Forest View.

The staff drew on a pastoral power model in their work with Emily. They monitored her behaviour by observing and writing notes that were stored in specific files and passed on verbally to other staff members at the daily handover meetings, weekly staff team meetings and through more informal conversations between the staff members. They attempted to induce Emily to monitor, evaluate and take responsibility for her behaviour and used a number of strategies to achieve this. They encouraged her to practise DBT skills to help her control her emotions. One staff member talked about taking a disinterested approach in which they focused on bureaucratic processes and avoiding confrontation. Finally, an important strategy promoted by the unit as a whole was an anti-disciplinary approach, avoiding punishment and reflecting a progressive ideology of learning through self-discovery. Emily's response to the staff's approaches was inconsistent: occasionally, her talk was in line with the recovery approach in that she stated that she took responsibility for her actions and their consequences. She regularly attended the DBT sessions despite her ambivalent attitude to them. However, she also frequently presented herself as unwell, at-risk and needing to be protected by the staff as well as constructing the staff as experts who should tell her what to do. She talked about mental illness being unpredictable and uncontrollable as a reason why she was unable to control her behaviour. She also

called for a disciplinary approach to her behaviour, wanting to be punished for her failures to control her emotional responses adequately.

## 6.5 Conclusion

As with the service users considered to be in recovery, the staff's strategies for enabling these service users to recover also draw on a pastoral power model and reflect the values of the recovery approach. They monitor the service users' behaviour, thoughts and feelings, record them using institutional tools and, in general, work in a caring way. They consistently prioritise strategies that induce the service users to self-manage, take control, make choices and take responsibility for their behaviour and its consequences. Mental illness or distress are constructed as something that is manageable, and service users are constructed as capable of doing this management. However, unlike with the recovering service users discussed in the previous chapter, these service users often reject these strategies in a number of ways. They construct mental illness or distress and even life in general as not amenable to self-management or control (other than perhaps by medication) and, as a consequence, construct themselves as unable to manage their distress. They reject responsibility for their recovery, sometimes calling for a more paternal approach of professional control, punishment and discipline. They also often present themselves as at-risk and, therefore, needing continued or perhaps enhanced care and/or control. In addition, they reject the behaviourist approach taken by staff.

## Chapter 7: The Limits of Recovery Practice

### 7.1 Introduction

The previous two chapters have shown how staff practised a recovery approach through the use of pastoral power. Pastoral power in mental health services is exercised by professionals who monitor the service users' behaviour and encourage them to monitor and manage their own behaviour. It works by shaping the patients' subjectivities in line with a recovery discourse. I will refer to this as the pastoral recovery approach. This chapter will explore what happened when a pastoral recovery approach was consistently ineffective in leading to a service user's recovery. In this situation, the staff across all three services took one of two options: moving to a more authoritarian approach or discharge from the service. Each of these options was presented as a last resort (Emerson 1981) and was justified by the practitioners in a range of ways.

The staff across all three research sites consistently drew on a recovery discourse within a pastoral model of power in their work with the service users and their discussions about them. For some service users, such as Charlotte and David, who were discussed in Chapter 5, this approach appeared to be effective, and both the practitioners and clients believed that the clients were in recovery. However, there were occasions when this approach was not effective. For instance, in Chapter 6, we saw that Kate was not in recovery despite two years of recovery-focused support from the CMHT, Rob believed that his problems were insurmountable and Emily struggled to take responsibility for her behaviour. Some service users were not compliant with a pastoral recovery approach: they were not able or willing to take responsibility, work towards goals considered appropriate by the staff or engage in any activities considered to be helpful to their recovery. The staff's monitoring, encouraging and inducing did not appear to impact these service users' ability or willingness to self-monitor and manage their own behaviour. The staff talked frequently about the importance of engagement, both to me and to the service users. Their use of the term engagement was consistent with Boyle et al.'s (2009) definition of representing the involvement of the client in a positive working relationship with the practitioners such

that the client participates in treatment planning and activities. Engagement was considered to be essential to recovery.

In response to the failure of the pastoral approach to engage people with their recovery, in some cases, service users would be discharged from the service, and in other cases, the staff would switch to an authoritarian approach in which the service users were forced to undertake certain activities by the threat of various sanctions or, more rarely, being sectioned under the Mental Health Act and taken to hospital. The staff justified their decisions to discharge service users or take a more controlling role in a number of ways: the level of risk to the service user was a major justification for the decision to take a more controlling approach, but other justifications were also used for both discharge and increased control, including the past and expected future failure of the pastoral recovery approach to help with the service user's recovery, risk to the service's reputation, funding, efficiency or future operations or risk to potential (waiting list) service users, other (current) service users, the staff and guests.

Emerson (1981) explored the nature of last resort sanctions in response to those considered 'troubled and difficult to manage' (p. 1). He identified two procedures for justifying such last resort sanctions: the inappropriateness of normal remedies or the failure/exhaustion of normal remedies in resolving the problem. In the context of the three research sites, the normal remedy referred to a recovery approach, and the staff often justified their authoritarian approach or discharge by showing how their consistent and prolonged efforts at using a recovery approach had failed to lead to recovery.

When talking about discharge of a patient, the staff frequently talked about the notion of responsibility within neoliberal discourse, referring to the service users' responsibility to manage their mental health problems and proactively work in partnership with the staff toward their recovery. However, when they resorted to authoritarian approaches, they more often used the term responsibility within a relation of care discourse (Trnka and Trundle 2014). They talked about the responsibility of the service to care for the patient, the other patients in the service,



guests, staff and the service as a whole and prioritised this understanding of responsibility in order to justify their actions.

The authoritarian approaches varied between the three sites due to the different legal statuses of the service users and/or the legally mandated powers of the staff. At Cartref Hapus, the staff's legal powers to control the service users' behaviours were restricted to those of a landlord. The service users could be subject to regular inspections of their rooms or checks on their whereabouts if they were suspected to be breaking their licence agreement. They could also be evicted and/or discharged from the service. In the Llan castell CMHT and the Forest View Recovery Centre, many staff members were professionally registered, and some had certain legal powers to restrict the freedom of the service users under the Mental Health Act 1983. At the Llan castell CMHT, service users could be sectioned and forcibly moved to hospital. Across Wales, between 2016–2017, 1,776 admissions were made under the Mental Health Act. The 2018 census showed that on March 31<sup>st</sup> of that year, 589 patients were detained in mental health hospitals and units under the Mental Health Act. During my time at the Llan castell CMHT, I was only aware of one sectioning, although it is likely that several more took place. At the Forest View Recovery Centre, all the service users were already sectioned under the Mental Health Act; however, the staff could restrict their rights to escorted and/or unescorted leave or require constant observation. The service users could also be moved to more secure hospitals that allowed less escorted and/or unescorted leave. The use of sectioning or moving to a more secure setting was always justified by the risk of serious harm to the service user (although other factors were usually also mentioned). I will go on to describe the justification work carried out by the practitioners to account for their decisions to stop using a recovery approach and move to discharge or an authoritarian approach. The justification of the risk to the service user was the only kind of justification that applied to only one kind of alternative approach, the authoritarian approach. This reflected the services' duty of care to their service users and their responsibility to manage risk.

## 7.2 Risk to the Service User

The most extreme version of authoritarian power was applied in the case of sectioning where a service user currently residing in the community would be assessed as in need of enforced inpatient care for their own or others' protection. The main justification for sectioning a patient was a serious risk to the patient due to their mental disorder. The focus on risk is not surprising due to the action being based on and consistent with the provisions of the Mental Health Act 1983 that requires that patients who are a risk to themselves (or others) be taken to hospital, forcibly if necessary. However, despite the clear legal mandate for staff to section patients, the process of sectioning was not straightforward, and the discussions about it involved a range of ethical and organisational dilemmas that impacted the staff's decisions.

In the following case, the staff try to balance the values of the recovery approach with the use of legal and medical power to section a service user against her will. The field notes in the extract below were taken during a multidisciplinary team meeting at Llan castell CMHT. The meeting was attended by approximately 20 staff members, including psychiatrists, social workers, community psychiatric nurses, occupational therapists, psychologists and support workers. The extract refers to a long discussion in the context of this meeting (approx. 15 minutes) about how to go about sectioning a particular service user, Sandra, and shows how the staff at the CMHT justified their decision to take an authoritarian approach to section her:

Sandra's care-coordinator starts by saying 'I don't know what to do with her.' There is talk of a recent professionals meeting at which it was decided that Sandra should be sectioned, but apparently, no one can find her to do the section. Someone explains that she is usually at the job centre in the library on a certain day, but there is agreement that sectioning her there would be unethical. 'We can't really... it's not ethical... everyone swooping in on her.' There is talk about how Sandra will react and an assumption that she will 'kick off' – this assumption seems to be based on past

experience. Then there is talk of ‘the risks highlighted at the 115 meeting<sup>33</sup>’ and a discussion of police powers. Someone says that Sandra has not picked up her prescription from the GP since September. It is established that this is not only for mental health medication but also insulin for diabetes. This raises more concern from the staff. They talk again about the idea of going to the library to section her. Another staff member comments ‘it’s not illegal, it’s just a bit immoral.’ Concerns are expressed about Sandra’s dignity: ‘it would be undignified; she would run.’ One CPN comments ‘I could go there (the library), and she would kick off if she saw me.’ This was suggested as a way in which the police could be called out in order to section the client. Someone says, ‘we could use a section 136<sup>34</sup>, it’s not bad practice.’ Someone else says ‘but it would feel like trapping her.’ Someone asks what the GP is doing – there is agreement that the GP is not doing anything. There seems to be a general opinion in the group that the GP should do more, especially because there is a physical health risk.

(Llan castell CMHT, field notes)

The decision to section Sandra had already been made at a previous professionals meeting: the current meeting focuses on how, when and where this section will be carried out. However, despite this, the staff constantly justify the section in their conversation, emphasising the risks to Sandra and constructing her as too unwell to be able to take responsibility for herself. The staff also display ethical concerns throughout the discussion. Although they could legally and practically section Sandra in the library, this is rejected as ‘not ethical’, as ‘trapping her’ and ‘undignified’. The possibility is described as legal but immoral. By questioning the morality of a legally allowable action, the staff demonstrate their awareness of the importance of justifying the way in which they exercise legally mandated authoritarian power. They show how legal/psychiatric and ethical discourses, such as those promoted by a recovery approach, can be in conflict with each other.

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<sup>33</sup> Section 115 of the Mental Health Act (MHA) gives powers of entry and inspection to approved mental health professionals to enable them to enter the home or residence of a person who has a mental disorder and whom they suspect is not receiving proper care.

<sup>34</sup> Section 136 of the MHA 1983 allows police to take someone to a place of safety, including a hospital, if they consider the person to have a mental disorder and need care or control. This is considered since the staff believe that Sandra will not agree to come with them to hospital and will run away.

The staff emphasise that Sandra is at risk: they express concern that Sandra has not picked up her medication for her mental or physical health problems and agree that the GP is not doing enough to protect her from the physical health risk she is at. This works to emphasise their responsibility for protecting her as the other professional, who they believe should take responsibility, is not doing so.

They discuss Sandra's reaction to being sectioned. There is a shared assumption that Sandra will be shocked, angry, confused and possibly aggressive in trying to get away. Another member of staff says 'I don't think she understands, she's so thought-disordered; it's really sad.' (Llancastell CMHT, field notes)

The comment 'I don't think she understands, she's so thought-disordered; it's really sad' draws on a psychiatric term, thought disorder (Colman 2015), to emphasise the severity of Sandra's illness and justify the section despite Sandra's expected immediate suffering as a result. It constructs Sandra as being unable to understand or make decisions due to her illness, and therefore, it positions the professionals as needing to step in and take control for her. The reference to 'really sad' suggests that it is no one's fault and is unavoidable. In this case, the use of authoritarian power in sectioning the patient is justified on the basis of the risk to her physical and mental health caused by the severity of her illness and the responsibility of the team to ensure her welfare. The use of responsibility in this extract is, therefore, in line with the relation of care discourse discussed by Trnka and Trundle (2014). Care in this discourse involves taking responsibility for recognising what somebody else needs doing for them. The relationship of care may involve an unequal power relationship as it allows for varying degrees of dependence and need.

Anna, a patient at the Forest View Recovery Centre, was admitted to a general hospital after a severe self-harm incident and was then transferred from the Forest View Recovery Centre into a more restrictive mental health hospital. Paul, a senior nurse at Forest View, justified this in his interview with me by making clear the severe risk of physical harm to Anna and showing how they had consistently tried to use a recovery approach despite the extreme situation.

Paul described how Anna often self-harmed at 9 pm when the daytime staff went home. After this time, there were no more activities, and the patients had to occupy themselves and try to self-manage their anxiety and other negative feelings. Paul told me that Anna resisted this by harming herself, which she knew would lead to medical intervention and hence increased support into the night. He explained that the staff aimed to avoid reacting to Anna's self-harm with hospital visits as they believed it would strengthen the self-harming behaviour. They hoped that by doing this, Anna would learn to control her self-harming. This response reflects a behavioural recovery approach in its attempt to enable the service user to change their behaviour and learn to self-manage their emotions. Paul described a particular situation where he believed that hospital admission was unavoidable:

P: 'We went in [to Anna's room], and she'd done a very severe self-harm. The bed was absolutely soaked in blood, she was soaked in blood; she was white as a sheet and shaking like a leaf. I'd never seen her frighten herself so much, so I thought this is a pretty big one.' (Paul, senior nurse, Forest View Recovery Centre, interview)

Paul uses extremisation (Pomerantz 1986) and a three-part list format<sup>35</sup> (Jefferson 1990) to emphasise the severity of the self-harm and justify why they had to call an ambulance and have Anna taken to hospital: the bed and Anna were not covered in blood, they were 'soaked', Anna was not pale, she was 'white as a sheet', etc. He also uses a modalising term (Pomerantz 1986), 'never', to emphasise how this incident was more severe than any previous one.

Paul went on to say:

P: 'We pushed our limits to the brink; we tolerated behaviours that people here have never even heard of because of the mix of staff we have in order not to validate its effectiveness, but there were times where it was so extreme that you could not but

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<sup>35</sup> This can be read as a three-part list: 1) the bed was soaked, 2) she was soaked and 3) she was white as a sheet and shaking like a leaf. The first two parts describe the amount of blood involved and part three describes Anna's appearance after the self-harm.

validate it by hospital admission.’ (Paul, senior nurse, Forest View Recovery Centre, interview)

Paul continued to use extremitisation to emphasise the severity of the circumstances under which they made the decisions to initially continue to use a pastoral power approach, tolerating ‘behaviours that people have never even heard of’ and then to move to a more controlling approach (‘you could not but validate it by hospital admission’). Paul presents a picture of a staff team who have worked incredibly hard over a period of time to try to continue to use a recovery approach despite the extreme situation they were dealing with.

P: ‘That was the moment where I thought we’re knackered; we’ve done everything, frankly... She’s self-harmed since she was about six years old, which is, I’ve never heard of that, and it was extreme, and we’ve got staff here that haven’t actually worked in mental health before or they may have had their own experience of it, but there are people here that have never even worked in health care and then seeing all this stuff... So, I’m just amazed at the resilience of everyone here.’ (Paul, senior nurse, Forest View Recovery Centre, interview)

Towards the end of his description of this situation, Paul stated his belief that Anna can still recover and return to the unit:

P: ‘That’s where I felt like we had no further to go at the moment until she comes back, and I hope she does.’ (Paul, senior nurse, Forest View Recovery Centre, interview)

Paul justifies the move to an authoritarian approach with Anna by emphasising the extremity of the situation throughout his account. It was extreme in terms of the severity of the self-harm, the risk to Anna’s physical health and the length that the staff went to deal with this extreme situation. The move to an authoritarian approach is therefore presented as a last resort option: they could not do any more as staff, and the risk of a life-threatening injury was too high to justify any other approach. However, Paul demonstrates his continuing commitment to the recovery approach, despite its recent failure, by expressing his hope that Anna will come back to Forest View.

### 7.3 Risk to the Service

Risk to the service was another frequently used justification for an authoritarian approach. All three services were overseen and monitored by various statutory bodies, some of whom they were reliant on for funding and some of whom had considerable powers to restrict, sanction or even close down the services not meeting the minimum standards. In addition to this, the staff's accounts in interviews, particularly when discussing risk, reflected an awareness of the reputation of the service among the wider public, particularly as mediated by newspapers and social media. At the Llan castell CMHT, the staff mentioned the Echo test during an informal chat between colleagues in the office. They explained to me that it had been introduced by a former social worker in the team who, when asked if a particular decision was right, would ask: 'Would it pass the Echo test?', meaning if it was not the right decision, could it end up on the front page of the local Echo newspaper, thus damaging the reputation of the service? The references to the Echo test were always humorous, but they reflected the underlying awareness that their decisions could have a serious impact on the reputation of the service.

Controlling the service users' behaviours by authoritarian approaches was sometimes justified as necessary to prevent both reputational and/or physical damage to the service. At Forest View, two service users found it very difficult to keep themselves and their rooms clean, and the staff were constantly encouraging them to shower and clean their rooms. On one occasion, I was present when nurse Becky instructed Liam, a service user, in a very assertive manner, to go and shower and tidy his room. After Liam had left the room, Becky apologised to me for her manner that she said was not in line with the recovery approach. A few weeks later, in her interview, Becky referred back to this incident.

B: 'Right, OK, so you saw what happened. Um, I feel as a human being, not as a staff nurse; I'm a human first, so, um... A couple of weeks ago, there was a situation; you witnessed it: a person was quite smelly, and the room was filthy, and the care team – they're under the care team – was coming in the next day, so... My philosophy is that that is a reflection on us as a team. Even though I've asked on numerous occasions for the person to go in for a wash, give their room a cleanout—so it's

about having a duty of care, then, so you're smelling, you're offensively smelling, and we can smell you, so you need to have a shower, and I'm coming into your room whether you like it or not, and I'm going to strip your bed and put your laundry on, and that's what we're going to do today. That is, you know, a bit punitive, really, because it's like, OK, we're taking control, but if you've asked and asked and asked and asked, and it's becoming a problem on the unit, then I think, as a team, we need to do something because how long can that problem go on before something—Like we could have an infestation, you know, the person could have, I don't know, infections, so we have to be mindful of us as a team and guests and everybody in the community. It's acting in the best interests of the patient.'

(Becky, nurse, Forest View Recovery Centre, interview)

Becky uses several discursive strategies to manage the issues of accountability and blame and justify her authoritarian approach as the last resort in the circumstances. She begins by positioning herself as 'human first' rather than a nurse, suggesting that the situation was so extreme that anyone (not just health care professionals) would understand the need for action. Her assessment of the state of Liam's room as 'filthy' and (later on) at risk of causing an 'infestation' further emphasises the extremity of this situation. Becky uses a number of phrases, including 'that is a reflection on us as a team', 'duty of care'<sup>36</sup> and 'as a team, we need to do something', that apportion the responsibility for the welfare not only of Liam but everyone who spends time in the building to the staff. This use of responsibility within a relations of care discourse (Trnka and Trinkel 2014) helps justify her taking action rather than continuing to wait for Liam to make changes. Becky minimises the authoritarian approach she took, describing it as 'a bit punitive', and uses an extreme case formulation ('but if you've asked and asked and asked and asked') to suggest that 'taking control' is something she did as a last resort after trying hard to use a more recovery-oriented approach.

Becky mentions 'the care team', which refers to Liam's home CMHT who continue to retain the overall responsibility for his wellbeing.

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<sup>36</sup> Referring to the legal duty of the staff at the Forest View Recovery Centre to maintain Liam's wellbeing



Although Becky does not make explicit the implications of this visit, she knows my professional background and is therefore likely to have assumed that I was already aware of these. If Liam's care team believe that Forest View are not maintaining his wellbeing, they can choose to withdraw him from the service, impacting negatively Forest View's reputation, future referrals and funding, some of which comes through individual patients funded by their local health boards.

By stressing the extremity of the situation and showing that numerous previous attempts at using a recovery approach had failed, Becky's account justifies her use of an authoritative approach to manage Liam's behaviour. The failure of the pastoral recovery approach of encouragement and requests was often a major factor in justifying the decision to move to an authoritarian approach with service users.

#### 7.4 The Expected Continued Failure of the Recovery Approach

Alison, another service user at the Forest View Recovery Centre, was engaging in behaviour that the staff felt was unhelpful to her recovery and that they were encouraging her to change. Alison tended to get up late in the afternoon and then stay up until the morning when she would go back to bed for the day. She had difficulties in keeping herself and her room clean, and the staff constantly encouraged her to shower and clean her room. Alison was subject to the Mental Health Act as she was considered to be unable to protect herself adequately from harm outside of the unit. Discharge was, therefore, not an option in response to her refusal to engage with a recovery approach. This situation raised dilemmas for the staff: Alison was not at significant risk whilst at the centre, and she appeared to be quite happy with her current routine and level of cleanliness<sup>37</sup>. She was not, however, seen by the staff to be moving toward recovery in any way.

The following extract from an interview with Gemma (nurse) is reflective of the dilemmas expressed by many staff members in which they tried to negotiate between

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<sup>37</sup> In her one-to-one interview with me, as well as in informal conversations, Alison explained how she found meaning and a sense of peace through her night-time activities. She was not happy with her current level of leave.

the service users' rights to make decisions about their lifestyle and the staff's beliefs about what was best for their recovery.

G: 'I don't think anyone's not capable of recovery, but I think their idea of what is recovery is perhaps different to other people's, and I think it's important that we're aware of it because what we feel as living normal in the community and functioning—their idea—they can function at a lower level, which I think we've got to be open to. Some people aren't going to go and want to work, some people aren't going to want to do the things and have the sleep pattern that they should, really, like sleep all day and up all night, I think as long as they're functioning and that can be changed when they're in the community... I think with some people, it's a harder journey, and it's good to think is it us that's questioning it, or would they be quite happy as long as they're functioning in a safe manner and they're not vulnerable that may be all they want in their life. So, I think getting that and letting them have insight to knowing that, actually, they do need to put a little bit of tools in their bag—not dismissing the whole idea, but they can work towards some sort of—they can't live in squalor.' (laughs) 'They can't live in dirt, but they can live in the way that they want to as long as they keep themselves healthy and safe.'

(Gemma, nurse, Forest View Recovery Centre, interview)

Gemma starts by acknowledging different ideas about what recovery and normality might mean, demonstrating a non-judgemental attitude. However, she then suggests that some service users may function at a 'lower level', not having the routine they 'should' have, suggesting that Alison's choice of lifestyle is less valued than others. She asserts that sleep patterns can be changed in the community, suggesting that a daytime sleep pattern is not acceptable. She then moves back to a non-judgemental stance ('it's good to think is it us that's questioning it, or would they be quite happy') and emphasises that what is most important is that the person is healthy and safe. She adheres to a recovery discourse by showing respect for Alison's personal choices and right to take control of her own life whilst also displaying her professional knowledge based on medical and psychological discourses about what is best for Alison's recovery. The service's approach to Alison's behaviour changed over the few months I was there, demonstrating how the continued failure of a recovery approach to lead to recovery led to a more authoritative approach.

The following extract is taken from my field notes taken during a handover meeting in June 2018. This was a short (approx. 20 minutes) meeting in which the morning staff passed on information about the service users' activities, moods and behaviours to the incoming afternoon shift staff.

