

A DISCOURSE ANALYSIS OF TALK ABOUT SERVICE USERS IN EARLY INTERVENTION  
IN PSYCHOSIS TEAMS

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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## **Abstract**

Talk is a social action, used to reflect and construct versions of reality upon which future action is based (Austin, 1962; Fairclough, 1995). Constructions of psychological distress have been seen to reflect wider cultural discourses and affect the treatment of sufferers. Medical discourse has been found to be dominant in inpatient psychiatric settings (Platts, 2006) and interviews with CPNs demonstrated that they perceive organizational, legal and medical barriers to working in an empowering way with clients (Tilley, Pollock & Tait, 1999). EIP services were developed to provide community-based mental health services run on recovery principles of client empowerment and collaborative working, however they operate in a wider discursive context of risk-aversion and public protection.

The aim of this research was to investigate the ways in which EIP staff teams used different discourses to make sense of their clients' presentations and make decisions regarding their care. EIP staff team meetings were analysed using a combined Discursive Psychology and Foucauldian Discourse Analysis approach.

Staff used three core discourses – medical, psychological and recovery – along with others to achieve particular outcomes and position themselves in relation to other stakeholders. EIP teams appeared to negotiate a number of sometimes conflicting institutional, clinical and societal pressures. They appeared to have particular difficulty in resolving the conflict arising from clients holding different recovery goals to those stipulated in EIP policy guidance, which centre on seeking employment or education. The dissonance of these conflicting pressures generated anxiety that was managed in various ways including locating problems within clients. As a result, staff were seen to neglect potential environmental contributors to clients' difficulties and the inherent contradictions in their own roles. I proposed Open Dialogue as an alternative service delivery model which has the potential to address some of the difficulties EIP currently experience.

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## Abbreviations

**BPS:** British Psychological Society

**CAMHS:** Child and Adolescent Mental Health Service

**CBT:** Cognitive Behavioural Therapy

**CPN:** Community Psychiatric Nurse

**DA:** Discourse Analysis

**DLA:** Disability Living Allowance

**DoH:** Department of Health

**DP:** Discursive Psychology

**DUP:** Duration of Untreated Psychosis

**ECT:** Electro-Convulsive Therapy

**EIP:** Early Intervention in Psychosis

**FDA:** Foucauldian Discourse Analysis

**HVN:** Hearing Voices Network

**IPA:** Interpretative Phenomenological Analysis

**KGV:** Krawiecka, Goldberg & Vaughn scale – an assessment tool for psychosis

**NHS:** National Health Service

**NICE:** National Institute for Health and Clinical Excellence

**NIMHE:** National Institute for Mental Health in England

**S4L:** Strategies for Living

**STR:** Support Time and Recovery

**UKAN:** United Kingdom Advocacy Network

**WHO:** World Health Organisation

## **Introduction**

This study will investigate how different discourses are used in Early Intervention in Psychosis (EIP) team meetings to construct understanding of their clients' presentations and make decisions regarding their care.

In this chapter I will start by outlining my interest in this area, then go on to describe some common discourses about "mental illness" in their historical context and how the dominance of different discourses relate to popular "treatment" models. I will go on to outline salient movements in the recent history of mental health conceptualisation and the current cultural and political drivers that might be expected to affect UK mental health services' understanding and treatment of their clients. In particular I will focus on recovery principles and the development of EIP teams. Finally I will summarise the relevant literature and present my research questions.

### ***Declaration of Interest***

As a teenager, I had a conversation with a friend that shaped the way I understand the world. Prior to this conversation, I saw the world from a broadly positivist standpoint – that there were immutable facts of life that could be uncovered through investigation, and that debates from different standpoints served to establish which view was 'right' and which 'wrong'. I cannot now remember the topic of our conversation, but at some point I realised that I was 'wrong' or did not believe in what I was arguing for. I decided to continue arguing this 'wrong' position to see what happened. I 'won' the argument. This threw much that I had accepted as true into question – in particular I remember thinking what a farcical institution the criminal justice system must be, to be based not on straightforward guilt versus innocence, but who was the best at arguing!

With a career in law no longer an option, I became more interested in people's stories – the narrative threads and unacknowledged inconsistencies which allow people to make sense of their experiences, and the opportunities and limitations that these stories afford people – which led me into Clinical Psychology. I am interested in the power of language and the language of power in mental health services. There is scope to investigate this subject at many levels, from the experience of the Service User to the wording of government policy documents. On a clinical placement in a forensic

psychology service I had had the unfortunate but eye-opening experience of attending a ward round in which a Consultant Psychiatrist told a service user who had experienced a psychotic episode that he had “a lifelong illness ... like diabetes” for which he would have to take psychiatric drugs for the rest of his life. My conceptualisation of this person’s difficulties and how he could manage them was quite different, but within this ward round the Medical discourse dominated and I remained quiet and angry. I felt that mental health services, as the direct interface between powerful institutions and distressed individuals, was where I would like to conduct my research, and I decided to focus on a service that was not traditionally psychiatrically dominated to investigate how practice might be different.

### ***A Note on Language***

This project is concerned with talk about mental health Service Users - their behaviours, experiences and what can be done to help. Early Intervention in Psychosis (EIP) services provide support and treatment for people having experiences that can be categorised as ‘psychotic’, but their clients present with a range of difficulties. States of mental distress have been labeled differently through time. In my account of the history of mental health conceptualisation I will use contemporaneous terms, as it would be presumptive and potentially misleading to transpose modern labels to historical cases (Danziger, 1990), though I am aware that these may be considered offensive by some readers. In the remainder of the document I will use modern labels for different forms of distress, including the term ‘psychosis’, as this is a commonly used in current mental health services and is considered less stigmatizing than ‘schizophrenia’. Though I recognise that some people may use ‘psychosis’ synonymously with the diagnostic label ‘schizophrenia’, I use it to mean “behaviour and experiences which seem to lie beyond what is regarded as consensual reality” (Boyle, 2002, p.248). Given the sensitivity of the subject and being aware of the power of language I have attempted to present my findings in a clear and explicit but non-judgemental style.