Gemma (nurse) said that that morning she was 'on a mission' and went into Alison's room at 9.15 am and told her to tidy it. She went back at 11 am, and Alison had not done anything. Kirsty (a recovery practitioner), who had been with Gemma, described Alison's room as 'disgusting', 'diabolical' and 'smelly'. There was a used sanitary towel on the floor, lots of used cups, some of which were growing mould, there was poo spattered around the bathroom walls and over the toilet... Gemma described her and Kirsty's approach as 'mob handed'. The whole conversation had a humorous tone, and there was lots of laughter about the state of Alison's room. They told her 'you need to do this'... Lisa (peer support worker) talked about how people always push the limits when they first arrive (Alison is new). Lindsey (student nurse) said, 'what do you mean when they first arrive?' and everyone laughed. Gemma apologised for being 'pushy' with Alison. Lisa said, 'we need active people, otherwise you feel like you're the only one doing anything'. They all agreed that Gemma's assertive, enthusiastic, to-the-point attitude was good. (Forest View Recovery Centre, field notes)

Gemma's assertive approach with Alison is approved of by the other staff members, but there is no talk of authoritarian sanctions despite Alison's repeated refusal to tidy her room. Alison's behaviour is seen as 'pushing the limits' of normal and expected service user behaviour. There is a humorous tone to the conversation, suggesting the staff are not overly concerned with her behaviour.

In September, I interviewed staff nurse June, and by this time, the staff were beginning to consider a more authoritarian approach to changing Alison's routines:

J: 'We've recently had a meeting of qualified [staff]. ... It was a big, serious meeting where people were saying we can't nurse like this, um (pauses for three seconds), and so that's going to be hopefully... We need that meeting to be translated now into actions... We need a big therapeutic community meeting where all the patients are explained, this is what's going to be expected because what's happening is—let's take Alison: she's sleeping all day, she's getting up at 6 pm... She doesn't engage in anything at all, and [she] sits outside and smokes and drinks her pop and

leaves all her mess everywhere, goes back to her room that's a complete tip, and then the next day, it starts again. And as a nurse, you feel like you're not being a nurse, you're failing as a nurse because you're not even getting them to do their activities of daily living, the basics... And in no way is she sort of working within the therapeutic contract that she's signed, so you wonder what are we doing for this person, how am I nursing this person? I don't feel like I am nursing; I'm cooking and cleaning for her... So, yeah, things need to change, I think.' (June, nurse, Forest View Recovery Centre, interview)

June justifies the plan for a more authoritarian approach, explaining that the current practices do not allow the nursing staff to perform their professional role, and as a result, she feels that she is failing as a nurse. She suggests that they are enabling Alison's non-recovery to continue. June positions herself and the service as unable to help Alison unless they change their approach. The decision to take a more controlling approach to Alison's behaviour has not been taken easily. The staff have been trying to get her to change her behaviour through the consistent use of a recovery approach for five months. This recent plan to take a more controlling approach was made at a 'big, serious meeting' of qualified staff where the staff made significantly negative statements about the situation, such as 'we can't nurse like this'.

At Cartref Hapus, like at the Forest View Recovery Centre, the service users were required to learn how to look after themselves independently, which included the basic tasks of keeping their rooms and houses tidy. This was usually achieved by encouragement, requests, role modelling and friendly advice from the staff. However, this was not always effective, and the following extract from my field notes, taken at a house meeting with a senior member of the staff, reflects the more authoritarian approach sometimes taken with the service users. Observing the meeting described below was one of the few times I felt uncomfortable with the approach taken by a member of the staff, and I recorded my feelings in my field notes:

Elaine has a very authoritative tone – I feel like she is patronising. I feel uncomfortable as she is telling them off as if they were children. She goes through the cleaning rota, reminding everyone what their area of responsibility is; Liz, the new resident, is allocated an area. Elaine spends quite a long time talking about the cleaning and tells

them that warnings will be issued as this has been going on a long time. Everyone agrees to keep the house clean and clean up the rubbish outside.

Elaine says, 'I am going to check your rooms now if that's OK.' It is not really a question, and I wonder about the privacy of the residents – they may have left something private out in their rooms. They all agree she can check their rooms. Elaine comes down again very quickly. She tells Aiden and Callum that they need to clean their rooms as they both have plates, cutlery and food in there. She reminded them that there is limited crockery, and they need to consider the other tenants. Aiden and Callum agree to clean up their rooms, and Elaine says she will pop in again later to check.

We chat in the car on the way back, and Elaine explains that the situation with the cleaning has been going on for a long time, and now, she is concerned that as an older woman, Liz, the new resident, will end up cleaning for Aiden and Callum. She is concerned as she doesn't want Liz to have the responsibility of trying to make them clean. I get the feeling that Elaine has chosen to take a deliberately authoritarian stance as her previous, more gentle approaches have failed, and she sounds frustrated. She tells me that they are supposed to be in the supported house to recover and become ready for independent living, but they don't get this and are just using it for cheap housing. (Cartref Hapus, field notes)

Elaine justifies her authoritarian stance by suggesting that her previous gentle approaches have failed, and the problem persists. She suggests that the service is not achieving its main goal of preparing Callum and Aiden for independent living and presents her authoritative stance as necessary if Aiden and Callum are to recover and become independent citizens.

### 7.5 Agreement and Authority in Using Authoritarian Power

The switch to an authoritarian approach often required an informal approval or explicit agreement from other staff members or even legal authorities. The staff did not always agree on the use of authoritarian methods and in some cases, the lack of agreement meant frustration for some members. In the following extract, the professionals justify their belief that Kate should be sectioned by referring to the consistent failure of the recovery approach to bring about recovery. However, due to a

lack of agreement from the psychiatrist, they are not able to section her. Rather than emphasising the risk to the patient and constructing themselves as responsible for her in order to justify the proposed section, they continue to draw on a neoliberal discourse of responsibility that enables them to construct the patient as responsible for her own failure to recover.

The following recorded conversation from the Llan castell CMHT took place on the street outside Kate's (service user) house, following a meeting between Kate, Zoe (her care coordinator and social worker) and Dave and Ceri, community psychiatric nurses, who were part of the local home treatment team. Kate had recently been referred to the home treatment team after Zoe felt that she could not safely manage the risk she presented. The home treatment team visit daily and monitor a patient closely, aiming to keep them out of hospital. Kate had been with the team for approximately one week, and the high level of risk was considered to have subsided. The purpose of the meeting was to tell Kate that she was being discharged from the home treatment team, back into the care of Zoe and the CMHT, and to agree on a plan for her support in the immediate future. I went to the meeting, but after a minute or two, Kate expressed annoyance that I was present, so I left. I waited outside, further down the street, and when the professionals came out, I asked if they would be happy to tell me about the meeting and be recorded. They agreed.

Although I initiated the conversation with an open question, it immediately became a conversation between the professionals, as Zoe directs her question in line 2 to her two colleagues. They reflect on the meeting and then the situation with Kate in general.

Z: Zoe, social worker

C: Ceri, CPN from the home treatment team

D: Dave, CPN from the home treatment team

R: Rachel

1 R: 'How did it go?'

2 Z: 'Well, quite difficult, really, um; she didn't want discharge, did she?'

3 D: 'No, she did accept it.'

4 C: 'But then she didn't know what was helpful from us. It was— She was clear that we  
5 weren't helpful but didn't want us to discharge her.'

6 R: 'Mmm.'

7 D: 'But there's a good, solid, formulated plan in place; she's going to see the consultant  
8 tomorrow.'

9 C: 'She's got lots of plans.'

10 D: 'She's seeing C next Wednesday.'

11 Z: 'As much as she's—'

12 D: 'She's got the psychologist involved.'

13 R: 'Yeah.'

14 D: 'And she's got an appointment tomorrow morning.'

15 C: 'And she's got her own appointments.'

16 D: 'That she wouldn't tell us what it was.'

17 C: 'She goes out a lot more than she says.'

18 Z: 'I think she does as well, yeah; she said she's been out once.'

19 C: 'Then it turned into twice.'

20 D: 'And she's been going out every day.'

21 C: 'So...'

22 Z: 'I don't know what to make of it; she's in a mess.'

23 C: 'She doesn't know what she wants.'

24 Z: 'She says, "Nobody helps me, nobody cares about me", but she can't say what it is  
25 she—'

26 C: '... would need.'

27 Z: 'What would help.'

- 28 C: 'Everything in the past was better, but there's nothing's ever worked so...'
- 29 Z: 'She tells us what's wrong.'
- 30 Z: 'But I have seen reports for her, and it was "We can't do anything with her." It's just
- 31 crisis, crisis, crisis with no therapy, no recovery at all.'
- 32 D: 'But then she goes through periods where she doesn't have contact with us – it's got to
- 33 be 18 months.'

In lines 4–5, Ceri's statement justifies the discharge: the service was not helping Kate. By describing Kate as not wanting discharge despite criticising the service as unhelpful, Kate is constructed as irrational and unreasonable. Dave then uses a three-part list (Jefferson 1990) ('good, solid, formulated') to emphasise the good quality planning that the staff have been doing, thus presenting them as professional, continuing to support and care for Kate and manage risk, despite her criticism of them. However, Ceri's comment in line 9 is uttered in a sarcastic tone and works to suggest that despite their plans for Kate, they will not result in her recovery. Dave uses another three-part list to present the staff team as working hard to support Kate: she will see 'the consultant tomorrow', 'Zoe next Wednesday' and 'she's got the psychologist involved'. Ceri then mentions that Kate has her own appointments (line 1), and in lines 16–20, all three staff members agree that Kate is secretive and conceals the truth about how much she goes out and where to: 'she goes out a lot more than she says'. This works to construct Kate as untrustworthy and dishonest.

In line 22, Zoe admits that she does not know what to make of Kate's situation but assesses Kate as being 'in a mess'. The following discussion works to explain and excuse Zoe and the other staff's lack of knowledge about how to help Kate. From lines 23 to 28, they discuss Kate's inability to tell them what she wants or needs. Within a recovery discourse, the client is expected to decide (possibly with support) what it is that they want their recovery to look like and what might help them achieve this. Despite two years of support, Kate has been unable to do this but continues to criticise the support that has been offered based on the professionals' decisions about what would be helpful for her. Zoe and Ceri use extreme case formulations (lines 24, 28) to emphasise how critical Kate is of the team. To further strengthen their reasons for not



being able to help her, Zoe gives examples of how previous professionals have also been unable to help her (lines 30–31). She uses extreme case formulations ('we can't do anything', 'no recovery at all') and a three-part list ('crisis, crisis, crisis') to emphasise the extremity of the situation. This works to suggest that the problem is not with the staff but with Kate. Dave then points out (lines 32–33) that Kate sometimes goes without support from the team for periods of up to 18 months, suggesting that she is sometimes not unwell or does not wish to seek help but that her periods of wellness are not related to the support she receives from the mental health services, and although now, she wants the service to help her, at other times, she does not want any contact with them. This contributes to the construction of Kate as irrational: she requests the continuation and escalation of the services that have no impact on her mental health and/or moves from appearing desperate for help from the team to not wanting contact with them.

Following a brief discussion about Kate's extensive use of the psychologist's support and Zoe's difficulty in getting through to her on the phone, the conversation continues:

- 34 C: 'But there's no responsibility from her part.'
- 35 Z: 'No.'
- 36 C: 'It's everybody's shit at their job.'
- 37 D: 'And she wants to be cared for; she wants—'
- 38 C: 'Yeah.'
- 39 D: 'She wants care done to her, really, in essence, doesn't she?'
- 40 Z: 'It's sad. Shared Lives<sup>38</sup> won't work; nothing will work.'
- 41 C: 'No.'
- 42 Z: 'She needs to be in Oak Lodge, that's why.'
- 43 D: 'Do you know what, I nearly said that when we were sat there. Or Aneurin Court.'

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<sup>38</sup> Shared Lives is a housing scheme where people in the community take in adults with support needs as lodgers and are paid to support them.

44 R: 'What's Oak Lodge and Aneurin Court<sup>39</sup>?'  
 45 Z: 'Oak Lodge is a locked ward for people with personality disorders, so it's intensive  
 46 psychological therapy, and Aneurin Court is like a step down.'  
 47 C: 'You have to be sectioned if you're going.'  
 48 D: 'Yeah, under the Act.'  
 49 Z: 'When she was in hospital last time, I said to Jack, the consultant, I said "If you want her  
 50 detained, I'll do the application."' (all laugh) "coz it would be good for her, it would be  
 51 a kick up the bum that she needs to get her in some services she needs.'  
 52 D: 'Taking that power away to give it back in stages then, isn't it?'  
 53 C: 'That's what they do with her.'  
 54 Z: 'Jack just didn't; he likes to detain some people and not others, doesn't he?'  
 55 C: 'Yes, he does.'  
 56 D: 'Absolutely.'  
 70 Z: 'And she blamed me for bringing you along: "And why did you bring Rachel when I'm in  
 71 crisis?" Well, I didn't know you were in crisis. As far as I was concerned, you were fine,  
 72 and you were being discharged from the crisis team.'  
 73 R: 'Sorry.'  
 74 D: 'It's alright.'  
 75 C: 'Everything's someone else's fault.'  
 76 Z: 'I know, yeah.'  
 77 C: 'You had to take some blame.' (to R) (all laugh)

In line 37, Dave states that Kate 'wants to be cared for', then, perhaps realising that wanting to be cared for does not sound unreasonable, he corrects himself in line 39, where he explains that Kate wants 'care done to her'. This constructs Kate as wanting

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<sup>39</sup> Oak Lodge and Aneurin Court are pseudonyms.

to be looked after by others but not wanting to take any responsibility for looking after herself, an attitude that is not in line with a recovery discourse.

In line 42, Zoe states that Kate 'needs to be in Oak Lodge'. In contrast to the ambiguity of the previous conversation, this is clear attribution of need by the professional. It is not mitigated or prefaced as might be expected in line with a recovery discourse but instead prioritises the professional opinion and presents it as fact. Zoe states in lines 49–51 that for Kate, being sectioned is needed and would be helpful. The staff can be seen to propose this as a last resort decision (Emerson 1981). By showing that Kate has not been helped by any previous efforts by different professionals over many years and constructing her as unable or unwilling to take responsibility for her recovery, they justify their claim that there is no other option that would be effective. All support available in the community requires Kate's voluntary engagement and commitment that they have shown in the interaction she is not capable of<sup>40</sup>. Emerson (1981) describes last resort decisions as 'considered likely to compromise or defeat the very ends they are intended to achieve' (p. 2).

This section (lines 40–52) illustrates a core dilemma of the recovery approach: the contradictory possibility of using controlling methods as a way to force service users to take responsibility/control. As the recovery approach, promoted by mental health services, aims to give service users control and responsibility, sectioning into a secure hospital unit would clearly defeat these aims. However, the staff believe, as stated by Dave in line 52, that although Kate's power would initially be taken away, ultimately, sectioning would have the effect of giving this power back to Kate. Dave's comment implies that having her power and responsibility taken away would act as an incentive for Kate to want and value control and responsibility in a way that she currently does not. The staff cannot put their last resort decision into practice as they are reliant on

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<sup>40</sup> Kate is currently attending dialectical behaviour therapy sessions with the psychologist at the CMHT, but Zoe has previously told me that she is not engaging with it, and Kate has said in a previous meeting that it is not helpful to her. The home treatment team are aware of this situation.

the agreement of Kate's hospital consultant psychiatrist, Jack, who is not willing to section her (line 54).

Following the confirmation of Kate's various appointments and an agreement that they will all attend Kate's psychiatrist appointment the following day (lines 57–69, omitted), Zoe mentions that Kate had criticised her for bringing me into the meeting<sup>41</sup>: 'and she blamed me for bringing you along' (line 70). I apologised for causing Zoe difficulty (line 73), after which the staff reassured me that it was not my fault. Their jokes about the situation ('You had to take some blame.') (line 76) attempt to enrol me into their perspective that Kate always blames everyone else for her problems.

Given that the psychiatrist does not agree with Zoe, Dave and Ceri's belief that sectioning Kate is the only effective option for her, they are in effect forced into a position of planning actions and supports that they do not believe will significantly help Kate.

In this conversation, the professionals work to excuse themselves from being able to help Kate in a way that does not bring into question their competence as professionals. During the current conversation and in my previous meetings with Kate and Zoe, I have become aware that Kate and the staff believe that the services (the CMHT and the home treatment team) have not been helpful to Kate, they have not been able to build a good working relationship with her, and the staff have very little if any hope for her recovery. This could result in me or them perceiving them as incompetent or uncaring professionals.

Goffman (1990b) has argued that the interplay between teams of people can be analysed in terms of the cooperative effort of all participants to maintain a working consensus (p. 93). During this conversation, the staff work together to construct Kate as a bad client (Juhila 2003): she does not know what would help or what she wants, she is critical of the staff's efforts to help, she is irrational, wanting to remain in the

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<sup>41</sup> I had attended two previous meetings with Kate who had completed the full informed consent procedure and not given any indication before this meeting that she was no longer happy for me to attend.

services despite saying that they are unhelpful, she lies and is, therefore, unreliable and untrustworthy, she has unrealistic and unclear expectations and she does not accept any responsibility for her recovery. In addition to this, they talk about the fact that no one else has been able to help Kate in the past. Constructing Kate as a bad client whom no one has been able to help, alongside their continuing plans for Kate's ongoing support, enables them to construct themselves as competent professionals despite their failure to help her. This jointly constructed interaction also works to provide mutual support and understanding, enabling the staff to offload their frustration to colleagues who do not question their competence but support their explanations of why they have been unable to help.

## 7.6 Discharging Service Users

For many service users, the failure of a pastoral model of power within a recovery discourse led to more authoritarian approaches to managing their behaviour. However, this was not always the case. The other possible response to the failure of a pastoral recovery approach was discharge from the service. Discharging service users from a service for their failure to engage with the support they received was not a rare occurrence and almost all the staff I spoke to at all three sites talked about clients who they had or were considering discharging for this reason. A number of justifications were used for discharging a client. Most often, the staff described their repeated attempts to support the service user and their reluctant acceptance that the service was not able to help them. Another reason for discharge mentioned frequently related to the efficient use of scarce resources, often related to concerns about making space available for potential service users on the waiting list.

An important condition for discharge from the service at the CMHT or the Forest Green Recovery Centre was the absence of severe risk to the service user. Service users were sometimes discharged when engaging in somewhat risky behaviours, such as minor self-harm or excessive alcohol consumption, but any behaviour presenting a severe risk, such as life-threatening self-harm or psychosis resulting in a lack of awareness of danger, prevented discharge whether or not the service user was engaging with the support. The situation at Cartref Hapus was different: as the service

did not have statutory responsibility for managing risk, they could discharge or evict service users more easily. However, when a discharged service user was considered to be at risk, they continued to work with the person, using a pastoral recovery approach for up to four weeks to link them with other services that could manage their risk, including statutory mental health and homelessness services. The particular status of Cartref Hapus as a third sector organisation without a professionally registered staff<sup>42</sup> meant that they had no authority to restrict their clients' freedom: their only sanction in the case of service users refusing to engage with their support was to threaten discharge or eviction. Cartref Hapus's funding was based on contracts that required them to have regular contact with the service users. Contact with the service users was recorded electronically and coded into categories of allowable activities. These records were regularly scrutinised by the funding organisation; therefore, if a service user disengaged with the service, they were required to discharge them or face breaking the contract with their funder. A main justification for discharge at all the research sites was the past and expected future failure of the recovery approach to lead to the service user's recovery.

## 7.7 Consistent Failure of the Recovery Approach

At Cartref Hapus, the service users' cooperation was obtained by voluntary agreements and occasionally, the threat of discharge from the service. For those living in houses owned or rented by the charity, this meant eviction and potential homelessness. However, this sanction was rarely enforced with the staff preferring to persuade the service users to cooperate with their suggestions for change as Leanne, a service manager at Cartref Hapus, explained:

L: 'I always try to go in with the approach of "you have this within your control to change it", and I'll give them a few chances, probably more than I should do sometimes, and I think it really rests on their effort for change and keeping on tying in with that person and linked in with them over time to make sure that they are

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<sup>42</sup> Some staff members at Cartref Hapus had professional health and social care qualifications, but their jobs did not require these, and they did not have the authority held by professionals in statutory services.

making the efforts toward change, even if it's really small.' (Leanne, manager, Cartref Hapus, interview)

Leanne appears to use a pastoral recovery approach even after some service users have broken their licence agreements, persuading people that they have the power to make changes to their behaviour in order to keep their tenancy. Her statement 'it really rests on their effort for change' demonstrates a key ethos of the recovery approach: its belief in service user-led change. However, repeated warnings and failures to engage with the support or change their behaviour did result in evictions. During my time at Cartref Hapus, one tenant was evicted: this resident had a substance misuse problem and could not be persuaded to engage with relevant support services.

At Llancastell CMHT, I asked Hayley, a care coordinator, what happened when a service user did not engage with her:

H: 'I've got a lady today who I'm going to have to discharge because she's not, repeatedly... We've had repeated discussions, meetings, over the last five months, um, where she says one thing and literally does the complete opposite, and I cannot engage her, and it's hard 'coz I feel like I've spent a lot of time chasing her, which I just don't have the time to do, but you feel like you want to give people like one last chance, and I'm like "one last chance" and "oh, we'll try once more", and I took her to MDT, <sup>43</sup>and we discussed it today, and the team sort of agreed that she'd have to be discharged...' (Hayley, care coordinator, Llancastell CMHT, interview)

Hayley begins by stating that the lady who is not engaging will have to be discharged. However, this is presented as due to a lack of any other options rather than a positive choice ('going to have to'). Hayley stresses the effort that she has put into working with the service user in a recovery approach repeatedly over a period of months and then uses an extreme case formulation (Pomerantz 1986) to explain that not only does the service user not take on board her suggestions, but she 'literally does the complete

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<sup>43</sup> The multidisciplinary team meeting is a meeting at which the staff discuss difficult cases with colleagues to get advice, guidance and agreement with significant decisions, such as discharge.

opposite'. Hayley explains how her wish to work in line with the recovery approach has led to her spending a lot of time 'chasing' the service user, time that she does not have, suggesting that this has caused her stress in her job. The decision to discharge her has been agreed on by a group of staff who attended the multidisciplinary team meeting (MDT). Decisions taken to the MDT are generally considered to be too important, difficult and stressful for the members of the staff to make alone, suggesting that Hayley found this decision difficult and felt she needed the expert advice and support of her colleagues to make it. Hayley went on to talk about her personal experience of trying to help this particular service user:

H: 'I just can't—we're just not getting—we haven't got anywhere. We've had maybe a handful of sessions that were productive and therapeutic, and it's all the more frustrating 'coz I felt like we were in the moment when we had a good session. She was like "Yeah, I get it, I'm going to take this on board, and I'm going to try and do this", but nothing ever changed, and she's just not turned up for appointments, not got in contact with me, avoided me, and I can't take responsibility for it 'coz I cannot stop her from doing the things that she's doing. But I can't keep chasing her and trying to take—I can't take that off her, so she has to take some responsibility, and she consistently hasn't, so I can't. I just can't. I can't work with her, which is a really hard thing to say, actually, when you think "I can't actually do anything with you at the moment", and I think everyone definitely will have people like that.'

(Hayley, care coordinator, Llan castell CMHT interview)

Hayley uses the phrase 'I can't' (or equivalent) nine times, suggesting that the discharge is not about her not wanting to help, it is about the impossibility of being able to help this service user. At some points, Hayley suggests that she felt she was making progress, but it was thwarted by the service user who is presented as causing more frustration than if she had never managed to progress in the first place. Hayley employs a three-part list (Jefferson 1990) to emphasise the service user's lack of engagement ('not turned up for appointments, not got in contact with me, avoided me') and extreme case formulation (Pomerantz 1986) to stress that she had not made any progress in working with this service user ('haven't got anywhere', 'nothing ever changed'). Hayley's difficulties with this client highlight the dilemmas involved in accountability: Hayley is responsible for the welfare of her client, and yet, she cannot



control her risky behaviour (Hayley told me that this service user frequently engages in minor self-harm and contacts emergency services inappropriately). Her account of not being able to help this service user and, therefore, having to discharge her, presents the work as frustrating and describes the failure to help a service user as difficult to accept ('a really hard thing to say'). The idea of not being able to do one's job ('I can't work with her.') comes up repeatedly in the discussions about those service users whom the staff cannot engage in the pastoral recovery approach.

## 7.8 The Efficient Use of Scarce Resources

Another kind of justification for discharging non-engaging patients related to the financial pressures on the service, something alluded to by Hayley when she mentioned that she does not have the time to chase the patient. Louise, a psychiatrist, explained why people who do not turn up to appointments without giving a reason are discharged:

L: 'But for people that just don't come and there's no contact, you know, we would take that as they are choosing not to engage, and, you know, you've got a limited resource in a team like this, and that needs to be targeting people that are in the right place to use that. So, again, that comes down to people taking responsibility for their own health.' (Louise, psychiatrist, Llanastell CMHT, interview)

Kyle, a psychologist, talked about patients who did not engage with the therapeutic groups he ran:

K: 'So I recently worked with a lady who wasn't doing any homework, wasn't doing anything, wasn't really engaging... And I was like, "well, come back when you're ready, then" and, you know, like, there's lots of people who really need help and you're not engaging right now.' (Kyle, psychologist, Llanastell CMHT, interview)

Patients were seen as having a joint responsibility, along with the service, to use the resources available in the most efficient way, directing them at people who would make the most use of them and considering the needs of the people on the waiting list. Those service users who did not use the resources given to them by engaging with therapy or taking on board the staff's suggestions were considered to be wasting the resources and taking them away from other potential service users who needed them.

These statements and many other similar comments by the staff illustrate the seemingly conditional nature of care within a recovery approach: it is dependent on the service users being seen to take responsibility for their mental health and working in partnership with the professionals. The clients are expected to undertake work on themselves, and through this, the service aims to create more active, responsibilised citizens (Juhila et al. 2017).

## 7.9 Last Resort Decisions

Elements of last resort decision-making (Emerson 1981) can be seen frequently in the examples of movement away from a pastoral recovery approach. In cases of risk to a service user, the use of last resort authoritarian remedies, such as sectioning, is justified by showing that normal remedies are inappropriate due to the seriousness of the service user's behaviour (see also Emerson 1981, p.7). In the cases of Anna, who self-harmed, and Sandra, who was sectioned, this seriousness related to physical harm to the service user or severe mental illness and the resulting vulnerability. In other cases, the staff stress the failure/exhaustion of normal remedies (see also Emerson 1981, p.7). They show how the persistent use of the pastoral recovery approach, the first resort remedy, has not resulted in any move towards recovery for the service user and in fact, sometimes seems to keep the service user from recovering, such as in the case of Alison, whom the constant encouragement and advice did not help to develop a 'normal' or hygienic daily routine. In all cases, the use of authoritarian power or discharge results in compromise or defeat (Emerson 1981, p.2) of the aims of the mental health service. Authoritarian power is in opposition to the aims of enabling service users to take control and manage their own mental health and behaviour, and discharge is in opposition to the aims of supporting people to manage their mental health and reduce their distress.

In an introduction to a special issue of 'Psychiatric Services', a journal focusing on engagement, Salzer (2017) proposes that the use of authoritarian techniques 'could be considered a last resort or replaced altogether in favour of strident attempts and incentives to promote self-determination and shared decision making' (p. 753). In the

services I studied, the use of authoritarian power to force compliance was always presented as a last resort decision and the only available option in the circumstances.

### 7.10 Conclusion: The Limits of Recovery

The recovery approach practised by staff drew on behavioural principles of reinforcement and used the threat of various penalties to induce compliance with treatments proposed by staff. Penalties included the removal of the service or being physically forced to comply with staff advice. When positive reinforcement and/or threats failed to modify service users' behaviour staff took one of two approaches to address the consistent failure of the pastoral recovery approach: an authoritarian approach or exclusion from the service. Each of these approaches required justification work. In the case of the more severe authoritarian approaches, such as sectioning, this work related to a serious risk to the service user but also included other justifications, such as risk to the service's reputation, operations or efficiency, the rights of the potential (waiting list) service users and the expected continued failure of the recovery approach in leading to the service user's recovery.

Any change from the default pastoral recovery approach had to be justified and was presented as a last resort option. The staff constantly justified the use of authoritarian power both to me and to each other. Decisions about the discharge of unrecovered patients were agreed upon with managers and often taken to multidisciplinary team meetings for agreement and support. Decisions about the use of any more than minimum authoritarian power had to be discussed and agreed upon with managers or specific groups of professionals with certain legally mandated authority. This suggests that the recovery approach, in terms of its focus on responsibilisation, service user control and self-management, has now become the dominant model in these particular services with other, more paternal approaches needing to be strongly defended if used. However, the authoritarian approaches continued to be relatively frequent in practice, suggesting that the recovery approach continues to be dominant in rhetoric but not necessarily in reality.

## Chapter 8: Discussion

### 8.1 Introduction

Drawing on historical and ethnographic research conducted within mental health services in South Wales, this thesis has explored how the contemporary recovery approach to mental health has arisen, how practitioners and service users enact it and the challenges or tensions that arise in practising in this way.

The literature on recovery in mental health is limited by the research methods used, which do not show how mental health professionals actually practise recovery. This thesis has focussed on *how* the recovery approach is practiced in situ from the perspective of practitioners. The use of both micro and macro approaches to discourse analysis enabled me to consider the action accomplishments in talk within a broader socio-historical context. Through using ethnographic observation combined with Foucauldian ideas of governmentality and a discursive psychological analysis of my data, I have been able to show 'how subjectification processes unfold' (Brownlie 2004, p. 521) in the context of recovery in mental health services.

My findings have shown, contrary to previous research, that the practitioners of different professions and in different kinds of mental health service, work to a relatively consistent version of recovery that draws on a range of bodies of knowledge to propose psychological, biological and/or social treatments and supports for people with mental health problems whilst emphasising service user engagement and self-responsibilisation (O'Malley 2009). In particular, the thesis has demonstrated how practitioners facilitate recovery through the use of specific discursive strategies within a pastoral power approach, how service users exercise agency in aligning with or rejecting the recovery discourse and how the process of engendering recovery subjectivities in service users is complex, unpredictable and not always successful. In considering recovery as a neoliberal solution to mental health care, the study highlights the complex assemblages of people, policy, practices, laws and emotions that constitute the recovery practice and concludes that in the field of neoliberal

rationalities, recovery appears to be struggling to fulfil its programmatic aspirations and goals.

This chapter will summarise and reflect on the main findings of the study, outlining how the thesis has answered the research questions posed in Chapter 2:

1) What are the conditions of possibility for the development of different understandings and practices of recovery in the UK? 2) How are mental health professionals currently practising recovery across services for people with mental health problems in Wales? 3) What challenges, dilemmas or tensions are encountered in the practice of recovery by staff and service users?

I will offer some suggestions for potential future research, discuss methodological limitations and comment on the impact of my identity on the research as well as the influence of the research on my own subjectivity. I will make some recommendations for mental health services based on the findings and finish by outlining the contribution the thesis has made to the literature on recovery and governmentality.

## 8.2 Conditions of Possibility for The Understandings and Practices of Recovery in the UK

An examination of the various approaches to mental illness over the last 200 years revealed a plethora of understandings of which none has achieved a completely dominant status. The rising and/or dwindling power of these bodies of knowledge to shape the responses to mental distress was influenced by major events in history, such as wars, individual ambitions and personalities, cultural beliefs circulating at the time and political motivations, such as reducing costs. This supports Foucault's (1994b) argument that our current ways of thinking, rather than being the results of a progressive movement toward the truth, are emergent, contingent and could easily have been different.

All of the understandings of mental health and the associated treatments discussed in the history chapter (moral treatment, biomedical, psychoanalytic, behavioural, cognitive, humanistic and social approaches, anti-psychiatry, service user expertise) can be recognised within contemporary practice. The focus on self-discipline and

normal activities in the moral approach of the 1800s is reflected in the current focus on self-management and deinstitutionalisation. The belief in biological causes and treatments, first developed in the eighteenth century, continues through the regular prescription of medications and the belief in genetic heritability. The psychoanalytic approach is continued in the form of a concern with childhood trauma and its impact on mental health, and the mental hygiene movement is reflected in the belief that bad parenting leads to mental health problems. The behaviourist and cognitive approaches of the 1950s and 1960s continue strongly today in the frequent referrals to cognitive behavioural therapies, which have since developed to incorporate new 'third wave' CBT therapies such as DBT and mindfulness. The behavioural approach is also reflected in the way that service users are induced to engage through the threat of penalties. Service users who do not engage with proposed treatments or make efforts to change their behaviour are threatened with either discharge or authoritarian approaches in which their control will be taken away. The humanistic approaches of the 1950s, 1960s and 1970s are reflected in the importance of non-judgemental, person-centred practices by all contemporary mental health professions. The aims of the anti-psychiatry movement of the 1960s and 1970s and the service user movement of the 1980s and 1990s have been met to some extent and are visible in the efforts to use community-based facilities and avoid unnecessary confinement in hospitals, the understanding of structural factors impacting mental health, the belief in the value of peer-led support, in many professionals' efforts to listen to and derive meaning from service users' unusual (sometimes termed psychotic) experiences and in the now routine practice of involving service users in developing and monitoring services. The anti-psychiatry movement continues in the form of mad studies, psychopolitics and critical psychiatry (Bracken and Thomas 2010; Cresswell and Spandler 2016).

The recovery approach embraces many of the historical discourses discussed in the history chapter in terms of its acceptance of a range of explanations and treatments for mental health problems. However, it also envisages a particular kind of professional/client relationship in which the client is active, responsible and brings their own expertise. This aspiration to a relationship of equals is not compatible with many of the historical approaches, including psychoanalysis, the biomedical model and

the early behavioural therapies, all of which saw the professional expert as being entirely responsible for bringing about recovery. Psychoanalysis and the behavioural approaches both developed and were modified over time to incorporate a different and more equal therapist–patient relationship, but this had not been the case for the biomedical approach until more recently. The relationships within a biomedical model of mental health care have tended to be paternalistic, with practitioners understood as experts and patients expected to passively comply with their medical advice (Brennan 1991). Efforts to address this incompatibility with the recovery approach can be seen in contemporary practices, such as shared decision-making (Coulter et al. 2017), in which psychiatrists and patients make joint decisions about medication.

The recovery approach rests on a biopsychosocial model of mental health (Engels 1977, 1980) that informs mental health professionals’ training and advocates a range of causes and influencing factors in mental health. More recently, research in the field of epigenetics has shown how these factors are more interlinked than was previously understood (Weaver et al. 2004; McGowan 2010; Ressler et al 2011; Toyokawa 2011), and this provides support to a recovery approach that can coherently incorporate the acceptance and promotion of a range of understandings of mental distress.

An exploration of the history of recovery has shown how power in contemporary mental health services operates differently from how it did in the past. The practice of power is now more commonly pastoral than paternal, and it is exercised in a context of pluralism and a multiplicity of models where many ways of producing truths are accepted as valid. It seems likely the continued adherence to a biopsychosocial model has supported the move toward epistemic pluralism and multidisciplinary in mental health care.

The history also shows that until recent decades, the different mental health disciplines were often competitive, seeking to achieve dominance over other bodies of knowledge. For example, biomedical professionals emphasised the success of medical treatments over moral ones (Soutar 1897). However, the mental health practitioners in the current study accepted and valued each other’s knowledge and expertise. They drew on each other’s expertise in their own practice. For example, social workers

discussed medication with their clients, and psychiatrists discussed the patients' social circumstances and use of psychological therapies. The professionals sometimes suggested that their own discipline was not helpful in achieving recovery for a particular patient and suggested another discipline would be more successful. For example, psychiatrist Louise stressed how medication played a negligible part in recovery of patients who had experienced trauma.

The operation of the teams in terms of treatments can be seen as multidisciplinary: the different professions within and across the mental health services worked together to treat the clients' problems, each drawing on their own specific expertise. However, the professions shared the overarching conceptual framework of recovery, meaning that in terms of their ostensible values, including the ideal relationships and power dynamics between the staff and the service users, they worked in a transdisciplinary way, 'drawing together the discipline specific theories, concepts and approaches to address a common problem' (Choi and Pak 2006, p. 355).

The recovery approach has shifted the focus in services from cure or maximum symptom reduction to a more practical emphasis on integrating the clients back into the circuits of independent living, whether or not they have ongoing symptoms. This may have supported the reduction in competition and the increase in multidisciplinary and transdisciplinary work. This change in focus aligns with a recovery approach in promoting the opportunity for a normal, satisfying life, even with ongoing symptoms, whilst also supporting the liberal philosophy of the active, autonomous subject. Within a neoliberal rationality, the expertise of service users becomes a resource which they are expected to use in becoming autonomous partners in their own care.

### **8.3 How Are Mental Health Professionals and Service Users Practising Recovery?**

Critics have argued that the recovery approach in mental health services is in line with the neoliberal rationalities of the government and is, therefore, individualistic, assuming an autonomous, rational, choice-making citizen and focusing on the personal responsibility for changing attitudes, feelings, thoughts and behaviours, rather than on challenging the external social environment (Harper and Speed 2012; RITB 2016). However, these studies could be seen as embodying the critiques of some neoliberal



studies that see neoliberalism as totalising and monolithic (Ong 2007). In considering recovery as a possible neoliberal solution to the problem of mental distress, the present study found that, although some aspects of the recovery practice aligned with a neoliberal rationale, there was evidence of resistance, contradictions and ambiguity, and the processes involved were messy and incomplete.

Some aspects of the professionals' practices at the research sites appeared to clearly align with the features of neoliberal programmes. Contact with clients and proposed treatments were mainly individualised. The overwhelming majority of the patients I had contact with were attending or being encouraged to attend individual forms of therapy, including dialectical behaviour therapy,<sup>44</sup> cognitive behavioural therapy and behaviourist approaches, such as systematic desensitisation for anxiety as well as other individual practices thought to promote recovery, such as mindfulness or yoga. All these therapies promote individual changes in thoughts and feelings or change in the clients' relationships to their thoughts and feelings, rather than effecting any social change. Practitioners also drew on an individualised discourse of resilience in which service users were expected develop skills for managing emotions and behavioural responses to enable them to improve their functioning in society. The proposed routes to recovery were, therefore, in line with Harper and Speed's argument that in a neoliberal context:

[R]ecovery is thus framed as the need for the service user to acknowledge the inappropriateness of their negative beliefs, values and behaviours and to rethink these 'inappropriate' cognitions and behaviours into a set of more satisfying, hopeful and contributory values and behaviours. (2012, p. 12)

The practice of recovery in the services I studied relied strongly on a cognitive-behavioural approach. Hope was often placed in specific cognitive behavioural therapies to lead to recovery, but in addition, the recovery approach itself could be seen as form of behaviour modification. Service users were threatened with penalties

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44 Dialectical behaviour therapy often takes place in groups, but the aim is to achieve individual rather than social change.

such as discharge or sectioning if they could not engage with a recovery approach and take responsibility for their behaviour. Some service users resisted this behavioural approach; Emily offered a humanistic critique of this approach when she questioned whether DBT would help her recovery. She talks about the importance of maintaining her voice and her choice; concepts which align with a humanistic stance. Rob also appeared to want a humanistic approach to his distress. He was not keen to engage with the various activities or behaviour changes that staff advised were needed for his recovery, however, he told me that he valued the regular visits from empathic staff members. Rob wanted to be listened to and understood but without a requirement to make behavioural changes, reflecting the notion of unconditional positive regard key to a humanistic approach.

Hope has been recognised as key to recovery (Bonney and Stickley 2008; Slade 2009; Stickley and Wright 2011). In this study both service users and practitioners frequently talked about hope or the lack of it, such as when David and Zoe (chapter 5) were hopeful that David's next therapeutic intervention would be effective and when Paul (chapter 7) the DBT practitioner, talked about struggling to maintain hope for Emily's recovery. Practitioners appeared to maintain hope through attaching it to different options for treatment, however, it often 'settled' with behaviourist therapies such as DBT or CBT, despite their not uncommon failure to help service users. In addition, the broad approach of all the practitioners encompassed a focus on outcomes demonstrated through behaviour change. As discussed in chapter 5, this psychological approach offered unlimited possibilities for deeper understanding of service users' 'resistance' to recovery and hence became a never-ending source of hope.

The practitioners in my study focused on the responsabilisation of their clients, which was particularly evident in those interactions where a service user, such as Kate, Rob or Lisa, rejected responsibility despite the practitioners' consistent and repeated efforts to induce self-management but also where recovering service users, such as Charlotte, accepted responsibility and were praised for this. The need for the service users to engage with the service and take responsibility was accepted as essential to their recovery. The phrase 'you can't make someone recover' (or its equivalent) was

repeatedly stated by the staff in formal interviews and informal conversation with myself and each other.

In line with the neoliberal critiques of mental health services, there was also evidence of 'risk thinking' (Rose 2000, p. 332) in the professionals' interactions with their clients. Risk was discussed in almost all of the meetings with clients I attended and formed a significant part of the basis on which decisions were made about whether to (continue) to offer a service, discharge a patient or subject them to a more authoritative form of control, supporting Rose and Miller's (2008) argument that professionals, such as social workers, 'have been allocated accountability not so much for the cure [...] of patients [...] but for their administration according to a logic of risk minimisation' (p. 107).

Some patients who were considered to pose a low risk to themselves or others but who engaged in irresponsible behaviour, such as inappropriately calling emergency services or engaging in regular but minor self-harm, were discharged from the services. This would seem to contradict Rose's (2000) argument that patients who cannot self-regulate and govern themselves are subject to 'risk management strategies' (p. 331). However, the discharged patients were frequently in contact with a number of services and agencies who worked as a 'dispersed, expert system of risk management' (Ericson and Haggerty 1997, pp. 37–38, cited in Rose 2000, p. 332) to manage the risk posed by/to them. Social worker Zoe told me about the regular multi-agency meetings (informally known as frequent flyer meetings) in which the patients who regularly came into contact with the police or accident and emergency departments were discussed and managed. It seemed that rather than the patient being discharged from the networks of risk management, the mental health services discharged themselves from the network when their friendly authority-based (Billig et al. 1988) recovery approach was not effective. The risk management in these cases was left to other agencies who were not required to engage in a recovery approach and could more easily exert authority to manage the risk posed by these individuals.

Although my study found that in many ways, the recovery approach practised by the professionals aligned with a neoliberal rationale of government, the process of

inducing responsibility among service users was far from straightforward and was not always successful. The professionals' efforts were often 'thwarted' or 'distorted' (Peck et al. 2018, p. 58), such as when Rob consistently refused to engage in any recovery-focused activities whilst still wanting to maintain regular contact with the staff or when Kate steadfastly refused to take responsibility for her behaviour. The available discourses offering alternative conceptions of the professional/patient relationship mitigated against the neoliberal aim of responsabilisation through empowerment. This was most clearly demonstrated when service users drew on biomedical discourses to reject a behavioural recovery approach. The effects of the neoliberal programmatic aspects of the recovery approach, such as responsabilisation and self-management, were unpredictable. The production of recovering, neoliberal subjectivities was, like the recovery journey, always an incomplete and contingent process rather than an outcome.

The process of how contemporary neoliberal rationalities come to produce particular subjectivities has begun to be explored through the notion of pastors. Drawing on Foucault's work on the role of pastors in the Christian church, recent research has shown how health and social care professionals play a role in inducing particular subjectivities in their clients. Waring and Martin (2016) describe these modern pastors as follows:

Specifically, pastors are crucial nodes in neoliberalism who translate prevailing mentalities or discourses into specific life worlds, articulating them in a language that makes sense to a given community of actors. They support individuals to internalise and embody new subjectivities in relation to these discourses (p. 138).

My study showed how mental health professionals attempted to induce their service users to take on a recovery subjectivity of self-management and responsibility by the use of specific discursive strategies that will be explored in the next section.

## 8.4 The Translation of Discourses into Subjectivities

A growing body of governmentality literature has drawn on Foucault's concept of pastoral power to explore the role of modern pastors in shaping, disseminating and translating governmental discourses into action, including within health fields (e.g. Wilson 2001; Holmes 2002; Rose 2007). This literature has been criticised for not exploring how governmental discourses are translated into the formation of subjectivities, a lack of focus on human agency and an assumption that subjectification is a one-way linear process (Martin and Waring 2018). There is little focus on the relational practices of pastors, the limits of their influence or the scope for resistance (Waring and Latif 2018). Within the governmentality literature, subjects have been seen as the 'passive conduits, bearers or sites of discourses of power/knowledge' (Caldwell 2007, p. 770) with little attention paid to diversity, heterogeneity or resistance (Bevir 2011, p. 462). My study shows that the process of the translation of the recovery discourse to service user subjectivities is complex, diverse and often involves resistance and rejection.

Waring and colleagues (Waring and Martin 2016; Waring and Latif 2018) have proposed a model of the way in which pastors translate discourses into actions, involving four kinds of practices: constructive, inscription, collective and inspection. My data supported this model, providing particular insight into the inscription practices used by mental health professionals to develop recovery subjectivities in their interactions with service users. I also found evidence of collective and inspection practices.

Across the three research sites, the discourse of recovery was integrated into systems, routines and everyday practice norms. In their interactions with service users, professionals used pastoral power to induce them to behave in line with a recovery discourse and see themselves as patients in recovery. They constructed their patients as capable of and willing to do recovery-oriented behaviour, and they constructed the desired recovery behaviour as possible or even easy to do (see Hayley and Charlotte, Chapter 5). They constructed and proposed treatments as successful and leading to recovery (see Zoe and David, Chapter 4) and they focused on inducing patients to take

responsibility and self-manage their behaviour and emotions (see Zoe and David, Chapter 5; Kate, Rob and Emily, Chapter 6). They also used partnership language to construct service users as active and engaged in their treatment and support in collaboration with staff, and to minimise the visibility of their power in the interactions. (e.g. Aiden and Ben, Chapter 5).

My data also showed collective practices between professionals that ‘instigated and maintained’ activities that ‘reinforced appropriate subjectivities’ (Waring and Martin 2016, p. 143). The conversation between the professionals outside of Kate’s house (Chapter 7) offers an example of how professionals reinforce the norms of expected patient behaviour to each other. By talking about examples of Kate’s behaviour and attitude that do not align with a recovery discourse, they are able to express their disapproval and construct her as a bad client, thus reinforcing the norm of expecting and encouraging recovery-aligned behaviours from the clients. The team meetings were also settings where collective practices could happen, in particular where decisions were made about whether to discharge a patient who was not engaging or to use a more authoritarian approach. In the discussion about how to section Sandra (Chapter 7), the staff reinforced recovery norms by demonstrating to each other their ethical concerns. Their prolonged discussion reinforced the norm that taking away a patient’s control and freedom (i.e. acting outside of the norms of the recovery approach) should be considered a very serious step and that efforts should be made to adhere to a recovery discourse as much as possible even when sectioning a patient, such as by showing respect for the patient and maintaining their dignity.

The professionals also engaged in inspection processes, observing, monitoring and recording the service users’ behaviours and their reported thoughts, emotions and opinions. They sometimes used this monitoring to assist in inscriptive practices, for example, by referring back to the notes they had made previously to justify their suggestions or feedback to the service users. Records of the service users’ histories could also be used to justify current staff attitudes, such as when Zoe reported looking at other professionals’ accounts of working with Kate to help support her claim that no one can help her, becoming part of the collective practices.

A number of studies have suggested that rather than being a one-way, top-down, linear procedure, the translation of discourses into subjectivities involves complex processes in which concepts, such as recovery, become the sites of struggles over meaning and implementation (Sharp and Richardson 2001). My study provides data to substantiate this. Service users sometimes rejected a recovery discourse; they refused to engage, undertake recommended activities or adopt the desired attitude towards their distress. The professionals' discursive strategies were very successful with some service users, and yet, with others, they had no impact and sometimes appeared to worsen fragile or conflict-ridden relationships. The staff occasionally suggested or implied that a recovery approach prevented recovery in some patients, such as Alison and Kate (Chapter 7), demonstrating the possibilities for resistance by the practitioners as well as the service users.

### 8.5 Classification and Looping Effects in the Recovery Approach

Hacking's (1996) work on the looping effects of human kinds can help explain the complexity of the processes of the translation of a recovery discourse into service user subjectivities. Hacking has argued that human kinds are classifications brought into being by the social sciences with their need to quantify, classify and intervene. Human kinds, such as homosexuality or teenage pregnancy, can be differentiated from natural kinds by their intrinsic moral dimensions as well as the awareness of those classified and their ability to react to being classified. According to Hacking's theory, classified people react to their classification and, as a result, may change their behaviour in some ways. This behavioural change will be noted by professionals and recorded, eventually becoming part of the body of knowledge that adjusts and changes the classifications. Human kinds and knowledge, therefore, grow together through a constant process of making, moulding and 'wandering' of the classifications (Hacking 1996, p. 375).

People with mental health problems have been classified many times over the last 300 years as possessed, mad, insane, ill, distressed, alienated, traumatised, etc., and the theories of causation have changed and proliferated over the same time from biological to psychological to social and back again. In contemporary mental health

services, a number of causal factors and knowledge remain concurrently true; a person can be diagnosed with an illness and/or form of distress that is accepted as having biochemical, genetic, psychological and social causes at the same time.

The sheer complexity of the classifications and associated causal relationships available and applied to mental health service users, and acknowledged by the practitioner participants in this study, can help explain their different responses to the professionals' efforts to induce a recovery subjectivity. Mental health professional education is based on a biopsychosocial model (Engel 1977, 1980) of mental health (Anderson and Sapey 2012; Richards and Lloyd 2017; Nursing and Midwifery Council 2018), and hence it is not surprising that in this study, the professionals, when asked, cited multiple, connecting factors in the causes and treatments for mental health problems. However, service users, as (mainly) members of the general public, have been exposed to competing discourses around mental health in an unplanned and haphazard way, for example, through their upbringing, the experiences of friends and family, the media, etc. In addition, they have not necessarily been exposed to any information about how these different casual relations link to each other and how they may, therefore, be true simultaneously. As a result, service users have developed personal understandings of the causes of and effective treatments (if any) for mental health problems. In addition, many of the classifications assigned to service users by professionals, such as service user, schizophrenic, survivor, etc., have powerful associations and meanings outside of the health and social care spheres that impact service users' reactions to them. The service users' and general public's understandings of mental distress may or may not be compatible with a recovery approach. For example, the notion of distress as an entirely biological illness or disease requiring medication to ameliorate the symptoms is not compatible with the idea of needing to engage with cognitive behavioural therapy: if mental illness is purely biological, then no amount of changing one's thinking will lessen or cure the symptoms.

To add to the complexity in the area of mental health, over the last 30 years, a new body of knowledge has formed, that of service user expertise by experience. Hacking (1996) explains how, in recent decades, the people who were traditionally only the



objects of knowledge, the known, have come to take control of at least some portions of the knowledge about their own classifications. By processes of self-ascription and rhetoric of taking control within collective self-help efforts, the known have also become the knowers. This seems particularly relevant in the context of the recovery approach that is believed by many to have originated in service user expertise before being institutionalised and professionalised by mental health services.

The knowledge of recovery enables a new storyline about mental illness/distress. The past can be redescribed (Hacking 1996, p. 369); people who are considered recovered can now be seen as responsible for their recovery by their personal efforts and self-discipline, rather than by, for example, finding the right drug or having a skilled therapist. For people currently diagnosed with and suffering from mental distress, a new future storyline becomes possible in which they embark on a journey of recovery, requiring personal effort, self-management and self-development, leading to a satisfying life in which they achieve their potential. It is a belief in and commitment to this possible future storyline that professionals try to induce in service users through their discursive strategies.

The recovery knowledge also enables new kinds of classifications to be made, such as the recovering service user and the non-recovering service user and the engaging service user and the non-engaging service user. In my study, any service user who was engaged with the services was considered to be in recovery, even if they were at the start of their journey, or their journey had continued for many years. Charlotte (Chapter 5) was in recovery even though she was unable to go to a nearby small town on her own and struggled with fear when leaving the house. David (Chapter 5) was considered to be in recovery despite having been with the team (on and off) for 14 years and still suffering from crippling anxiety that severely limited his life. Rob (Chapter 6), despite suffering from levels of anxiety and restrictions to his life of a similar kind and level to Charlotte and David, was not considered to be in recovery because he did not agree to engage with any proposed treatments and could not accept the recovery storyline for his future. Being in recovery within mental health services appears to be understood not as the experience of a more satisfying life but

an attitude of self-discipline, taking responsibility and playing an active role in the treatments offered.

Recovery was not considered to be possible with a service user who did not engage with the recovery approach. In this way, the classifications of recovering and engaging and non-recovering and non-engaging became merged into the same categories, demonstrating Hacking's idea of wandering.

The classification of the non-engaging service user had real implications for service users. For many, this meant discharge from the service, whereas for others, it meant being subject to an authoritarian approach. The classification of non-engaging raised the historical notions of deserving and undeserving; non-engaging service users presumed to have insight and not to be at serious risk of harm were seen as wasting the time of professionals and taking help away from people on the waiting list who needed it (see Chapter 7, comments from practitioners Hayley, Louise and Kyle). These understandings align with a neoliberal attitude of punitive sanctions for those who do not manage their own risk. However, other non-engaging service users, such as Sandra, were instead constructed as too unwell to understand the need to engage with the services. In this case, a biomedical discourse was invoked, enabling the staff to adopt a paternalistic relationship to Sandra. Responsibility in this interaction was understood within a 'relation of care' discourse which was drawn on to justify the need to section Sandra.

In line with Hacking's (1986) theory, it is possible that non-engaging service users react to being classified and to the resulting outcomes and might change their behaviour as a result, leading to the ongoing adjustments to the knowledge about non-engaging service users.

## 8.6 Challenges, Dilemmas and Tensions in the Practice of Recovery

The literature on the barriers to a recovery-oriented practice has suggested a number of reasons why services and professionals do not always practise in a recovery-oriented way. The dominance of the medical model in health service systems is seen as a significant barrier (Hoy 2008; Davies and Gray 2015) as well as the professionals'

reluctance to give up their power (Shera and Ramon 2013; Davies and Gray 2015; Neech 2018). In addition, the impacts of new public management are also seen to negatively impact a recovery approach (Gilburt et al. 2013; Le Boutillier et al. 2015). My study found evidence, in line with the findings of Simpson et al. (2016), that some recovery practices were impacted by organisational needs relating to austerity and prioritisation. This was evident in the way in which patients considered to be at low risk were discharged from the service if they did not engage with their recovery and in the staff comments relating to the best use of limited resources.

Previous research has found that practitioners find it hard to reconcile risk management practices with a recovery-oriented approach (Holley et al. 2016). I did not find, like Holley et al., that practitioners tended to revert to an illness-management model when faced with higher levels of risk. I observed several occasions in which the recovery approach was abandoned, seemingly due to the level of risk, such as with Sandra and Anna (Chapter 7). However, I also observed several instances where the staff maintained a recovery approach for significant periods, attempting to work in partnership with service users (sometimes) considered to be at high risk of harm, for example, Anna and Kate (Chapter 7). The factors influencing the continuing use of a recovery approach, therefore, appeared to be more complex than just risk: service user engagement also played a key role. However, these two factors were sometimes closely related; for example, Sandra was considered to be too unwell to be able to engage with the staff.

My study also found different barriers to recovery than those suggested by the current literature. The service users' exercise of power to reject or accept the recovery approach had a significant impact on the effectiveness of the staff's recovery-oriented practices.

Wallace et al.'s (2016) evaluation of the REFOCUS randomised controlled trial found that although some service users recognised and appreciated a recovery approach, others did not find it helpful. This was reflected in my study in which service users seemed to fall into two categories: they either appeared to accept and value a recovery approach (e.g. Charlotte, David, Geraint) or they found it unhelpful (e.g. Rob,

Kate, Emily). Wallace et al. (2016) concluded that the lack of benefit for some service users was due to the professionals' failure to fully implement the approach. However, my study suggests that some service users take an active role in rejecting the recovery approach. It may be that this decision is made on the basis of their own beliefs about the nature of mental distress and recovery, or it could be that they are taking up a biomedical and/or humanistic position in the discourse as a way to resist the recovery programmes that they do not wish to engage with. In addition, in my study, I observed the same practitioners interacting in very similar ways with different clients in terms of their use of a recovery discourse and specific discursive strategies, and yet, the service users responded to these strategies in very different ways, again highlighting their agency.

The service users who rejected the recovery approach constructed themselves and their distress in ways that did not align with a recovery discourse, for example, by seeing their distress as unresolvable and/or themselves as unable to take responsibility for self-management. Sometimes, service users drew on an alternative discourse, the biomedical model of mental illness, to construct their distress as fatally biological and themselves as, therefore, unable to self-manage. Sometimes, they also expressed an expectation or wish for more paternal power relations in keeping with a biomedical model. Kate repeatedly said she needed to be sectioned, and Emily asked to be grounded. Emily also suggested that, rather than asking her what she thought would help, the staff should know what to do to help her, an attitude in line with a biomedical approach in which the staff have expertise and tell the passive patient what to do. This finding is contrary to the previous studies that have found patients struggling to gain control in the context of medically dominated services (Shera and Ramon 2013; Davies and Gray 2015). Howell (2015) points out that it is important not to assume that certain programmes of governance, such as the recovery approach in services, are successful or 'fait accompli' (p. 70). Service users across the three sites demonstrated resistance to the recovery discourse in various ways, including open confrontation, refusal to take part in recommended activities and making it clear that the professionals' contributions or efforts were unhelpful or irrelevant (Brownlie 2004). With many service users in this study, the practices of subjectification were not

complete, uncontested and straightforward but reflected instead a strategic struggle (Brownlie 2004).

My findings also challenge the assumption of the homogenous growth of medicalisation (Miller 2017). Many of the service users were encouraged to understand their problems in nonmedical ways, and the staff and some service users believed that these alternative views and their associated practices would aid the service users' recovery. In addition, the psychiatrists I spoke to emphasised psychological and social factors in causation and treatment and suggested that medical treatment was ineffective and not appropriate for some service users. For example, Louise, a psychiatrist at Llan castell, explained how medication could not really help a patient with a significant history of trauma as they 'need[ed] psychological input'.

The discussions between staff and the service users who rejected a recovery approach were complex and delicate. The staff continued to use discursive strategies to induce self-responsibilisation but were routinely thwarted by service users. They also occasionally used what Galbraith (1983) referred to as condign power, winning submission by offering an unpleasant alternative, in this case, the threat of discharge from the service. The recovery approach appeared to operate as a behaviour modification regime in which professionals attempted to induce behaviour change through positive reinforcement and sometimes threats of penalties. By the end of my fieldwork, Rob was considering engaging with a recovery approach, possibly due to being threatened with discharge as he did not want to lose his weekly visits from the staff (Chapter 6). In Rob's case, the recovery approach as a behaviour modification regime was apparently effective in inducing him to change his behaviour.

The translation of a recovery discourse into service users' subjectivities did not always go smoothly, and sometimes, it did not appear to happen at all. The staff expressed frustration about working with service users who did not engage with a recovery approach. They felt unable to help the client or do their job. This appeared to cause levels of stress for the staff in keeping to their aims of recovery-oriented practice. My observations of the professionals working with Kate suggested that rather than Kate being induced to take on a recovery-aligned subjectivity by the staff, Kate herself

engendered the staff to take on a paternal stance, aligned with a biomedical discourse, that they used to justify their view that she should be sectioned (Chapter 7).

My study did not support previous findings that professionals are reluctant to give up their power (Shera and Ramon 2013; Davies and Gray 2015). At some points in the interactions I observed, the professionals seemed almost desperate for the service users to take control, say what they thought would help them and work in partnership. There was a sense that without the service users engaging in a recovery approach, practitioners could not do their jobs, such as when Hayley repeatedly asserted that she could not work with the service user she had reluctantly discharged (Chapter 7) or when nurse June explained that she could not do her job as a nurse with Alison (Chapter 7). My findings resonate with the work of Broer et al. (2010, 2012) and others (Leung 2016) on the notion of mutual powerlessness. Broer et al. found that ‘many [staff] teams feared [being accused of] exerting power and did not want to do anything that might be categorised as power’ (2012, p. 217).

This appeared to be the case in the present study where the staff in all three sites made significant attempts to conceal or withdraw their power. They engaged in what Billig et al. (1988) have described as a friendly authority using ‘delicate semantics and syntax’ (p. 70) to avoid any obvious displays of power differentials. This tactic worked well in engaging with those service users who welcomed a recovery approach and did not challenge the practitioners’ suggestions or advice. However, there was sometimes a sense that neither the service users nor the practitioners knew how to involve the service users in their own care. The practitioners were sometimes frustrated and unsure of how to proceed in working with a service user whom they saw as unwilling or unable to take responsibility, and the service users sometimes did not know what they wanted or what would help them, leaving both the practitioners and service users ‘paralysed’ instead of ‘freed’ (Broer et al. 2012, p.217).

The recovery approach in mental health services could be described as a responsibility project (Ilcan 2009) in which service users come to understand that they are responsible for their own recovery (Lynch 2000, cited in Ilcan 2009). This belief was apparent in the data when the staff repeatedly said that they could not make someone

recover. It was also noted in a recent study by Jorgensen et al. (2020, p. 3017) whose Danish nurse participants stated '*we cannot recover the patient; it must be done by the patient*'. Within a responsibility project, the clients are given tools to help them recover (Juhila et al. 2003), but the responsibility is with them to use those tools. Some service users, such as Emily, found this difficult. She explained that the staff told her they had given her the tools to manage her own behaviour, but she did not find this helpful. There was also some evidence that, as Rose (2000) suggested, service users who could or would not take the opportunities offered to them to learn to become independent and self-managing, might be excluded from the services. This was the case in all three of the services, where service users who did not engage with the opportunities offered, such as DBT skills, appointments with care coordinators or substance misuse services, were sometimes excluded from the services.

Trnka and Trundle (2014) argue that the term responsibility has been colonised by neoliberalism and that multiple framings of the term should be considered. Mental health service users do not just exist within a neoliberal discourse of responsibilisation but in a 'matrix of dependencies, reciprocities and obligations' (Trnka and Trundle 2014, p. 150). The framework of relations of care is particularly important in the context of mental health services, in which the staff are motivated (among other factors) by a commitment to the welfare of the service users. The professionals in this study used this framing of responsibility in their talk with and about service users. Mol (2008, cited in Trnka and Trundle 2014) states that relations of care may be better understood in terms of responsibility rather than love or affection and that relationships may be uncomfortable and conflicted, something that was very apparent in my study.

In my data, there was evidence that the staff invoked different framings of responsibility to justify different responses to service users who seemed to be unable to take responsibility for their behaviour. With service users who were to be discharged, they used a neoliberal framing of responsibility in which the service users were held responsible for their failure to engage with the services and help themselves recover. For example, when Hayley talked about the lady who she felt forced to discharge, she explained that the lady 'has to take some responsibility and she

consistently hasn't', meaning that Hayley 'cannot' work with her. When Kyle talked about the client who was not engaging with the DBT sessions, the responsibility for her lack of engagement as well as the impact on the other (waiting list) patients was clearly attributed to the client:

K: 'I was like "well, come back when you're ready, then" and, you know, like, there's lots of people who really need help and you're not engaging right now.' (Kyle, psychologist, Llancafellon CMHT, interview)

However, when the staff made decisions to take an authoritarian approach, they more often used a relation of care framing of responsibility to position themselves as responsible for the wellbeing or safety of the service user, thus justifying their need to take control. When the professionals talked about sectioning Sandra, they stressed the severity of her illness, the risks she faced and the fact that she could not understand these risks, all of which worked to emphasise their responsibility to protect Sandra from harm by sectioning her. When nurse Becky described the way in which they forced patient Liam to clean his room and have a shower, she clearly attributed the responsibility not only for Liam's welfare but the welfare of the staff, other residents and guests, to the staff team, which helped justify their authoritarian action. The staff moved between different framings of responsibility in response to different complex situations that required them to negotiate between their duty of care and their need to empower and responsabilise service users in line with mental health policy.

## 8.7 Limitations and Methodological Considerations

My study provides a detailed examination of services that are actively working (or aiming to work) in a recovery-focused way which is appropriate for what I wanted to explore. As a qualitative study, my research was not aiming to generalise the findings to all mental health services or all mental health service users. However, my three research sites were in some ways self-selected and, therefore may have been unrepresentative of mental health services in South Wales. I approached these services because I was made aware that they would be interested in research on recovery; they were, therefore, likely to consider themselves as working in a recovery-focused way and to agree to be observed by a researcher. In this way, they might differ



from other services who might not be keen to work in a recovery-focused way or who might not consider themselves to be doing recovery very well.

Goodman (2008) explains how discursive findings can be seen as ‘highlighting generalizable actions performed by a rhetorical strategy’ (p. 268) where it can be demonstrated that a particular action is achieved across contexts by different speakers employing a particular rhetorical strategy. In my study, the practitioners of different professions across the three mental health services, used similar kinds of discursive strategies to achieve the same ends, suggesting that this might be common to a wider population of mental health professionals. For example, they constructed service users, mental health problems and treatments in particular ways, they presented optimistic appraisals of service users’ prognoses and abilities, and they praised any service user efforts at self-management and independence. The service users across the three services, with various diagnoses, ages and genders, also used the same kinds of discursive strategies to accept or reject a recovery discourse, again suggesting that these strategies may be used more widely among mental health service users<sup>45</sup>.

I had originally intended to use recorded meetings between the staff and service users as my main source of data from all three sites as these tend to be where care planning takes place and, under the legal framework<sup>46</sup>, where recovery is usually practised. However, ethical concerns meant this was not possible at the Forest View Recovery Centre, so I gathered alternative data, including ethnographic field notes and interviews with the staff and service users. At Forest View, recovery was understood as an underlying principle of the service, and a recovery approach was encouraged in all interactions and activities with the clients. I was, therefore, confident that I had gathered relevant data. The analysis of the data at Forest View clearly aligned with and supported the overall findings of the thesis.

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<sup>45</sup> My participants were all White British and therefore the findings should be considered with particular caution in relation to non-White British service users.

<sup>46</sup> The Mental Health (Care Coordination and Care and Treatment Planning) (CTP) Regulations (Mental Health Measure, Wales) Welsh Assembly Government 2010.

As explained in chapter two, the early writings of service users diagnosed with serious mental illness contributed to the development of recovery ideas and critique of mental health services. In the 1980s and 1990s people with these diagnoses were often considered to be chronically ill with no hope of recovery. The recovery approach is therefore especially relevant to people diagnosed with serious mental illness, particularly schizophrenia and/or psychosis.

Overall, I gathered data relating to six service user participants who had been given a diagnosis of schizophrenia or psychosis; two at Llancastell and four at Forest View. However, there is relatively little analysis of this data presented, particularly in chapters five and six. There are a number of reasons for this, relating to data quantity and quality.

I was not able to observe the four participants at Forest View in formal meetings with staff, due to ethical issues around the extreme sensitivity of the material discussed. I did observe one meeting at Llancastell involving a participant who had been given a diagnosis of schizophrenia. Unfortunately, the sound quality of the recording was low and the data obtained was therefore limited. Although my analysis of notes taken from this meeting aligned with the overall findings, meetings with other service user participants provided more convincing evidence of the discursive strategies used by staff and service users.

Two of the service user participants at Forest View, who had been given a diagnosis of schizophrenia, left early in my fieldwork period and I did not get to gather significant data relating to them before they left. I did interview one of these service users, however, his learning disability impacted on the amount and depth of data I was able to obtain. Data relating to three service users who had been given diagnoses of schizophrenia and/or psychosis was analysed in chapter 7 (Sandra, Alison and Liam). The lack of data relating to service users who have been given a diagnosis of schizophrenia or psychosis is a weakness of this research. Future research could focus specifically on exploring interactions between staff and service users who have been given diagnoses of schizophrenia or psychosis. As noted previously in the methodology chapter, my identity as a social worker offered both advantages and disadvantages. Whilst writing the discussion chapter, I undertook further reading on reflexivity and was struck by how much criticism there was of the researchers' attempts at reflexivity. I was warned that some academics might see excessive reflexivity as self-indulgent (Patai 1994; Kemmis 1995). In addition, reflexive work has been criticised as superficial and failing to analyse 'how identities are constructed, reproduced, established, mediated, changed or challenged over the fieldwork process' (Coffey 1999, pp. 10–11)

or how emotions can be 'epistemically productive in the analysis of fieldwork and the fieldworker self' (Coffey 1999, p.12). Pillow (2003) has noted how many researchers attempt to redress the power imbalances and issues of representation by various power-sharing practices, such as co-production, reviewing the findings with the participants, etc. However, these processes are usually intended to enhance the truthfulness of the findings, an aim incompatible with the poststructuralist critiques of truth as a goal in research. In addition, Pillow (2003) notes that identity work is often reduced to the researcher finding things in common with the participants and questions what this process can add to the research.

I recognised some of these critiques in my own work. I had initially identified the ways in which I was similar to my participants, such as by my experience of working in mental health services and having experienced mental health difficulties. I had assumed that by making these transparent, the participants would be more open and truthful in their responses. I had engaged in what Coffey (1999) would perceive as superficial reflexivity in which I had not considered how my identity was challenged or changed by the research process.

Harper (2003) focuses on reflexivity in the analysis stage of the research. He argues that analysis requires difficult choices that have consequences for the kind of analysis produced. These choices should, therefore, be made explicit in the context of the researcher's own position in relation to the research topic, making the researcher accountable for his/her analysis. He proposes that reflexivity should be 'an active, rebellious practice that drives individuals into action as they identify the exercise of power that pins them into place and the fault lines for the production of spaces for resistance' (Parker 1999, p. 131, cited in Harper 2003, p.78).

My personal and professional background meant I was pinned into place by multiple discourses: as a mental health professional, I had worked within a biomedical psychiatric discourse and had aligned myself with some of the values associated with that discourse in order to do my job authentically. Yet, my experience of and beliefs in the benefits of an alternative to the biomedical model positioned me in opposition to that discourse. My approach has, therefore, been ambivalent, sometimes fully

committed to a recovery approach whilst contemporaneously believing that it does not work in the real world.

My personal experience of mental distress means that I do not only belong to the category of mental health professionals (the knowers) but also to the other or the known (Hacking 1996). In line with a recovery discourse, I am in possession of expertise acquired through lived experience, although I am yet to work out what this means for me. For me, at the intersection of these discourses was the space for resistance (Parker 1999, cited in Harper 2003) from which, although I could not escape my embeddedness, I could explore recovery in ways that both aligned with and resisted these discourses.

The findings seem to reflect my own experiences of the recovery approach and my undecided stance in terms of its effectiveness. I found evidence that the approach is effective in helping some service users to have a more satisfying life, but I also found evidence that it led to ongoing conflict and failure to recover in others. In some ways, these findings are not surprising, given my awareness of the promises and problems of recovery.

In hindsight, I can see how the ethnographic fieldwork and subsequent analysis have allowed me to understand my experiences differently, retell my own story and remake my own subjectivity (Hacking 1996). Rather than seeing my statutory social work experience as a personal failure to enable all of my clients' recoveries and the recovery vision as both a desirable goal and as unrealistic and naïve, I have been able to integrate my experiences. The combination of micro and macro analysis has enabled me to recognise and better understand the complexity and contradictions of the recovery approach and relate to the desirability of recovery as a framework for mental health services whilst understanding that it will always be a process rather than an endpoint. Within the services that retain responsibility for risk management, this is inevitable and not necessarily a problematic situation.

## 8.8 Future Research

My work drew on the ideas of Waring et al. (Waring and Martin 2016; Martin and Waring 2018; Waring and Latif 2018) about how modern pastoral practices sustain particular discourses and mould subjectivities. Waring et al. (2016) developed a model of four processes involved in enabling people to internalise and embody particular discourses.

My study focused on inscription processes: the ways in which a recovery discourse was inscribed into everyday interactions, routines and systems. I also found some evidence of collective processes and inspection processes. One aspect of Waring et al.'s model my study did not explore was constructive processes: how practitioners initially gained information about the recovery discourse, how they made sense of it and how they translated it into a form they considered appropriate for use with service users. In their work on patient safety initiatives in the NHS, Waring et al. (2016) noted that this process was not one of passive transmission but that practitioners played an active role in the translation of materials, suggesting that they have a significant influence on the discourse in use and the resulting effect on subjectivities. This, therefore, seems an important area to explore in the field of mental health services.

Another potential area for future research relevant to studies of governmentality is that of resistance. My study focused on how some service users resisted a recovery discourse. However, there was evidence that in some circumstances, the staff also resisted a recovery approach, for example, when the practitioners discussed how Kate needed to be sectioned, following the repeated failures to persuade Kate to take responsibility for her behaviour. Future research could focus on staff resistance and explore how, why and in what kinds of circumstances they resist a recovery discourse and work in alternative ways.

Drawing on the work of Hacking (1986), my study showed how a recovery discourse is associated with particular classifications, including recovering and non-recovering service users, and how these, in turn, are closely linked with the categories of engaging and non-engaging service users, that had important implications. Future research could explore how service users react to these classifications and whether and how

they change their behaviour as a result. It could also look further into how staff understand these classifications and the impact of these on the practices of mental health services.

My study also showed that some service users drew on a biomedical discourse to resist the recovery approach and its associated behaviourist regime. As a social constructionist study using discursive analysis, my study aimed to explore how service users used language to perform actions in the moment-to-moment context of interactions. However, future research taking an alternative epistemological perspective might explore service users' underlying beliefs about the causes of mental health problems or distress and effective treatments. It is possible that service users, as members of the public, do not understand the complex mixture of psychological, social and biomedical factors that the professionals now believe contribute to the onset and maintenance of mental health difficulties. This may explain why some service users reject the possibility of psychological treatment being effective. However, there may be other reasons, for example, the effort required and the possibility of increased mental distress whilst undergoing psychological treatment. In addition, some service users' talk suggested that they would prefer a humanistic or person-centred psychological approach as opposed to the behavioural approach which was frequently the only type of psychological treatment offered. An understanding of service users' beliefs about mental distress could help illuminate why some of them reject some kinds of treatments and inform the design of psychoeducation to enable service users to consider a broader range of treatments. It might also inform the development of more person-centred therapeutic treatments.

My study suggested that the staff spent considerable time trying and failing to engage some service users in various treatments or supports and that this caused them significant stress. Ongoing stress in mental health professions is related to burnout and mental health problems in the staff (Morse et al. 2012; Johnson et al. 2018), so it seems important that any sources of stress should be investigated. I did not have the scope in my study to explore this area in any depth, however, future research could explore what it is that staff find stressful about non-engaging service users and the ways in which these situations and the resulting stress might be better managed.

This study focussed on the practice of recovery in mental health services, however, future research could also explore ways in which people experience or practice recovery outside of formal services.

## 8.9 Recommendations

Drawing out recommendations for practice from discourse analytic research is not straightforward. Interventions do not become immediately apparent from the research findings but instead require 'practical and reflexive engagement' with the ideas that might inform potential interventions (Harper 2003, p. 89). This study was not aiming to recommend a recovery approach nor was it an a priori critique of that approach. Therefore, recommendations are aimed at improving the experience and effectiveness of mental health services for staff and service users, without proposing that any particular approach should be taken.

One issue raised by the study was that of different understandings of mental illness/distress within and between professionals and service users. Some service users presented their illness as purely biological and, therefore, could not see how thinking differently about it would improve their quality of life. The practitioners found it frustrating to work with service users who did not seem to want to help themselves by their own efforts at changing their thinking. The discourse of biological fatalism actively resists and denies the recovery ethos.

Psychoeducation, where service users are given information about their illness, medications and sometimes how to self-manage, could be developed to include education about the many factors implicated in mental distress and how these interact. Service users might then be enabled to develop more sophisticated understandings of the causes of their distress and be open to a wider range of treatments that might be helpful to them. Staff could be given further training, not just in these factors and their linkages but in how to explain these links in plain English (or Welsh) to service users. Service users are also members of the public, and the public are potential future users of mental health services. It, therefore, makes sense to think about how to educate the general public about the complexities of mental distress.

Recent anti-stigma campaigns have focused on promoting a biogenetic view of mental illness causation, advocating medical treatments for these medical conditions. This approach was based on research showing that people's etiological beliefs about mental distress impacted the levels of stigmatisation (Mannarini and Rossi, 2018). It was thought that if mental illness was assumed to be biological and hence beyond the individual's control, then less blame would be attributed to the individual, leading to reduced stigma (Mannarini and Rossi 2018). However, this view does not promote the understanding of the multiple factors thought to be involved in many mental health conditions and mitigates against efforts to encourage people with mental health problems to engage with nonmedical treatments. In addition, it does not raise awareness of the links between mental health problems, trauma, abuse, poverty, disadvantage and oppression. Given that anti-stigma campaigns, based on biologizing mental illness, have not been unequivocally successful in reducing stigma and in some cases, have increased it (Angermeyer et al. 2011; Mannarini and Rossi 2018), public education campaigns could focus on communicating the complexity of causation in an accessible way.

I observed in my fieldwork that much staff energy and time was spent attempting to engage unwilling service users who were sometimes discharged without experiencing any significant improvement in their wellbeing. Months spent trying to engage these service users resulted in high levels of staff stress and frustration as well as negative implications for managing workload. Some service users may need years of support before they feel able to engage with recovery due to their symptoms, chaotic life circumstances and/or a lack of trust in professionals based on previous experiences. Increased support and guidance for the staff in working with non-engaging service users could reduce their stress and enable them to know when/if they have done enough. Practitioners in mental health services commonly work alone with clients, and therefore, a team approach might also help manage the stress caused by service users' consistent non-engagement.

In the present study, non-engagement was often experienced as the failure of the client and sometimes the practitioner. Framing the issue differently could help reduce staff stress. Playle and Keely (1998) describe noncompliance as an ideology based on



the assumption of professional power that views noncomplying service users as 'deviant, irrational and problematic' (p. 309). Although the term noncompliance usually refers to the refusal of psychiatric medication, a view of service user non-engagement as problematic aligns with this same ideology: it is assumed that the service user is mistaken or irrational. However, non-engagement with the proposed treatments may instead suggest that the service user is thinking independently and critically about the service being offered and making a rational decision that it is not right for them. In this way, they may be demonstrating independence and self-management, qualities encouraged by a recovery approach. The quicker acceptance of a service user's choice not to engage might reduce stress on the part of the practitioners as well as demonstrating respect for the service user's decision and the appreciation of their right to self-determination. Under the Mental Health Measure (Wales) (2010), service users who have been under secondary care can directly rerefer themselves to statutory services so could quickly re-engage with the service should they feel that it would be helpful.<sup>47</sup> Efforts to increase understanding of service users' choices not to engage may also help inform future treatments, including more person-centred approaches.

Another way to frame the issue of 'non-engagement' is to consider the development of the concept. My findings suggest that the emergence of the non-engaging service user as a *problem* is associated with a behaviourist recovery approach in a policy context of neoliberalism.

In my study, the focus on responsabilisation and self-management in the institutionalised recovery approach, combined with a behaviourist approach led to a pressure on both service users and practitioners to quickly effect behaviour change in service users. The focus on achieving 'outcomes', intensified by a lack of resources, meant that practitioners experienced little time for 'being with' service users, and for accepting, tolerating and understanding their distress (Gilbert 2005, 2010; Spandler and

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47 This approach would, of course, not be compatible with some services' legal requirements to manage risk in the case of service users who may pose a serious risk to themselves or others.

Stickely 2011 p. 559). This requirement to quickly effect change led to stress for practitioners who frequently talked about their frustration related to non-engaging service users. In staff talk, I recognised aspects of Deegan's (1987, pp. 6 - 8) description of the typical practitioner response to an 'apathetic' service user. The initial 'frenzied saviour response' was evident in an increase in plans, staff contact and treatment options offered; such as when the professionals talked about the plans they had made for Kate (chapter 7), or when Rob was offered numerous treatment options to engage with and encouraged to agree to more frequent visits in order to put a 'plan to action' (chapter 6). There was also evidence of anger<sup>48</sup> and service user blaming (Deegan 1987) such as when Zoe and her colleagues at Llan castell constructed Kate as a 'bad client' or when nurse Gemma explained that she was going to make less effort with a service user because:

'I'm working harder than they are and I'm going to run myself in the ground because they just expect, they're not putting things themselves to move forward'

(Gemma, nurse, interview, Forest View)

The behavioural approach to recovery in the mental health services I studied appeared to militate against the development of compassion, reflecting Spandler and Stickley's (2011) argument that an emphasis on evidence-based, technical, measurable interventions such as CBT have contributed to a compassion deficit in contemporary mental health services. A scientific behavioural approach could be understood as the opposite of what the recovery approach calls for; a humanistic relationship which recognises service users as equals and in which human capacities for compassion and warmth are more important than scientific or professional knowledge and theory (Borg and Kristjana, 2004; Ljungberg et al, 2017).

A focus on behavioural outcomes alongside limited resources could limit the development of a nurturing environment. In the services I studied, I experienced a

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<sup>48</sup> In my study, anger was never expressed openly to service users and it took the form of frustration shared with me and other practitioners.

sense of urgency for change which did not always allow for service users to 'go at their own pace' (Balter 1987 cited in Deegan 1987) and did not allow practitioners 'to wait patiently, to sit with, to watch with wonder' as the nurturing environment they had created resulted in a patient gradually regaining their hope and agency (Deegan 1987 p.8).

Conceptualisations of person-centred in the context of contemporary health systems have emphasised service users as consumers, citizens and participants (Nolte et al. 2020). This understanding was evident in my data; there were numerous examples of practitioners attempting to induce service users to participate in their own care, to make choices to engage with therapies or other activities and to express their views about what would be helpful to them. However, Deegan (1987) warned that empowering language does not necessarily lead to empowering practice and this was also evident in my data; strategies of empowerment through engagement and self-management sometimes had disempowering consequences; they led to 'forced responsabilisation' as service users were held responsible for their choices whilst also having limited choices in terms of responses to their distress (Dent and Pahor 2015; Nolte et al. 2020). Practitioners often verbally expressed care for service users but they appeared to have few options within the current system to do anything other than require rapid behaviour change and to force self-responsibility onto service users.

Practitioners and service users in my study grappled daily with complex and distressing situations. Many of the service users labelled as 'non-engaging' struggled to manage their daily lives as a result of their experiences of extreme trauma, abuse, cruelty and oppression. Practitioners strove to maintain hope, kindness and patience in the face of rejection, criticism and repeated failure to enable their service users' recovery. The journey to recovery for many patients was long and never fully completed, but despite this, hope was endlessly rekindled by both practitioners and service users.

Efforts to introduce person centred approaches into services that focus on compassion and mutual humanity might support both service users and practitioners to foster and maintain hope in the face of seemingly insurmountable obstacles.

## 8.10 Contribution to the Literature

This is a substantial empirical study of the practice of the recovery approach across three mental health services in South Wales. Using historical, ethnographic and discursive methods, the study examined recovery through an analysis of power. Power was understood as exercised rather than owned, and this led to a consideration of agency and resistance.

In contrast to previous research, this study found that professionals across the three research sites practised a relatively consistent version of recovery in which various discourses relating to the nature of mental distress and its treatment were considered true, and an emphasis was placed on service users engaging with professionals and taking responsibility for their recovery. Adverse childhood events and trauma were considered to be key in explaining many service users' problems and a neoliberal discourse of resilience informed approaches to working with these patients. Hope for recovery was constantly threatened but maintained through its association with psychological approaches through which service users' 'resistance' to recovery could be endlessly explored and better understood.

The mental health professionals acted as modern pastors, attempting to translate the recovery discourse into patient subjectivities by the use of specific discursive strategies. They constructed service users as capable, responsible and motivated; mental distress as controllable; and treatments as successful. They disguised their power in interactions, constructing service users as active decision makers in their own care. They also consistently attributed responsibility for recovery to service users.

These strategies were not always successful, and tensions were identified relating to service user agency and competing discourses. The professionals made considerable efforts to practise in a recovery-focused way, and yet, the last resort options of discharge or authoritarian approaches were not uncommon at any of the research sites. Some service users could not be persuaded to believe in the possibility of recovery. Some, from the perspective of the staff, refused to accept responsibility for their behaviours, and others requested or demanded a style of relationship with the

services incompatible with a recovery approach. In the field of neoliberal rationalities, recovery appears to be struggling to fulfil its programmatic aspirations and goals.

The data showed that, in the services studied, patients considered to be in recovery were those who engaged with recovery focused activities (as defined by staff). The importance of recovery as a process seemed to have led to a neglect of recovery as an outcome (Liberman and Kopelwitz 2005; Davidson and Roe 2007). Those patients who were described by staff (and often themselves), as not in recovery, did not generally experience more severe symptoms of distress, but unlike patients considered to be in recovery, they did not engage with activities considered to lead to recovery by staff.

Recovery as practiced in the three research sites, operated as a behaviourist regime to mould service users' behaviour in line with professional ideals of recovery focussed activities. Service users were consistently praised for undertaking recovery focussed activities as advised by staff, and interactions with these service users were friendly and comfortable. Interactions with service users who did not engage in the recommended activities were often uncomfortable and difficult for both parties. These service users were not offered alternative options (including what they sometimes requested), but instead were often threatened with the withdrawal of services or an authoritarian approach to their non-compliance.

This finding highlights a key contradiction in the recovery approach as practised in services; service users are encouraged to be independent and autonomous but are only considered to be in recovery if their autonomy is exercised in line with certain professional ideals. This finding lends support to McWade's (2016) argument that recovery has been used by policy makers to silence service users voices and to support increasingly coercive practice.

The combination of a recovery approach with its focus on behaviour modification and responsibilisation, in the wider context of scarce staff resources, led to pressure on staff to achieve rapid behaviour change in service users. Staff had little time just to be with service users in their distress, which militated against the development of compassion, a key aspect of recovery. Although some staff described taking a person or client-centred approach, in reality the options for treatment were mainly medical or

behavioural, and service users' requests for alternative approaches or treatments were not generally granted due to a lack of availability of appropriate services or a lack of staff time. Humanistic options for treatment may offer a way in which truly person-centred approaches can be practiced. This would allow staff time to be with service users in their distress and remove pressure for quick outcomes, removing some stress from staff as well as offering service users what they believe would be helpful to them.

The study is unique in its approach to investigating recovery. In using ethnography and specifically, recorded observations of meetings between the staff and clients, the study was able to capture the complex lived reality of recovery practice. The approach taken to the analysis also appears to be unique in the literature on recovery in terms of its use of discursive psychology underpinned by a Foucauldian understanding of power. Although a number of studies of recovery in mental health have been informed by specific discourse analysis approaches (e.g. Ringer and Holen 2016; Waldemar et al. 2019; Jorgensen et al. 2020), this study builds on work in the field of counselling (Brownlie 2004; Miller and Silverman 1995) in using an eclectic approach to discourse analysis. The analysis draws on Foucauldian ideas whilst also using a discursive psychology analysis to uncover detail of how staff translate recovery discourses and attempt to induce recovery-aligned subjectivities in their clients.

The study contributes to the Governmentality literature by developing knowledge about how modern pastors translate discourses and induce particular subjectivities in their 'flocks'. It contributes to studies of actually existing neoliberalism (Brenner and Theodore 2002), in line with recent work that moves away from monolithic understandings of neoliberal rule (Higgins and Larner 2017). It shows that neoliberal rationalities of responsibilisation in mental health services are not translated easily into service user subjectivities but involve messy and incomplete processes, involving resistance and agency, contradiction, ambivalence and failure. The analysis avoids an automatic reading of processes and practices as neoliberal but instead is able to consider agency and practices of service users as well as professionals and to look at how these interact to facilitate or thwart the practice of recovery. The historical study of recovery is used alongside Hacking's (1996) idea of the looping effects of human kinds to explain the complexity involved in the processes of translation in mental

health services. This research identified that the use of a recovery discourse had led to the emerging new classifications of service users as engaging or non-engaging that had practical consequences for the service users so classified as well as for staff, who experienced stress as a consequence of their failure to engage service users. In line with these new classifications, recovery had become about engaging in recovery focussed activities rather than achieving improvements in quality of life. The findings illustrated a paradox in the recovery approach: that service user independence and control is considered to demonstrate recovery only when it conforms to professionals' views.

The study contributes to the literature on recovery by identifying in detail how practitioners successfully engender recovery in some service users and by also identifying some novel barriers to recovery that point to the importance of service user agency. A number of observations have been drawn from the analysis to inform mental health service delivery and develop research in this area.

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## Appendices

### Appendix 1: Staff participant information form



## **A study of the recovery approach in mental health services**

### Information for staff participants

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or

#### **Who is doing this research?**

I am carrying out this research for my PhD in Social Work at Cardiff University.

My research will be supervised by Dr Michael Arribas-Ayllon and Dr Steven Stanley and has been approved by the Cardiff University School of Social Sciences and an NHS Ethics Committee.

#### **What is recovery?**

Recovery is an approach developed by people who have mental health problems. It does not mean cure; it is about building a meaningful and

satisfying life whether or not there are ongoing symptoms of mental illness.

All mental health services in Wales are required to take a recovery approach although there is disagreement about the extent to which they are achieving this or are able to achieve this in the current policy and practice context. Also, there are lots of different versions of recovery, which can be confusing for staff and service users.

### **What is the purpose of this study?**

The aim of the research is to explore how service users and staff in mental health services talk about and do the recovery approach and how this is affected by other important perspectives in mental health, such as medical approaches and risk management. I will be observing staff and service users in three research sites in South Wales for four months at each site. I would also like to interview staff and service users and to look at care planning documents, such as care plans and case notes. I hope that increased knowledge of how people understand, talk about and do recovery will help in the debate about how mental health services should be run.

### **Who can take part?**

To take part in this research, you must be aged at least 18 years and be employed or volunteering in the research site organisation in a role, which involves supporting service users. In addition, the main issue for which you are giving support to service users must be mental health problems.

### **What would taking part involve?**

Taking part in this study would involve up to three things:

- 1) Being observed and sometimes audio-recorded during meetings with participating service users, staff team meetings and other activities at the research site over the next 12 months
- 2) Taking part in an interview about your experiences of working in this mental health service and your thoughts about the recovery approach
- 3) Agreeing for care planning documents to be seen and analysed by the researcher

I will attend some meetings with you and participating service users. I will observe you both, take notes and audio-record what you say. Later on, in the research project, I would like to interview you about your experience of working in this mental health service and your thoughts about recovery. Questions might include 'what does recovery mean to you?' and 'do you feel able to practise in a recovery-oriented way in your work?'. The interview will be very informal and might last from one to two hours, depending on how much you want to talk. I would like to audio-record the interview to make sure that I capture exactly what you say and don't miss any important details. Your interview will be arranged at a time to suit you in a comfortable and private location. I would also like to analyse care plans and related documents, such as case notes, which have been written during the time I am based at your organisation.

### **What are the possible disadvantages of taking part?**

It is possible that you might feel uncomfortable with someone observing you in meetings – if this happens, you can tell me not to observe you in

advance, or if the meeting has already started, you can ask me to leave and to delete any recording I have already made of the meeting.

In the interview, it is possible that you might become distressed when talking about your work with people with mental health problems. We can discuss in advance what you would like to do if you become upset in the interview, for example, you might choose to stop the interview, take a break or change the topic.

### **What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time just by letting me know (see below for contact details). After the interview or any meeting I have recorded, you can request to withdraw the information/recording without giving a reason, and I will do so without any disadvantage to you.

### **What if there is a problem?**

In the event that you wish to complain about any aspect of the study, please contact, in the first instance, Dr Michael Arribas-Ayllon (Tel: 02920-875390, [arribas-ayllonm@cardiff.ac.uk](mailto:arribas-ayllonm@cardiff.ac.uk)).

### **Will my taking part in this study be kept confidential?**

Yes, I will treat all information in this study in confidence. The audio-recordings of meetings and your interview will be stored securely under a password and any transcript will be stored securely without your name or other identifying details. The care plan documents will be accessed at the research site and will not be taken off the premises. Neither you nor any individuals or organisations you might mention in your interview will be identified in the report of the study or in any subsequent work based on

this research. Confidentiality may exceptionally be breached where legal or safeguarding requirements for disclosure occur. All data will be destroyed within five years of the end of the study in line with Cardiff University's clinical research data retention policy.

The transcripts of recordings will only be seen by me and possibly my supervisors, Dr Michael Arribas-Ayllon and Dr Steven Stanley.

### **What will happen to the results of the study?**

The findings will be published in a report for the purposes of my academic qualification. I will produce a summary report, which will be shared with participants, local mental health services and service user groups. The findings may also be published in academic journal articles or book chapters. The findings will be written up in a way that no individual participant can be identified.

### **Further research**

You have the option to allow your contributions to the research, including interview transcripts, transcripts of meetings and notes from observations, to be used for further research within five years after the end of the PhD study. If you choose to allow this, the information you have given will be used for further research about mental health issues. It will be kept confidential and will be reported anonymously as part of further research reports or articles. If you choose not to allow this, your information will only be used for the current study; your participation in the current study will not be affected.

### **Contact for further information**

If you would like to find out more, please contact Rachel Waters:

You can email me at: [WatersRL2@cardiff.ac.uk](mailto:WatersRL2@cardiff.ac.uk) or ring me on 0792-107-4440.

For independent advice about taking part in the research, you can contact Dr Tom Hall, head of the School of Social Sciences on 02920-876288 or email him at [hallta@cardiff.ac.uk](mailto:hallta@cardiff.ac.uk).

**Thank you for considering taking part in this study.**



## **A study of the recovery approach in mental health services**

### **Information for service user participants**

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or

#### **Who is doing this research?**

I am carrying out this research for my PhD in Social Work at Cardiff University. My research will be supervised by Dr Michael Arribas-Ayllon and Dr Steven Stanley and has been approved by the Cardiff University School of Social Sciences and an NHS Ethics Committee.

#### **What is recovery?**

Recovery is an approach developed by people who have mental health problems. It does not mean cure; it is about building a meaningful and satisfying life whether or not there are ongoing symptoms of mental illness. The key themes of recovery are:

- Taking control of life and illness
- Hope – pursuing hopes and dreams

- Building a meaningful, satisfying life

All mental health services in Wales are required to take a recovery approach, but there are lots of different versions of recovery, which can be confusing for you and staff working in mental health services.

### **What is the purpose of this study?**

The aim of the research is to explore how people who use mental health services and staff in those services talk about and do the recovery approach and how this is affected by other ways of working in mental health services, such as medical approaches and risk management.

I will be observing staff and service users in three mental health services in South Wales over a period of 12 months, 4 months at each service. I would also like to interview staff and service users and to look at documents, such as care plans and case notes. I hope that increased knowledge of how people understand, talk about and do recovery will help in the debate about how mental health services should be run.

### **Who can take part?**

To take part in this research, you must be experiencing mental health problems and be aged at least 18 years. You must be expecting to use this mental health service for at least 6 months, and the main reason for which you are receiving support must be because of your mental health problem.

### **What would taking part involve?**

Taking part in this study would involve three things:

- 1) Being observed and sometimes audio-recorded during some meetings with members of staff and during some activities connected to the research site over a period of 4 months



- 2) Being interviewed about your experiences of having a mental health problem and using this mental health service
- 3) Agreeing for your care plan documents and some case notes to be seen by the researcher

I will attend some meetings with you and staff from the service. I will observe you both, take notes and audio-record what you say.

Later on in the research, I would like to interview you about your experience of using this mental health service and of having a mental health problem. The interview will be very informal and might last from one to two hours, depending on how much you want to talk. Questions might include 'What does recovery mean to you?' and 'Do you feel you have experienced recovery?'. I would like to audio-record the interview to make sure that I capture exactly what you say and don't miss any important details. Your interview will be arranged at a time to suit you in a comfortable and private location.

I would also like to look at your care plan and related documents, such as notes about your care plan, which have been made during the time I am doing my research.

### **What are the possible disadvantages of taking part?**

It is possible that you might feel uncomfortable with someone observing you in meetings – if this happens, you can tell me not to observe you, or if the meeting has already started, you can ask me to leave and to delete any recording I have already made of the meeting.

In the interview, it is possible that you might become distressed when talking about your mental health problems and how they have affected your life. We can discuss in advance what you would like to do if you become upset in the interview, for example, you might choose to stop the interview, take a break or change the topic.

There might be very personal information in your care plan or case notes that you don't want me to see. In this case, you can decide which case

notes or documents I can see, or you can choose to remove sections before I see them.

### **What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time just by letting me know (see below for contact details). After the interview or any meeting I have recorded, you can request to withdraw the information you have given me without giving a reason, and I will do so without any disadvantage to you. If you decide not to take part or you withdraw at any point, this will not affect your current or future care.

### **What if there is a problem?**

In the event that you wish to complain about any aspect of the study, please contact, in the first instance, Dr Michael Arribas-Ayllon (Tel: 02920-875390, [arribas-ayllonm@cardiff.ac.uk](mailto:arribas-ayllonm@cardiff.ac.uk)).

### **Will my taking part in this study be kept confidential?**

Yes, I will treat all information in this study in confidence. The recordings of meetings and your interview will be stored securely under a password, and any transcript will be stored securely without your name or other identifying details. Your care plan documents will be accessed at the research site and will not be taken off the premises. Neither you nor any individuals or organisations you might mention in your interview will be identified in the report of the study or in any other work based on this research. Confidentiality may exceptionally be broken where this is required by law or if I am seriously worried about your or someone else's safety. All the information you give will be destroyed within five years of the end of the study in line with Cardiff University's clinical research data retention policy.

The transcripts of recordings will only be seen by me and possibly my supervisors, Dr Michael Arribas-Ayllon and Dr Steven Stanley.

### **What will happen to the results of the study?**

The findings will be published in a report for the purposes of my academic qualification. I will produce a summary report, which will be shared with

participants, local mental health services and service user groups. The findings may also be published in academic journal articles or book chapters. The findings will be written up in a way that no individual participant can be identified.

### **Further research**

You have the option to allow your contributions to the research, including interview transcripts, transcripts of meetings and notes from observations, to be used for further research within five years after the end of the PhD study. If you choose to allow this, the information you have given may be used for further research about mental health issues. It will be kept confidential and will be reported anonymously as part of further research reports or articles. If you choose not to allow this, your information will only be used for the current study; your participation in the current study will not be affected.

### **Contact for further information**

If you would like to find out more, please contact Rachel Waters:

You can email me at: [WatersRL2@cardiff.ac.uk](mailto:WatersRL2@cardiff.ac.uk) or call me on 07950-499179.

For independent advice about taking part in the research, you can contact Dr Tom Hall, head of the School of Social Sciences on 02920 876288 or email him at [hallta@cardiff.ac.uk](mailto:hallta@cardiff.ac.uk).

**Thank you for considering taking part in this study.**

## Appendix 3: Staff participant consent form



# A study of the recovery approach in mental health services

## Consent form for staff participants

*Please write your initials next to each statement to indicate that you agree with it.*

\*You may decide to take part in some aspects of the study but not others. For example, you can agree to be interviewed but not observed or recorded in meetings. Or you may agree to being recorded in an interview and meetings but not to having care planning documents looked at.

I have read the accompanying participant information sheet and have been given a copy to keep for reference .....

I have had the opportunity to ask questions about the study by email, telephone or in person before agreeing to take part .....

I understand that information I provide may be published as part of the project reporting but that the data collected will be made anonymous and my identity will not be disclosed (subject to legal and safeguarding exceptions) .....

\*I consent to being observed in meetings with service user participants .....

\*I consent to participate in an interview with the researcher .....

I agree to the meetings and/or interview being audio-recorded and

transcribed .....

\*I consent to the researcher having access to care plans and related documents I have written or co-written .....

I consent to being observed in some team meetings and in general activities at or related to the research site .....

I understand that I will be asked for consent again before each *recorded* observation or interview and that I can decide not to participate on that day .....

Having given this consent, I understand that I have the right to withdraw from the project at any time before the analysis is completed, without disadvantage to myself and without giving any reason .....

I understand that the recordings, transcripts and observation notes will be kept securely for 5 years in line with Cardiff University clinical research data retention policy. ....

I consent to the information I contribute being used for further research about mental health for up to 5 years after the PhD study has ended. I understand this is optional and will not affect my participation in the current study .....

**Name of participant..... Date .....**

**Signature of participant .....**

**Witnessed by**

**Name of participant..... Date .....**

**Signature of researcher.....**

## Appendix 4: Service user participant consent form



# A study of the recovery approach in mental health services

## Consent form for service user participants

*Please write your initials next to each statement to indicate that you agree with it.*

\*You may decide to take part in some aspects of the study but not others. For example, you can agree to be interviewed but not observed or recorded in meetings. Or you may agree to being recorded in an interview and meetings but not to having your care planning documents looked at.

I have read the accompanying participant information sheet and have been given a copy to keep for reference .....

I have had the opportunity to ask questions about the study by email, telephone or in person before agreeing to take part .....

I understand that information I provide may be published as part of the project reporting but that the data collected will be made anonymous and my identity will not be disclosed (unless required by law, or if myself or others are at risk of serious harm) .....

\*I consent to being observed in meetings with staff

participants .....

\*I consent to participate in an interview with the researcher .....

I agree to the meetings and interview being audio-recorded and  
transcribed .....

\*I consent to the researcher having access to my care plans and  
related documents .....

I consent to being observed in general activities at or related  
to the research site .....

I understand that I will be asked for consent again before each  
*recorded* observation or interview and that I can decide not  
to participate on that day .....

Having given this consent, I understand that I have the right to  
withdraw from the project at any time before the analysis is  
completed, without disadvantage to myself and without giving  
any reason .....

I understand that the recordings, transcripts and observation notes  
will be kept securely for 5 years in line with Cardiff University  
clinical research data retention policy .....

I consent to the information I contribute being used for further  
research about mental health for up to 5 years after the PhD study  
has ended. I understand this is optional and will not affect my  
participation in the current study .....

**Name of participant..... Date .....**

**Signature of participant .....**

**Witnessed by**

**Name of participant..... Date .....**

**Signature of researcher.....**



## Appendix 5: Exclusion and inclusion criteria

### **Participant Inclusion and Exclusion Criteria**

#### **Staff Participants**

##### **Participants can be included if:**

- They are over 18 years
- They are working (in a paid or voluntary capacity) at the research site organisation in a role which involves supporting service users, and expect to be working there for at least 6 months
- The main issue for which they are giving support is mental health problems\*

##### **Participants will be excluded if**

- They are under 18 years old.
- The main issue for which they are giving support is for substance misuse, learning disability, or any other issue which is not a mental health problem\*
- The participant cannot understand spoken English as the researcher does not have the resources to conduct the research in a language other than English. In line with the principles of the Welsh Language Act potential participants may request a copy of the participant information sheet and consent form in Welsh

#### **Service User Participants**

##### **Participants can be included if:**

- They are over 18 years

- They are being supported by the research site organisation and expect to be receiving support for at least 6 months
- The main issue for which they are receiving support is mental health problems\*
- They are happy *or* unhappy with the service they are receiving
- They are supportive *or* unsupportive of a recovery approach to mental health problems
- They are *or* are not considered to be in recovery or likely to experience recovery (either in their own or others' opinions)

**Participants will be excluded if:**

- They are under 18 years
- The main issue for which they are receiving support is for substance misuse, learning disability, or any other issue which is not a mental health problem\*
- The participant cannot understand spoken English as the researcher does not have the resources to conduct the research in a language other than English. In line with the principles of the Welsh Language Act potential participants may request a copy of the participant information sheet and consent form in Welsh
- One or more members of staff at the research site believe that taking part in the research would put the service user at risk of harm or worsen their mental health problem
- Either the service user, the researcher or one or more members of staff at the research site believe that the service user is incapable of giving informed consent at the start of the research

\*In this study a mental health problem includes depression, anxiety disorders, eating disorders, bi-polar disorder, personality disorder, schizophrenia or any psychotic disorder. It does not include dementia,

learning disability, substance misuse problem, ADHD or autistic spectrum disorders.

## Appendix 6: Interview guide for staff participants

### **The Recovery Approach: History and Current Practice.**

**Initials:**

**Interview Guide: Staff**

**Date:**

#### **Demographic Info**

Role in organisation

Length of time in this service/in this role in mental health

Qualification/experience (professional and/or lived experience)

If have lived experience is this a requirement of their role and are they open about it?

**1) What does recovery mean to you?**

**2) Have you heard of the recovery approach in mental health services?**

If yes – What do you think it means? Do you think it's a good approach? Why/why not?

If no – briefly explain main features of the approach (holistic, not symptom focussed, shift of power, appreciation of SU expertise, Su taking control)

**3) (if aware of recovery approach) Would you say you take a recovery focussed approach in your work in this mental health service?**

Examples of recovery focussed practice – why do they think it is recovery focussed?

If not – why? (Conscious decision, not possible, not considered it, try but don't think they are achieving it, doing it anyway - recovery just a new name for something previous.... )

**4) Are there any parts of your work which you feel are less recovery focussed?**

(might be certain task or certain su's or types of su) What do they think makes it less recovery focussed? Risk assessment?

**5) Can you tell me about how you do care planning?** (process, who takes responsibility, who writes it, is SU involved? Are clients interested?)

**6) Can you tell me about risk assessment?** (encourage to talk about how they do risk assessment, how they feel about risk assessment)

**7) Do you think it's possible for service users to 'manage' their mental health - do things to lessen the severity, frequency or impact of their mental health problems?**

What kind of things can people do to manage their mental health? (How) do they help?

(exercise, seeing friends, complimentary therapy, relaxation, mindfulness, hobbies, monitoring symptoms- diary keeping, nutrition, reducing stress)

If no – Can you tell me why you don't think it's possible for people to manage their mental health problems? What do you think can be done to help these people with their mental health problems?

**8) To what extent do you think service users should be expected to take responsibility for their own recovery?**

- 9) The recovery approach advocates shifting control from professionals to service users. Do you think this is a good idea?** How can this be done? Is there anything you do to try to give control to service users?
- 10) What do you think causes mental health problems (if anything)** (biological, genetic, social, childhood experiences, trauma , normal part of human experiences etc)
- 11) Views on biopsychosocial model?**
- 12) What do you think are the most helpful kinds of treatments or support?**  
(Kinds of clients or diagnoses suit different approaches? Why? How would this help? Link to cause?)
- 13) Is there anything else you would like to talk about or tell me?**

## Appendix 7: Interview guide for service user participants

**Initials:**

**Date/time**

### **The Recovery Approach: History and Current Practice.**

#### **Interview Guide: Service Users**

##### **Demographic Info**

Age

How long have they been receiving a service from this organisation?

How long have they been receiving support with mental health problems?

How long have they had mental health problems?

Diagnosis?

#### **14) What does recovery mean to you?**

(if you had experienced recovery what would your life be like?)

#### **15) Have you experienced any kind of recovery? Do you expect to?**

If yes – what constituted the recovery? How did it happen? Did anyone help with the recovery? Did they intend/try to recover or did it just happen?

If no – why do you think this (it doesn't exist/ won't happen for me etc)

#### **16) Have you heard of the recovery approach in mental health services?**

If yes – what have you heard about it? What do you think that means? Do you think it's a good approach? Why/why not?

If no – briefly explain main features of the approach (holistic, not symptom focussed, shift of power, appreciation of SU expertise, Su taking control/responsibility)

**17) (If they are aware of the approach) - Do you think this mental health service uses a recovery approach?**

What makes you think that? Explore what they are doing which makes it a recovery approach/not a recovery approach or a mix. (note which kind of profs they are talking about – e.g. Dr or SW or OT etc.)

**18) Do you feel that you have any control over the services you receive?**

(whether/what service they get, from who, what they have help with etc)

Explore who has control/ is there recognition of SU expertise, who do they feel is responsible for their recovery?)

**19) Do you think it's possible to 'manage' your mental health - that you can do things to lessen the severity, frequency or impact of your mental health problems?**

What things do you do to manage your mental health? (How) do they help?

(exercise, seeing friends, complimentary therapy, relaxation, mindfulness, hobbies, monitoring symptoms- diary keeping, nutrition, reducing stress)

If no – Can you tell me why you don't think it's possible to manage your mental health problems? What do you think can be done to help with your mental health problems?



**20) Can you tell me about your care and support plan?** (do you know what's in it?

Did you write it? - who wrote it? Are you happy with what's in it?)

**21) What do you think has caused your mental health problems (if anything)**

(biological, genetic, social, childhood experiences, trauma etc)

**22) What do you think would be the most helpful kind of treatment or support?**

How would this help? Why would this be the most helpful?

**23) Is there anything else you would like to talk about or tell me?**

## Appendix 8: Letter of favourable opinion from the research ethics committee



Gwasanaeth Moeseg Ymchwil  
Research Ethics Service



Pwyllgor Moeseg Ymchwil Cymru 5  
Wales Research Ethics Committee 5  
Bangor

Clinical Academic Office  
Ysbyty Gwynedd Hospital  
Betsi Cadwaladr University Health Board  
Bangor, Gwynedd  
LL57 2PW

Telephone/ Facsimile: 01248 - 384.877  
Email: [rossela.roberts@wales.nhs.uk](mailto:rossela.roberts@wales.nhs.uk)

18 August 2017

Ms. Rachel Waters  
19 Riverside Terrace  
Machen  
Caerphilly  
CF838NE

[WatersRL2@cardiff.ac.uk](mailto:WatersRL2@cardiff.ac.uk)

Dear Ms. Waters,

**Study title:** The recovery approach in mental health services:  
history and current practice  
**REC reference:** 17/WA/0250  
**Protocol number:** SPON1603-17  
**IRAS project ID:** 230786

The Research Ethics Committee reviewed the above application at the meeting held on 17 August 2017. Thank you for attending in teleconference to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net) outlining the reasons for your request.

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

### Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

### Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

#### Amendments to the Participant Information Sheet

1. In section "What happens if I do not want to carry on with the study" please include an explanation that a decision to not take part or withdraw later will not affect their current or future care.
2. In paragraph "What if there is a problem", in sentence "In the unlikely event [...]" the word "unlikely" should be removed.
3. Please list an independent contact point for complaints about the study; for projects sponsored by the University, this is usually the Head of School or the Head of Doctoral School.

The Committee also recommended that the word "service user" which appears very often is replaced with "you" - but this is a recommendation only, not a condition of the favourable ethical opinion.

**You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

#### Management permission must be obtained from each host organisation prior to the start of the study at the site concerned

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

#### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

##### *NHS Sites*

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### **Summary of discussion at the meeting**

**Ethical issues raised by the Committee in private discussion, together with responses given by you when invited to join the meeting in teleconference**

The Chair welcomed you and introduced the Committee members.  
The following issues were discussed:

##### Social or scientific value; scientific design and conduct of the study

The Committee concluded that the research question was highly appropriate: exploring current practices of recovery in mental health services in South Wales has the potential to inform policy development and practice.

The Committee discussed whether the design and methodology makes use of accepted scientific principles and methods to produce reliable and valid data.

The Committee queried whether there is bias in the study, as it is only looking at services that already implemented the recovery model and no data is being gathered from services where this has not been implemented due to challenges that the service might have identified.

You clarified that the policy aim is to use a recovery model approach throughout the service and the objective of the project is to establish how the recovery model is put into practice and what impact do other laws and regulations affecting mental health practice have on the implementation of this model. The Committee concluded that the conduct of the study is appropriately described in the protocol, the study design robust and the proposed analysis adequate to answer the research question.

##### *Public Involvement*

The Committee noted that service users will be involved in reviewing the research documents including the information sheets and consent form for service user participants. Service users and staff at the research sites will be involved in planning and undertaking local dissemination of the findings.

##### Recruitment arrangements and access to health information; fair participant selection

The Committee discussed the recruitment method and queried whether the project will have unreasonable impact on staff time.

You clarified that the interviews will require approximately one hour of staff time and they can choose not to take part in the interview if it is felt that their workload will suffer.

The Committee was satisfied that participants will be recruited fairly and sufficient details are provided in the protocol regarding the inclusion and exclusion criteria.

##### Informed Consent process and the adequacy and completeness of participant information

The Committee agreed that the procedures described in the protocol have been adequately addressed in the Information Sheet, but felt that minor amendments should be made to ensure that individuals understand the information and can make a voluntary informed decision to enrol and continue to participate.

Section "What happens if I do not want to carry on with the study" should explain that a decision to not take part or withdraw later will not affect their current or future care.

In paragraph "What if there is a problem", the sentence "in the unlikely event" may be construed as condescending, and the Committee recommended removing the word "unlikely"

An independent contact point should be listed for complaints about the study.

The Committee noted that the word "service user" appears very often and recommended that this is replaced with "you".

#### Suitability of supporting information

The Committee discussed the suitability of the supporting information and enquired whether it is envisaged to inform the GP or other professionals with clinical accountability for participants. You clarified that in most cases the service user will be living at the site and staff will be aware of the project. CMHT staff are also aware of the study, as they will be invited to take part.

The Chairman thanked you for your availability to speak to this submission and gave you an opportunity to ask questions. You did not raise any issues.

The Chairman confirmed that the Committee will deliberate and will be in touch shortly.

The teleconference was terminated.

#### **Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.**

No ethical issues were raised in relation to:

- Favourable risk benefit ratio; anticipated benefit/risks for research participants
- Care and protection of research participants; respect for participants' welfare and dignity; data protection and confidentiality
- Suitability of the applicant and supporting staff
- Independent review
- Other study procedures
- Other general comments missing information/ typographical errors/ application errors/
- Suitability of the study summary

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

#### **Approved documents**

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Cover Letter]	1	14 July 2017
REC Application Form [REC_Form_17072017]	-	17 July 2017
Research protocol or project proposal	1	29 June 2017
Participant information sheet (PIS) [Staff participant information sheet]	1	29 June 2017
Participant information sheet (PIS) [Service user participant information sheet]	1	29 June 2017
Participant consent form [Staff participant consent form]	1	29 June 2017
Participant consent form [Service user consent form]	1	29 June 2017
Other [Participant inclusion and exclusion criteria]	1	29 June 2017
Letter from sponsor [letter of sponsorship]	1	06 June 2017



Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	-	18 July 2016
Summary CV for Chief Investigator (CI) [Rachel Waters CV]	-	-
Summary CV for supervisor (student research) [Dr. Ayllon CV]	-	-

### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

No declarations of interest were made in relation to this application.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

### HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

17/WA/0250	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely

**Dr Philip Wayman White, MBChB, MRSM**  
Chair

E-mail: [rossela.roberts@wales.nhs.uk](mailto:rossela.roberts@wales.nhs.uk)

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments*

*"After ethical review – guidance for researchers"*



SL-AR2 After ethical  
review - research oth

Copy:	Sponsor:	Helen Falconer Cardiff University <a href="mailto:FalconerHE@cardiff.ac.uk">FalconerHE@cardiff.ac.uk</a>
	R&D Office:	Professor Sue Bale Aneurin Bevan Health Board <a href="mailto:sue.bale@wales.nhs.uk">sue.bale@wales.nhs.uk</a>
	Academic Supervisor:	Dr. Michael Arribas-Ayllon Cardiff University <a href="mailto:arribas-ayllonm@cardiff.ac.uk">arribas-ayllonm@cardiff.ac.uk</a>  Dr. Steven Stanley Cardiff University <a href="mailto:stanleys1@cardiff.ac.uk">stanleys1@cardiff.ac.uk</a>

## Wales Research Ethics Committee 5

### Attendance at Committee meeting on 17 August 2017

#### Committee Members

<i>Name</i>	<i>Profession</i>	<i>Capacity</i>	<i>Present</i>
Dr Karen BE Addy	Clinical Psychologist	Expert	Yes
Dr Swapna Alexander	Consultant Physician	Expert	Yes
Mrs Kathryn Chester	Research Nurse	Expert	No
Ms Geraldine Jenson	Retired College Vice-Principal	Lay +	Yes
Mr David Rhys Jones	Retired Teacher	Lay +	Yes
Mr Eliezer Lichtenstein	Student	Lay +	No
Dr Mark G Lord	Consultant Pathologist	Expert	No
Dr Pamela A Martin-Forbes	NISCHR Research Officer	Expert	Yes
Dr Paul G Mullins	Reader, MRI Physicist	Lay +	Yes
Mr Vishwanath Puranik	Associate Specialist ENT Surgeon	Expert	No
Mrs Lynn C Roberts	Matron, Emergency Department	Expert	Yes
Dr Judith L Roberts	Research Officer	Expert	Yes
Dr Jason D Walker	Consultant Anaesthetist (Vice-Chairman)	Expert	No
Dr Philip W White	General Practitioner (Chairman)	Expert	Yes
Ms Sydna A Williams	Lecturer	Lay +	Yes

#### In attendance

<i>Name</i>	<i>Position (or reason for attending)</i>
Dr Rossela Roberts	RES Manager



## Appendix 9: Full transcript of meeting between Aiden and Ben

FILE: Site 2 28.6.18 mtg Aiden and Ben LENGTH: 51:07

Key:

A – Service User  
B – Support Worker  
R – Researcher

- 1 B: So, you've got... you've got no sort of plans to go back there?
- 2 A: No, I was just saying to everyone, if I do go down there, it's not going to be  
3 to the two places there that I went to. If I go to [county], I'll probably go to  
4 [town]...
- 5 B: Yeah.
- 6 A: ...or just like... [town], or something like that, but...
- 7 B: [town's] a nice place.
- 8 A: Yeah. Just *not* (*inaudible – 00.29*)
- 9 B: That's where I'm from! [Chuckles]
- 10 R: Oh!
- 11 A: Yeah, just...[town], and [town], I can't go there (*inaudible, muffled – 00.34*)
- 12 B: Yeah. Do you know anybody in [town]?
- 13 A: My mate Dave<sup>1</sup> lives down there...
- 14 B: Yeah
- 15 A: ...and what I'm... what I'm thinking is... because I thought I was like  
16 probably going to get myself in a place that (*inaudible – 00.46*) exactly the  
17 same as... like it's about to take off.
- 18 B: Yeah, it's a bit weary, isn't it? So, because you spent a lot of money on this  
19 trip, didn't you? Like you said you spent... it was £99 for that ticket?

---

<sup>1</sup> All names are pseudonyms

20 A: Yeah, £99 to get back, yesterday...

21 R: Oh!

22 A: ...so, I was going to... it was going to be £30 but I couldn't get the tickets  
23 on time because my mate kicked me out at like...

24 B: Didn't you get a return, when you bought your ticket?

25 A: Because I didn't know... I didn't know when I was coming back, I was like..

26 B: Oh, so you just bought a single?

27 A: Mm.

28 B: So, how much was the single?

29 A: What, down there?

30 B: Yeah.

31 A: The single down there cost about £30.

32 B: Oh, wow!

33 A: So, on the way back, it would have cost me £12... oh, no... obviously  
34 *(inaudible – 01.38)*

35 B: Because it was erm... something we discussed last time... are you sure  
36 you're ok about...

37 A: Yeah.

38 B: Yeah? Just like...

39 A: Yeah, just... don't worry about it!

40 B: [Laughs] Something we discussed last time was about budgeting, and  
41 that's... so, I've brought some forms for us to really start looking at putting  
42 things onto paper.

43 A: Yeah, I mean, erm... Pam said what *(inaudible – 2.07)* basically, she was  
44 going like that *(inaudible, muffled and music over – 02.09)* this week...

45 B: Mm.

46 A: So, I'm going to get a new PlayStation (*?? or an X-Box – 02.11*) because  
 47 I've realised I can survive on like the money from Universal Credit, including  
 48 the Housing Benefit come out...

49 B: Yeah.

50 A: ...erm... not Housing Benefit, Service charges come out, I can actually still  
 51 survive on that money, it's just... food, really, that I need to get.

52 B: Mm.

53 A: And... because I was like thinking of opening up a savings account...

54 B: Yeah.

55 A: ...and putting money away every month, so say put £100 away every  
 56 month.

57 B: Do you know why it's a good idea to budget? Do you know... have you...?

58 A: I guess... save the money, I guess (*inaudible, muffled – 02.48*) I actually  
 59 don't...

60 B: No?

61 A: You see, I've always *tried* to budget, but I've never been able to.

62 B: Yeah. Why do you think you haven't been able to budget? You don't mind  
 63 me asking these questions, do you?

64 A: Well...

65 B: It's just getting me... understanding it better.

66 A: What was that question again? I completely lost what the question was,  
 67 then.

68 B: Well, it was just a question around why do you think it's a good idea to  
 69 budget, but you said you did *try* and budget, but...?

70 A: I can't stick to (*inaudible – 03.22*)

71 B: You can't stick to it, yeah. But... and I think my question was...

72 A: I do *try*... I do try to stick it...

73 B: Yeah.

---

74 A: But any... I'm walking down town and that, and I look around, I'm like 'Ooh!  
75 I've got some money for that'.

76 B: Yeah.

77 A: Or I'm pretty sure I've got it... because most of the time it's like I've got food  
78 money, and I'm like 'Ooh! Ah, I could knock off that if I have a... out of my food  
79 money'.

80 B: Yeah, yeah.

81 A: And then it'll be a tenner out of my food money, and just go (*inaudible* –  
82 03.49)

83 B: Yeah, yeah. Yeah. Because though... from what I understand in the... of  
84 budgeting, is about looking to your future. Because you obviously can't stay  
85 here...

86 A: Yeah.

87 B: ... you know... for ever...

88 A: Yeah, that's why I'm thinking of putting some money away, as well.

89 B: Yeah. Erm... yeah, looking to your future, and... so, you've got money and  
90 not – like you said – I think you said a couple of minutes ago here – you said,  
91 'you can survive' on... but... like 'living' isn't about 'surviving'.

92 A: Yeah, I mean like... I can spend like all my everyday needs, I could  
93 spend... I think it's like £170 for my everyday needs for a month.

94 B: Yeah. So, you've sort of *thought* about it – you've got some sort of figure in  
95 your head that you can live on, then?

96 A: Yeah. And that's with my service charges going out...

97 B: Yeah, yeah.

98 A: ...as well – that's out of my Universal Credit, and that'll be an extra (??  
99 £220 – 04.47)

100 B: Yeah.

101 A: So, I'm like... like I say, I think I've got £100 every month from PIP – my  
102 PIP money – into a savings account, (*inaudible* – 04.58) saving that.

103 B: Do you *have* a bank account?

104 **A:** Yes.

105 **B:** Have you set up a standing order to pay your rent?

106 **A:** Yeah. That was the first thing I had to do...

107 **B:** Yeah.

108 **A:** ...I had to do that, otherwise I wouldn't have been able to... erm...

109 **B:** Yeah, I wasn't sure...

110 **A:** ...I would be in like *(inaudible – 05.17)* if I didn't.

111 **B:** Yeah, yeah. Yeah. So, you've got a standing order. Is it a... do you put the

112 basic in, the... do you pay the £17...?

113 **A:** I know it's like £17.60... or £17.73 or something, but I put in like... a bit

114 more, now...

115 **B:** Ah, for *(?? saving – 05.30)*

116 **A:** ...because it... because... erm... well... I've got the *old* rates that are going

117 in...

118 **B:** Yeah.

119 **A:** ...which were... was a lot more. Which was a bit more.

120 **B:** It was £17.60 I think, wasn't it?

121 **A:** Yeah, it was like £17.60 and now it's like *(inaudible – 05.48)* I think it's

122 actually £16, or *(inaudible, muffled – 05.51)*

123 **B:** So, do you put more in, then?

124 **A:** Yeah, because of that change, I thought I'm not going down there and I'm

125 not going to change it, because I... I don't really need to *(inaudible – 06.00)*

126 **B:** Ok. So, you pay enough to... well, obviously to cover your rent, so you...

127 erm... because something that other people might sort of do, is they pay their

128 rent and they pay a slightly... a little bit more?

129 **A:** Yeah, I know, I mean, I still need to do my excess *(?? service – 06.19)*

130 charges that I need to pay off.

131 **B:** Yeah, no, I mean... so, you've got arrears, then?

132 A: I think it's just *(inaudible, muffled – 06.28)*

133 R: Is there any way we could turn the music down a little bit? I'm just a bit  
134 worried... we might not be able to hear *(inaudible – 06.36)*

135 A: Yeah, *(inaudible – 06.36)*

136 R: *(Inaudible – 06.37)* I don't want to get home and then find that I can't hear  
137 anything except that music!

138 B: [Laughs]

139 R: It should be fine, but...

140 [Music volume is turned down]  
(break in transcript – service user has left the room)

141 B: What's that, mate?

142 A: *(?? I'm looking – 08.43)* for my phone charger.

143 B: *(Inaudible – 08.45)* put some juice in it, yeah?

144 A: Yeah. For some reason... didn't charge my *phone (inaudible, muffled –*  
145 *08.50)* so... there we go.

146 B: [Laughs] That's a long lead! Is that for your PlayStation thing, is it?

147 A: Yeah. *(?? This one now – 09.11)* doesn't reach.

148 B: Yeah! [Laughs] So, you've got... you've got rent arrears, but you're paying  
149 a little bit extra, to pay them off?

150 A: Yeah, because I mean I...

151 B: Is that what the plan is, yeah?

152 A: I... I... yeah, I will pay a little bit extra, whenever I can.

153 B: No, that... that's fair enough – as long as you're paying your rent, you're  
154 paying a little bit extra, I think... I can just mention that to Sarah... does Sarah  
155 know that's what the plan is?

156 A: Yeah.

157 B: Yeah? Oh, that's fair enough. Because I think you were like about £120 in  
158 arrears, I think.

159 **A:** Oh, yeah. So, it's... probably because it... erm... yeah, I think it might have  
 160 been like a *(?? cheque – 09.47)* about 2 weeks ago, or so, but I got paid last  
 161 week. So, it should have gone out by...

162 **B:** Ok. But you've got a standing order set up...

163 **A:** Yeah.

164 **B:** ...to pay your rent? Ok. [Pause from 09.56 to 10.10] So, with... erm... with  
 165 budgeting, erm... yeah, so it's sort of a ... you know... looking to your future,  
 166 and not 'surviving', having enough money to live on. And then getting into that  
 167 mindset of erm... how much money you've got coming in, and how much  
 168 money you've got going out.

169 **A:** I know the exact amount...

170 **B:** ...so you know...

171 **A:** ...of my Universal Credit.

172 **B:** Sorry?

173 **A:** I know the exact amount of my Universal Credit...

174 **B:** Yeah, yeah-yeah. Yeah. So, erm... do you want... do you want to have a  
 175 look at this; it's just a budgeting form... erm... it can be adapted, and I guess  
 176 this is just for us to look at and to work to. So, you've got... well, you can rub  
 177 out 'partner' because you're on your tod.

178 **A:** [Giggles] Togs!

179 **B:** So, you're looking at... erm... yourself, and you're looking at your income,  
 180 you've got erm... I don't know, is this up to date? You've got 'benefits, child' –  
 181 you don't get Child Benefit.

182 **A:** No.

183 **B:** Income Support – that's an old... I think that should say 'ESA' instead of  
 184 *(inaudible, over-talking – 11.21)*

185 **A:** Yeah, ESA. No, because there's DLA on there, as well.

186 **B:** Yeah.

187 **A:** Disability Living Allowance – that is ESA.

188 **B:** Right. Yeah. So... and you've got... and PIP – PIP's not on there, is it?

189 A: No.  
190 B: You *do* get PIP, though, don't you?  
191 A: Yeah.  
192 B: Yeah. So, you just get ESA and PIP?  
193 A: I get Universal Credit and PIP.  
194 B: Yeah.  
195 A: Universal Credit is quite new though... well, actually, no, it's not – it's been  
196 out for a couple of years, now.  
197 B: Yeah.  
198 A: Since I was 18... 3 years.  
199 B: Ok. So, how much... how much ESA do you get...  
200 A: Erm... Universal.  
201 B: ...a month?  
202 A: I get £251.77.  
203 B: [Laughs]  
204 A: Like I said, I know it all, to the dot!  
205 B: [Laughs] And your PIP?  
206 A: Actually, I think I get £230, now – I thought I got £220, but I looked at my  
207 bank...  
208 B: Yeah.  
209 A: ...and I got paid for my PIP, and it said £230, and I was like that (*inaudible*  
210 *– 12.12*)  
211 B: £230? Right, ok. Is it *exactly* £230?  
212 A: Yeah (*inaudible, over-talking – 12.18*)  
213 B: Or is it any pennies?  
214 A: I think like a couple of pence, I think – I'm not entirely sure...



215 B: Mm. Ok.

216 A: ...but that's my... that's all (*inaudible, muffled – 12.26*) so...

217 B: Ok. So, on your... on that side of the sheet, then, it's got your outgoings.

218 So, it's got... it's got 'rent', and I think 'rent' covers *everything* here, doesn't it?

219 It covers all your heating, gas, electric...

220 A: My service charges – that's what the gas and electric and all the (*?? others*

221 *– 12.51*)

222 B: Yeah. So, it covers *everything*, doesn't it?

223 A: Yeah. It's £80... I've got rent coming out with... erm ... you know... Housing

224 Benefit.

225 B: So, how much... so, you pay your rent – about £17 rent?

226 A: I pay rough... roughly, I'm like... I always work it out that I pay £80.

227 B: Eighty?

228 A: Well, I always round it up to the biggest number...

229 B: Ok.

230 A: I say 'Right, £80 is coming out'...

231 B: Ok. So that's per month, yeah?

232 A: Yeah, it's roughly £80 coming out per month, with my service charges.

233 B: So, that's £20 a week. And that covers... well, there's no mortgage – you

234 don't pay Council Tax, do you?

235 A: No.

236 B: Mm. Water – you don't pay water?

237 A: I pretty much don't pay *any* of these.

238 B: No. Service charge... house... you don't pay house repairs... I don't

239 know... this is a... quite a strange list.

240 A: Well (*inaudible, muffled – 13.44*) going down to more what...

241 B: Life insurance, buildings... you don't pay gas/electric?

242 A: No, it's covered in the service charges.

243 B: Yeah. Fuel?

244 A: No.

245 B: Right. 'Housekeeping' erm...

246 R: Does that mean food?

247 A: Yeah.

248 B: Yeah, Housekeeping and... erm... your... erm... cleaning – you don't pay  
 249 for cleaning either though, do you? The cleaning products. So, food... erm...  
 250 how much, roughly, do you think you spend on food, per week?

251 A: Oh... I roughly spend about £50 a month.

252 B: £50 a month? Ok, so that's about... erm... erm... can we round it off to  
 253 £60? £15 a week?

254 A: So, it's usually between £50 and £80...

255 B: Ok.

256 A: So, we'll do it like £80.

257 B: So, that's £20 a week.

258 A: Yeah.

259 B: Ok. So, with your food, erm... are you... are you still interested in having  
 260 support with that? Because I think, looking back, it had 'support with...  
 261 planning'?

262 A: Yeah, I mean, even down in [town], I actually went in and spent £30 on...  
 263 kebab, because I was *really*, really hungry.

264 B: Yeah.

265 A: So, I was like 'Oh, I'll get a kebab'...

266 B: Yeah.

267 A: And I thought to myself 'Well, both my mates are here – I don't want them  
 268 to... look at me not eating – look at me eating, while they're not' – so, I was  
 269 like that, and like 'I'll buy everyone a kebab'.

270 B: Yeah.

271 A: They all ate theirs – both of them – I ate a quarter of mine.

272 B: [Laughs]

273 A: I ate a quarter of mine – and I was *really*, really hungry, I was like I hadn't

274 eaten all day – so, I was wondering what was wrong with me and like

275 *(inaudible, muffled – 15.29)* actually I do want that kebab *(inaudible – 15.32)*

276 B: Yeah. Starving, are you?

277 A: Yeah. Well *(inaudible, over-talking – 15.34)*

278 B: *(Inaudible, over-talking – 15.34)*

279 A: I went out yesterday, when I went to go to sort out my internet banking, and

280 I went and got stuff for like... paella.

281 B: Yeah.

282 A: Like a chorizo and Quorn paella.

283 B: Yeah. Well, this is one of the good ideas that... the... I... good ideas about

284 budgeting, yeah? So, you can budget, and you can save for... like ... you

285 know... going away, and treats and ... you know... like you said, you want to

286 buy stuff. So... so, you've got a pot of money, and you know that's not going to

287 impact on the rest of your stuff, like your rent and your food, and... things like

288 that.

289 A: Yeah.

290 B: So, you... do you know, that's sort of the idea of it. So, if you *want* to buy 6

291 kebabs, you can look at how much you've saved then you can go and buy 6

292 kebabs, you know?

293 A: Yeah. I mean...

294 B: And it won't affect you for the rest of the month, do you know?

295 A: Yeah, I mean, I only bought it because I left my card round my mates, so I

296 couldn't go in and get... like enough... I... but I still had the pictures of my card

297 in my phone, and I was like that, right? Booked it, and put them down on my

298 arm and downloaded that 'Just Eat' app, and I just ordered from that

299 B: Yeah. It's so easy these days, isn't it?

300 R: Mm.

301 A: I literally just... I had to do that... I had to jot it down and then (*inaudible –*  
302 *16.46*)

303 B: Yeah.

304 A: I was like 'Right...' and went to my phone, and just started frickin'... I was  
305 just glad about that, because I would have hated it if I hadn't had anything to  
306 eat that night.

307 B: Yeah, yeah.

308 A: Or it would have been even worse.

309 B: So, thinking about what... whilst you're here, so... do you... still want  
310 support with like menu planning, and maybe... erm... what about cooking? I'm  
311 not sure...

312 A: I'm fine with cooking.

313 B: Yeah. What about cooking... sort of like cheese and potato pie or  
314 something, you... could you do that, yeah?

315 A: Mm.

316 B: A lot of those basic...

317 A: Yeah.

318 B: Yeah? Ok. So, it's mainly maybe menu planning?

319 A: Yeah, that's...

320 B: So... are we going that far?

321 A: Just to...

322 B: Well, so... you could sort of like plan your...

323 A: I guess it's like the type of foods that I get, because...

324 B: Right?

325 A: ...most of the time, I'll (*?? Look online – 17.41*) but... but I get something  
326 that's really (*?? cheap – 17.44*) I'll look and go 'Ooh, that's a nice one there,  
327 and I can get that but it's a bit more expensive then...

328 B: Yeah.

329 A: ...rest of the money for some other stuff, and like (*inaudible – 17.51*) 'Oh, I  
 330 can just get (*?? rid of the stuff – 17.52*) and get something a bit more  
 331 expensive'.

332 B: Yeah, but this... this... this menu... this budgeting, can... can change. So,  
 333 if you find you want to spend more money on food, then we can change that.

334 A: Yeah.

335 B: And maybe look at taking that money off somewhere else, do you know?  
 336 So, if you find you want to buy some exotic stuff ... you know...

337 A: Yeah, I mean...

338 B: ...and cook things like...

339 A: ...I mean, the stuff for a Paella, that I bought last night, I mean the truth is I  
 340 was surprised how... I was just surprised at how cheap it all came to.

341 B: Yeah.

342 A: I mean, I looked for Paella rice, and I was like 'that' – looking around – I  
 343 could not see... I can't even see one bag of paella rice, and I was like 'that's  
 344 £1.20' right...

345 B: Yeah.

346 A: I thought to myself 'Is there anything cheaper?'

347 B: Mm.

348 A: Which (*inaudible – 18.35*) there wasn't, and I was like 'Oh, I'll have to work  
 349 with it'.

350 B: Well I guess it's about trying different things – trying out things that you do  
 351 enjoy eating.

352 A: Yeah, I mean, I haven't made paella before, so this is going to be a first  
 353 thing, and I'm going to be like 'Right...'

354 B: You'll have to let me know how it goes! [Laughs]

355 A: Well I was like (*inaudible – 18.50*) I said to like Pam – and they're going to  
 356 have some as well, because there's going to be a *lot* of paella! [Laughs]

357 R: You're making me hungry, now! I'm starving!

358 B: I know! [Laughs]

359 R: [Laughs] I'm thinking 'Oh, fried rice!'

360 B: Yeah 'Get home!' [Laughs] So, are you... so, just to recap, are you sort of  
 361 saying that you want support with menu planning, yeah, so you... we can...  
 362 we can sort of... plan your menus for the week, and then off that, then, comes  
 363 your shopping list.

364 A: Yeah.

365 B: Does that sound like a plan?

366 A: Yeah.

367 B: Ok. [Pause from 19.19 to 19.29]  
 (break in transcript as bank details are discussed)

368 B: Just go on there. So, right...

369 A: No, (*?? It's unavailable – 22.06*) £198.54, but (*inaudible – 22.13*)

370 B: *Oh, no way!* Is that all you've got? Till *next* month? £3?

371 A: Well, as you know, Pam has given me £60 for the PlayStation, so I'm going  
 372 to be able to buy more food and everything.

373 B: Ok.

374 A: So...

375 B: Mm. So, you've got money for the month, then? Ok. Erm... you don't pay  
 376 any TV License?

377 A: No.

378 B: Any TV rental... what about public transport?

379 A: I don't really go out that much (*inaudible – 22.55*)

380 B: Do you want to... do you want to put some money away for... just in case  
 381 you need to go to like [town] or [town]? So... like £2 a week?

382 A: Mm.

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383 B: Yeah? So, you've got... you know you've got money there, for... if... if you  
384 want to catch a bus?

385 A: Yeah. (*Inaudible, muffled – 23.14*)

386 B: I should have *looked* at this... thing.

387 A: I (*inaudible – 23.19*) the first time I had to pay for my rent – I've got in, now.

388 B: Go on then...

389 A: £73.08.

390 B: Ok. So, that's...

391 A: That's... erm...

392 B: £73.08. Ok. Erm... mobile phone?

393 A: Erm... that would be... I can (*inaudible – 23.41*) tell you (*?? what all them*  
394 *are – 23.41*) Erm... £15.60, but I think... well, I think it's main actual thing is  
395 about £15, or £14.99 – it's only £15.60 is because my billing date is on a weird  
396 date...

397 B: Mm.

398 A: ...so, I go a couple of days without it, and of course it's... a contract, so...

399 B: Ok.

400 A: ... I go into (*inaudible – 24.08*) per... on top of that.

401 B: Ok. And that's per month?

402 A: Yeah.

403 B: Do you go for newspapers?

404 A: Nope.

405 B: Magazines, anything like that? Erm... clothing.

406 A: I do need to get some new clothes, so I'm (*inaudible, muffled – 24.38*)

407 B: What... people usually... sometimes do, is they save about £15 a month for  
408 clothing...

409 A: Yeah.

410 B: Yeah? And then... like after a couple of months, then, you know you've got  
 411 like x-amount of money, you can go and buy some clothes, so you've ... you  
 412 know... you know you've got that money.

413 A: Yeah.

414 B: Is that ok?

415 A: Yeah.

416 B: I should have got a different list, I think. Have you got any... any... erm...  
 417 arrears, or anything like that, that you...?

418 A: Oh, I've just... just seen, I do have another account. I have 2 accounts.

419 B: What, bank accounts?

420 A: Oh, like a... a savings account, but I haven't got a card for it.

421 B: Can you transfer one to the other?

422 A: That's what it says here. 'Please access (inaudible – 25.26)' Yeah, it just  
 423 says here 'move money'. To... yeah, you can move it (inaudible – 25.37)  
 424 transfer.

425 B: Mm. Have you got any money in it, or...?

426 A: No, I've got nothing in there (inaudible – 25.44)

427 B: So, you... you've got... erm... you've got a 'bills' account and a savings  
 428 account, is that right?

429 A: Yeah, I've got a... my normal account – debit card...

430 B: Yeah.

431 A: ...and I've got an 'Easy Saver'?

432 B: Ok. Well that's... that's handy.

433 A: Yeah, I didn't even know I had that – but that's good.

434 B: For real, huh? So, erm... you could look at... and you could transfer  
 435 money?

436 A: Yeah, I can transfer money (inaudible, over-talking- 26.10)

437 B: Yeah, back and forth, yeah.



438 **A:** Makes it easier than ringing them up.

439 **B:** Yeah. So, you... you can actually... you could have one account for all your  
 440 essential bills, and then you could have another account, maybe for... erm...  
 441 erm...

442 **A:** See, because I've decided to get a passport and everything...

443 **B:** You need to get a passport? You could put that on the list, to save for?

444 **A:** Yeah.

445 **B:** Yeah?

446 **A:** That's the main thing I want to do, is save up for a passport, so I've got  
 447 some 1) that I've got a form of ID, and 2) my Nan said she was going to pay  
 448 for my flight over to [place] to go and see her.

449 **B:** Right, Ok. When? When are you thinking about doing that?

450 **A:** I need to get it sorted out, first! [Laughs]

451 **B:** Yeah, ok. So, you want to save for a holiday?

452 **A:** Not yet, no. Because my Nan's going to pay for my ticket over there.

453 **B:** Yeah, but you're going to need some money whilst your over there.

454 **A:** Yeah, but that's what I'd save up for, it's just something... to go over there  
 455 with.

456 **B:** Yeah, spending money. So, you... ok – that's something to look forward to,  
 457 isn't it? Do you have any... erm... any debts, or anything like that, apart from  
 458 your rent?

459 **A:** Not as far as I remember, no.

460 **B:** No. Any... anything lurking?

461 **A:** Well if I did, I probably would have like have... a letter through the door  
 462 about it.

463 **B:** Yeah, you haven't got any... you don't get letters, do you, people chasing  
 464 you for money or anything like that, no? You don't pay for furniture, do you?  
 465 Because this is... this is one of the things that other people do; you know, with  
 466 like, your rent? Some people pay like an extra £10, £11, £12 - £15 per  
 467 month...

468 A: Yeah...

469 B: ...and then they... they're sort of like a savings thing, because ... you  
 470 know... when you move out, you have to have a bond, and you have to get  
 471 stuff – furniture and all that – because you ... you know...

472 A: Yeah, that's what I might do – I might actually just save some money  
 473 *(inaudible, over-talking – 28.16)*

474 B: Or yeah, you could actually just save money. But it's sort of a way that...  
 475 you can't get it, unless you *really*, really want it? You know, you've got to...  
 476 like... you've got to... obviously, it obviously is... it's your money, and you can  
 477 have it whenever you want, but... it's... you can't just get it at the flick of a  
 478 button...

479 A: Yeah.

480 B: ...you know? So, it's... it's *there*, erm... obviously, you can get the money  
 481 back whenever you wanted to. So, it's maybe something you could think  
 482 about, just paying a little bit extra in your rent, and then when you move out  
 483 and stuff...

484 A: Yeah.

485 B: ...erm... Bryan... *[another resident in the housing project]*

486 A: I... I mean, when I first...

487 B: ... *has made his money back*

488 A: ...when I first moved in here, I think my first payment was meant to be...  
 489 what – I don't know - £17?

490 B: Mm.

491 A: But my payment was the £73, so I had a *lot* more extra on there.

492 B: Yeah, so the...

493 A: Luckily enough, that actually helped me when I *(?? accepted the – 29.12)*  
 494 ...erm... when my payment for my service charges came in on a different day,  
 495 and I totally forgot about it...

496 B: Yeah.

497 A: ...so...

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498 B: Ok.

499 A: ...luckily enough, I had that extra little bit of money, so it's not... I haven't  
500 got a really, *really*, really big... erm... payment to pay out, so...

501 B: Mm. Ok. Erm... smoke? Or that type of thing?

502 A: Oh, I vape and that.

503 B: Yeah. How much do you spend a month on that?

504 A: £5 for the (*?? cones – 29.56*) and probably about... so, about £50 a month.

505 B: Fifty?

506 A: See, they say it might be cheaper – I don't think it is.

507 B: Oh, it's definitely cheaper than...

508 A: I'd make a pouch of baccy last me 2 weeks to a month. (*Inaudible – 30.22*)  
509 make a pouch of baccy last me, but...

510 B: But by the time you get to the end of it, it's dust!

511 A: The other day, when I had it... like... (*?? A quarter – 30.31*) was lasting me  
512 a month and a half, and I was like 'that' – the little bits, down at the bottom, I  
513 was like... I opened up the packet, got my key out to scrape it off the sides,  
514 because it sticks to the sides (*inaudible – 30.42*) well, 'waste not – want not'.

515 B: Mm. What about... erm... your art stuff – your pens, and paper and...

516 A: Yeah. (*Inaudible – 30.53*) oh, well the college is going to be helping me with  
517 that...

518 B: Ok.

519 A: ...I'm going to be getting £500 a term.

520 B: Oh, are you? When?

521 A: When I start – as soon as I start, I'll be getting £500 a term.

522 R: That's good!

523 A: So...

524 B: How are you going to manage that? That's quite a lot of money!

525 A: Erm...

526 B: How do they want you to spend that money?

527 A: They said it's mainly for travel...

528 B: Ok.

529 A: ...and stuff for your... erm... course (*inaudible, over-talking – 31.28*)

530 B: (*Inaudible, over-talking – 31.28*)

531 A: But I mean... or... and it can be for like... lunches, during the (*?? day –*  
532 *31.32*)

533 B: Oh! Right, ok; travel, food, expenses...

534 A: Yeah.

535 B: ...your... all right, all right, yeah.

536 A: Yeah.

537 B: And do they... do they *give* you that, like a cheque, or... do you know  
538 how... or they'll just give you cash, or...?

539 A: I think they put it in my bank.

540 B: They put it in your bank? Ok.

541 A: Yeah.

542 B: Erm... do they want to see like... receipts and things, or...?

543 A: My step-brother's got it – he had it...

544 B: Yeah.

545 A: ...he had it differently; they didn't give him £500 a term, they gave him the  
546 money for a *full year*.

547 B: (*Inaudible, over-talking – 32.07*)

548 A: So, they gave him, basically, two grand...

549 R: (*Inaudible – 32.09*)

550 B: Yeah.

551 **A:** ...in one go. So...

552 **B:** Does that worry you at all, having £500?

553 **A:** No.

554 **B:** Do you think you'll stick to it? That's what I'm trying to ask. Yeah?

555 **A:** Yeah. Yeah, I'll be able to... I mean... because erm...

556 **B:** Do you think you'll be able to *manage* that money?

557 **A:** Yeah. I mean, £100 of that will be going on something that I'll need – it's

558 basically like an art table...

559 **B:** Yeah.

560 **A:** ...so, it's all slanted and everything. I can have everything in specific slots,

561 and I can go 'Right, I need to use this'. Drawers underneath for my books, and

562 everything like that. And it comes with its own little chair, as well.

563 **B:** [Laughs]

564 **R:** [Chuckles]

565 **A:** I'll put that upstairs. Yeah.

566 **B:** Ok. Well that's... that sounds... but before erm... when do you think that

567 might start? Sorry, I'm really out of the loop with that, aren't I?

568 **A:** It starts... I think it's the beginning of (*inaudible, over-talking – 33.07*)

569 **B:** So, we're talking of September, are we?

570 **A:** Yeah.

571 **B:** Yeah. The beginning of the new term, after the summer holiday, so it would

572 be like the first week in September or so, wouldn't it? Ok. Erm... what about...

573 erm... saving for a holiday – or for your... is that something you wanted... you

574 want to look for...

575 **A:** (*Inaudible, quiet – 33.34*)

576 **B:** ... you know... do you want to do that, or do you want to leave it for a little

577 while? Do you want to get your passport sorted, and then...?

578 **A:** Yeah, that's my first thing – just get my passport sorted. I needed to get

579 that sorted out for 3 years, so...

580 B: Ok. So, we'll get your passport sorted?

581 A: Yeah.

582 B: Right. And I believe they're about £90?

583 A: £90 to £110.

584 B: Yeah. So, how quickly do you want this passport?

585 A: I do kind of want it before the summer holidays start.

586 B: Before...?

587 A: The summer holidays start.

588 B: Start? Or during...?

589 A: Or kind of during the summer holidays, but not *too* far in.

590 B: So, we're *(inaudible, over-talking – 34.12)*

591 A: Just so that I could go to...

592 B: We're... we're June, so you're looking at your July's pay.

593 A: *(Inaudible – 34.23)*

594 B: Maybe do... maybe look at your August?

595 A: I.. I'll... yeah...

596 B: Maybe look at August?

597 A: I was thinking of August, yeah.

598 B: Yeah? So, if you can save... it depends how quick you'll be able to get it

599 together. So, you're looking at saving £50 for 2 months, and then buying it

600 whilst... saving it in July, the £50, and then buying it in August with £50. So,

601 you've only saved the £50.

602 A: Yeah. So, I'm *glad* I've got that savings account now – I don't have to go

603 back down and *(inaudible – 34.55)* open up a savings account.

604 B: What about... like... personal care – your hair, and... and haircuts and

605 things like that?

606 A: Well, I'm not going be cutting my hair for about a year. I'm going to get...  
 607 I'm not going to cut my hair for a year, I'm going to wait until it grows.

608 B: Are you?

609 A: Yeah.

610 B: It'll get a bit long!

611 A: Yeah, I want it so it looks, like, long, (*?? I want to be doing it – 35.18*)

612 B: Ok. So, you don't want to put any money away for haircuts? [Laughs]

613 A: Not haircuts, no.

614 B: No. What about hair dye?

615 A: Not too sure about that, at the moment, mainly because Leah said that I  
 616 can use any of her hair dye (*inaudible, over-talking – 35.50*) ...

617 B: Oh, ok. Cool.

618 A: ...and whatever I want.

619 B: Ok.

620 A: And shampoos, and that, that probably goes under 'toiletries', so...

621 B: Yeah, toiletries – we haven't covered that yet, did we? We covered, like,  
 622 cleaning products, but not toiletries.

623 A: No.

624 B: Erm...

625 A: Probably just... probably be about £ a week.

626 B: Yeah? Is there anything else? Erm... anything else you can think of?  
 627 [Pause from 36.01 to 36.17] Right. What about... erm... dentist?

628 A: I don't have to pay.

629 B: You don't? No.

630 A: Actually, I need to go to Specsavers.

631 B: You don't pay for your specs, either?

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632 A: Huh?

633 B: You don't pay for eye... no.

634 A: I have to go there to... my... erm... to Specsavers – I need to get my eyes  
635 tested.

636 B: Ok.

637 A: I was meant to wear glasses when I was younger for, like, say, computers,  
638 reading or anything like that.

639 B: And what, you're going to...

640 A: *(Inaudible – 36.51)* because I hadn't worn them for years...

641 B: Yeah, because...

642 A: ...because I lost them.

643 B: ...you're going to be doing... erm... lots of art and stuff, and looking at  
644 reading and...

645 A: Yeah.

646 B: ...so... can you think of anything else? I can't.

647 A: *(Inaudible, muffled – 37.12)*

648 [Pause from 37.12 to 37.31]

649 B: So, your monthly income is what?

650 A: It's £77, so that will be a 7 there.

651 B: Right. I've got £71 on there. Or was that £77, not £71?

652 A: Yeah.

653 B: Oh, sorry. £77.

654 A: £151.77.

655 B: Ok. So, it's £481.77

656 A: I'll be able to actually tell you how much PIP went in exactly, now. *(??*  
657 *making... it makes things easy, like – 37.58)*



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658 [Pause from 37.58 to 38.36]  
659 A: Ah, that's £229.20.  
660 B: Two hundred and...?  
661 A: Twenty-nine pound, and twenty pence.  
662 B: Two hundred and twenty-nine pound and... and... sorry, what was the  
663 pence?  
664 A: Twenty pence.  
665 B: Twenty pence.  
666 R: It's too hot to think!  
667 B: Yeah. [Laughs]  
668 A: [Chuckles]  
669 B: Ok. Let's try and... you can talk amongst yourselves [Laughs] (*Inaudible –*  
670 *39.02*)  
671 R: (*Inaudible – 39.02*) doing the calculation.  
672 B: It's going to take me a while, because some of it's in weeks, and some of  
673 it's in months.  
674 R: Oh, yeah!  
675 B: Monthly, like, so I've got... [laughs]  
676 R: Oh, my God! I wouldn't be able to work out how to *do* that. Divide it by...  
677 B: Yeah.  
678 R: ... (*inaudible – 39.15*)  
679 B: So, that's... weekly... so, that's £20 a week, that's (*inaudible, muffled –*  
680 *39.23*) [Does calculations under his breath]  
681 A: I'm just glad I've got a frickin' savings account – I really am.  
682 B: Mm.  
683 A: (*?? Oh, it's got – 39.15*) an interest rate though.

684 R: You've got an interest rate on your savings? What's the interest rate?

685 A: Erm... 0.20%.

686 R: None... none of the interest rates are very good at the moment, to be  
687 honest.

688 A: (*Inaudible – 39.49*) interest rate.

689 R: You'll be getting another *little* bit more, but it wouldn't be...

690 A: What is 'interest' rate... what is (*inaudible – 39.54*)

691 R: Well, it means you... erm... the bank will pay you a little bit of money, for  
692 everything you save. So, if it's 0.20%, that's... for every pound that you save, if  
693 your pound was in your savings account for a year, I think you would get... oh  
694 God! 0.2... it would be something ridiculous like 2 pence, or... possibly even  
695 0.2pence – I can't work it out. It's tiny...

696 A: It sounds... terrible.

697 R: Yeah, it is. You get better interest rate if you've got loads of money and you  
698 put it in there for 20 years, you'll get more, but ... you know... I don't know a  
699 great amount of people that...

700 A: Yeah.

701 R: But still, it's good to just have your savings account, you know we've got  
702 one. It's currently got £5 [chuckles] but ... you know... we're trying.

703 A: Yeah, I know. I've (*inaudible – 40.39*) putting like £100 a month (*?? In –*  
704 *40.41*)

705 R: Yeah, it's like (*inaudible – 40.43*)

706 A: And trying not to touch it.

707 R: Go away for a weekend, you can afford to treat yourself and... buy  
708 something – some clothes – without having to worry, then, that you can't afford  
709 food, or something like that.

710 B: So, so that's working out that £129.40...

711 A: What, I'd have left?

712 B: No, no – that's... erm... yeah, £129.40 you're spending.

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713 A: Oh!

714 B: Mm.

715 R: That's what you spend (*inaudible* – 41.14)

716 B: Yeah.

717 R: On...

718 B: But that's not including your £50 for your passport, though.

719 A: Oh. Yeah, but I mean... but that's still really, *really* good.

720 B: Let me just double check this, ok, because it doesn't sound right to me. I

721 think it might be wrong.

722 A: Ok (*inaudible* – 41.36)

723 B: Sorry. Right, that's £18.70 a week...

724 A: Month.

725 B: ...rent.

726 A: Oh, £18.70... yeah.

727 B: A week, rent, yeah.

728 R: Is that a week, or a month?

729 B: That's weekly.

730 R: Is it?

731 B: Yeah.

732 R: You pay £18 a week?

733 B: Yeah.

734 R: Oh, right, ok.

735 B: Your housekeeping is £20 a week – your food money. Public transport, like

736 £1 a week? So, you've...

737 A: Yeah.

738 B: ... you know... £1 a week. Your telephone is £15.60 a month.

739 A: (?? *Half that – 42.11*)

740 B: Yeah?

741 A: £15, so that's £7.50... £7.90...

742 B: Eighty? Sixty?

743 A: £7.80.

744 B: A fortnight?

745 A: A fortnight.

746 B: So, you're talking about £3.50?

747 A: Yeah.

748 B: Oh, it's gone to sleep. [Laughs] Plus £3.50... Clothing, we've got £15 a

749 month, so...

750 A: That's £7.50 again.

751 B: Sorry, I've only got '£3.50' again. Erm... cigarettes; £50 a month?

752 A: Erm... about £10, I'd say, actually...

753 B: Yeah?

754 A: £10 a week. And that's just... don't need to (?? *worry about – 43.19*) the

755 passport, then.

756 B: No.

757 A: Times that by 4.

758 B: Yeah, so that's... sorry, that's £56 a week, so times that by 4... oh, what

759 happened *then*? Fifty-six times four...

760 A: £224, there you go.

761 B: Yeah, so, that's...

762 A: That seems better!

763 B: Two... four... yeah.

764 A: It's about, say £129, it seems *really*, really good.

765 B: I know. Sorry about that! I didn't mean to... erm... it's... I blame it on the  
 766 weather! [Laughs] So, £56 a week, £224 a month. So, if I... minus your...  
 767 erm... £251.77, minus £229.20, it's £256.

768 A: So *(inaudible – 44.17)* £56 left.

769 B: So, you've got a *massive* room to... to... erm... manoeuvre with, saving  
 770 and getting things...

771 A: Yeah

772 B: ...in order, and saving money for... this is a really good opportunity for you  
 773 to get some money behind you, for the future, as well – for when you move  
 774 out.

775 A: Yeah.

776 B: Getting yourself something really nice – as well as treating yourself, as well.

777 A: Yeah. A couple of months' time, I'm going to be having another £500 on top  
 778 of that.

779 B: Yeah, yeah, but that's for your... that's for your school stuff, yeah?

780 A: Mm.

781 B: So, do you think this... do you think that it's... it's a good idea to move  
 782 forward with this, then, to get some sort of budget plan in place – get some  
 783 sort of saving plan in place?

784 A: Yeah.

785 B: Get... get your menu plan, and your shopping list... because... erm... if... if  
 786 you stick to this, yeah, you'll have money. Because you can see by what  
 787 you've done – what you've got there – you've got nothing...

788 A: £3

789 B: ...you've got £3. So, you're going to *(inaudible, over-talking – 45.30)*

790 A: Yeah, I've got my mate coming round, so he's giving me £20 tomorrow.

791 B: Yeah, he... erm...

792 A: He's transferring me £20 tomorrow.

793 B: Ok. You're going to have to pay that back though, aren't you?

794 **A:** No.

795 **B:** No? Oh. A good friend! [Laughs]

796 **A:** Yeah. It's only because I gave him £10 when I was down there...

797 **B:** Yeah.

798 **A:** ...for him to get some food – because I already had food when I was down  
 799 there – so I gave him a tenner to get some food, so he's giving me £20  
 800 when...

801 **B:** Ok. So, you've got the £60 for your...

802 **A:** Yeah. I've got £60 from that, then I've got £20 coming from my mate, so  
 803 that's £80.

804 **B:** Ok. So, shall I... it... erm... I don't know how you want to do it; shall I get  
 805 this in some sort of order, bring some menu plans, bring some... bring sort of  
 806 like erm...? And then we can build a shopping list of that menu plan, yeah?  
 807 Work around your £20 a week, look at your ... you know... you can look at your  
 808 favourite foods, looking what you would like cooking – look at what you can  
 809 cook...

810 **A:** Yeah.

811 **B:** ...erm... it might help your diet, then – you might be able to focus on your  
 812 diet a bit more, when you've the stuff in the cupboards.

813 **A:** Yeah, I mean, (*?? like yesterday – 46.47*) I actually *had* 3 meals a day. I  
 814 had something in the morning...

815 **B:** Yeah.

816 **A:** ...when I was on the train, that was (*inaudible – 46.54*)

817 **B:** That's expensive, isn't it, on the train?

818 **A:** Didn't even cost (*?? me that much, I don't think – 46.58*)

819 **B:** No?

820 **A:** (*Inaudible, muffled – 46.57*)

821 **B:** Well, I know a sandwich is about a fiver!

822 **A:** Pending transactions... £328.20...

823 B: When will that go out? Or has that gone out, that's why you've... it says one  
 824 figure, and it's got the other figure, is that right?

825 A: Yeah, it's got (*inaudible, over-talking – 47.18*)

826 B: It's taken it off already?

827 A: Yeah, it's taken it out of my... how much I *can* spend...

828 B: Ok.

829 A: ...and it's just been put on a 'pending transaction', so it should be out by  
 830 the end of tonight.

831 B: Ok.

832 A: But that's £8.20, but I also did go... when I was on there, I was really  
 833 stressed and everything, so I was like 'Oh, they've got beer there – yeah, I'll  
 834 have a beer as well'...

835 B: Mm.

836 A: So, that probably cost... of course, that'll cost a bit more.

837 B: Mm. Ok. So, if I do that for next week – bring some sort of menu plan, bring  
 838 some shopping form/list?

839 A: Yeah, I mean, I did have a...

840 B: We can write down your... some...

841 A: I did have cookbooks.

842 B: Cookbooks? Oh, right.

843 A: Yeah. One's for... like, students.

844 B: Ok.

845 A: I've got one upstairs, like a vegetarian one...

846 B: Well, do you want... do you want... do you want to bring that down, next  
 847 week, so you could look at them and you could...

848 A: Yeah, because I've got a vegetarian...

849 B: ...you could...

850 A: The only one I've got up there is a vegetarian one, because I left my  
 851 other... my...

852 B: Yeah.

853 A: ...other one all the way in [county], and it's in [county] now.

854 B: Yeah.

855 A: So...

856 B: Well with... with your free Wi-Fi, you can google a lot of stuff as well,  
 857 though. Erm ... you know... you could google... cookery... erm... and then I'll  
 858 get this budget plan together – because it's all scribbles – is that ok?

859 A: Yep.

860 B: Erm... like a... a weekly one, so it's in there weekly. And then what we can  
 861 do, then, is... erm... well, we can look at like bringing money forward, and...  
 862 from one week to the other week, because sometimes you might not spend  
 863 that amount, so you can... that's... you'd be in 'positive', then, so you can  
 864 carry that forward.

865 A: Yeah.

866 B: So, you could spend more money on your food the *following* week... I don't  
 867 know...

868 A: Yeah.

869 B: Yeah? Then if you're into 'negative', then we can take some money off...  
 870 off your saving, and put it back into your food money, so you've always got  
 871 that amount.

872 A: Yeah.

873 B: Maybe look at it into more depth that way next week, is that ok?

874 A: Mm-hm.

875 B: Yeah? Does that sound like a plan?

876 A: Yeah.

877 B: Ok. Is there anything else you want to... anything else you want to talk  
 878 about?



879 A: I think that's it, (*?? to be honest with you – 49.37*)

880 B: Mm. Okey-doke.

881 A: (*Inaudible, muffled – 49.46*) that *did* get taken out.

882 B: Well, we'll leave it there then, shall we?

883 A: Yeah.

884 B: Yeah. Don't lose that!

885 A: I'm not. If it... if I had (*inaudible, noise by mic – 49.57*) I had my phone case

886 [laughs] (*inaudible – 50.02*)

887 B: Yeah, I thought it would be a good idea to take a scan of it, but I think that

888 would be a *really, really* bad idea, to take somebody's personal log-in details!

889 [Laughs] I was going to... yeah.

890 R: As long as it doesn't say... I mean, I guess it's whether...

891 A: I mean, I mean I've got my Universal...

892 R: ...you get them (*inaudible, over-talking – 50.15*) along with your *other*

893 details, and (*inaudible, over-talking – 50.16*)

894 A: I've got my Universal Credit log-in details... like, you guys have got *that*

895 already (*inaudible, over-talking – 50.21*)

896 B: Yeah, but that's... that's access to your *banking* details, though, I mean...

897 A: Yeah.

898 B: Erm...

899 A: Well, it's not *all* of it.

900 B: Hmm.

901 A: It's not *all* of it.

902 B: But if I had that, I could log onto your...

903 A: Yeah.

904 B: Yeah. So, I can't have it. It's a bad idea. Ok. So, we'll look at doing that

905 next week – I'll bring some stuff with (*inaudible, muffled – 50.44*) we could go

906 on getting down to the nitty-gritty.

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907 R: Erm... great. So, I don't need to come to any more meetings with you...

908 B: Oh, right, ok.

909 R: ...but I was wondering if you might be interested in doing an interview with  
910 me, just... just us two, just a one-to-one...

911 A: Yeah.

912 R: ...would that be ok?

913 A: Yeah.

914 R: *(Inaudible – 51.04)* I'll turn this off, now, shall I? Erm...

915 *End of audio at 51.07*

Appendix 10: Table showing data collection across the three research sites

Type of data	Site one Llan castell CMHT		Site two Cartref Hapus Housing		Site three Forest View Recovery Centre		Totals
	No.	Total hrs/mean time per meeting or interview	No.	Total hrs/mean time per meeting or interview	No.	Total hrs/mean time per meeting or interview	No. Total hrs Mean length
Recorded meetings between staff and service users	13	13 hrs 52 mins	8	5.6 hrs 42 mins	0	0	21 18.6 hrs Mean: 47 mins
Recorded meetings between staff only	2	9 mins 4.5 mins	0	0	0	0	2 9 mins Mean: 4.5 mins
Interviews with staff participants	9	9.6 hrs 63 mins	9	6.7 hrs 45.7 mins	11	7.9 hrs 42 mins	29 24.2 hrs Mean: 50.2 mins
Interviews with service user participants	5	6.1 hrs 73 mins	2	2 hrs 58 mins	4	2.6 hrs 39 mins	11 10. 7 hrs Mean: 56.6 mins
Ethnographic field notes	35 pages		9 pages		90 pages		134 pages