## **Conceptualisations of Deviance: The Historical Context**

### ***Why Consider History?***

People who think and behave outside of 'normal' social parameters are often experienced as challenging by those around them. This may have been the case since time immemorial, but the popular ways in which individuals, specific communities and wider societies think about and behave towards these people change over time in line with wider social, political and cultural movements, and in response to other dominant ideologies. Boyle (2002) asserts that as much can be learned from examining the history of a concept as from reading current research on the subject. She goes so far as to claim that overemphasis on the latter effectively silences the former and demeans the deeper understanding that a historical perspective can afford us. Foucault's (1967) 'Madness and Civilization: A History of Insanity in the Age of Reason' presents a history of European conceptualisations of psychological distress and their impact on people's attitudes and service provision. Foucault draws the reader to make links between dominant social institutions, the language they use and the implications for treatment of those who behave outside of social norms. Although he has been criticised for excluding or distorting information that contradicts his schema (Sedgwick, 1982), Foucault does convey the ambiguous and sometimes uncomfortable relationship between society and madness whereby, for example, madness may be seen as a spiritual malady whilst lunatics are simultaneously turned away from the church.

## ***Historical Conceptualisations of Deviance***

### **The Age of Reason**

Medieval accounts of madness portray it as occurring *within* society, with communities positioned as responsible for its management. Madness became a more widespread concern from the 15<sup>th</sup> century when fear of death from leprosy was replaced by fear of madness – “the déjà-la [already there] of death” (Foucault, 1967, p. 16) – and social deviants were confined to the old leprosariums. Such institutions filled quickly and by the late 16<sup>th</sup> Century, the British government stipulated that there be ‘houses of correction’ run within a legal framework in every county. At this time, ‘mad’ and ‘bad’ were not distinguished, and deviant behaviour was described in religious or moral terms as resulting from demonic possession, sinfulness or criminality (Bynum, 1964).

The ‘mad’ were in time separated from the ‘bad’ and confined in madhouses. Foucault (1967) proposes that the dominant conceptualisation of lunatics as inhumane and driven by impulse, like animals, protected man from considering his own fragility and justified their cruel and inhumane treatment (Bynum, 1964). Such ‘treatment’ was considered literally fit for a king, with King George III reportedly, “no longer treated as a human being. His body was immediately encased in a machine which left it no liberty of motion. He was sometimes chained to a stake. He was frequently beaten and starved, and at best he was kept in subjection by menacing and violent language,” (Countess Harcourt, quoted in Bynum, 1964, p. 319). During the mid-18<sup>th</sup> Century the number of private madhouses increased, run by laymen for profit. Before this time, the mad had not been considered ‘sick’ (Foucault, 1967), but towards the end of the century these institutions were increasingly run by physicians and called ‘hospitals’. The Madhouses Act of 1774 gave the Royal College of Physicians the power to license and inspect madhouses and also stated that people could only be confined therein with a medical certificate.

### **The Age of Enlightenment**

By the 19<sup>th</sup> century, responsibility for social deviance had firmly shifted from families and local communities to the state, and madhouses were full of people who were unwelcome in the rest of society. In response to the appalling conditions in many madhouses, exposed by the Parliamentary Select Committees of 1815 and 1816, the

reform movement of the early 19<sup>th</sup> century lobbied the government to provide humane services for pauper lunatics. The York Retreat, opened by the Quaker William Tuke in 1792, provided a viable model for such a service. Tuke saw lunatics as deficient in self-restraint and advocated the use of Moral Management individually tailored to people's needs and based on "kindness, reason and tactful manipulation" (Bynum, 1964, p.318) to encourage emotional self-regulation. Tuke also saw occupation as vital to recovery from lunacy, and madhouse staff, proprietors and politicians commonly considered early detection and treatment to be important as lunacy was most amenable to intervention in its early stages (Scull, 1979). Whilst the Moral Management approach is commonly seen as positive progress from previous service provision, Foucault (1967) argued that it supported the development of the medical model by locating difficulties within individuals, thus neglecting the socially constructed nature of 'deviance' from 'normality'.

English reformists such as Tuke had considerable impact on Government policy, with physicians' suitability as madhouse inspectors called into question and the physical and social environment considered more important in the development of lunacy. As such, moral management provided by kindly strangers away from the person's usual environment was recommended. The Lunatics Act and County Asylums Act of 1845 (Roberts, 1981) responded to this with the compulsory provision of moral treatment for pauper lunatics in county asylums, opening up a power vacuum in the management of these institutions.

### **The Birth of Psychiatry**

Physicians' historical management of madhouses and their membership of a professional body (the Royal College of Physicians) may have given them the appearance of being more qualified than moral managers (a collection of lay people with no organisational structure to unify and define them) to run state asylums. However, working within a predominantly moral framework, the physicians' claim to expertise was weak - to retain their dominance in the field, madness had to be medicalised.

In a traditionally Christian but increasingly secular society, the conceptualisation of insanity was a religious and political minefield. Moral managers such as Samuel Tuke (William's grandson) upheld the humanitarian aims of the reform movement but challenged the Christian concept of the immortal soul by arguing that

insanity was a disease of the *mind* amenable to psychological intervention – mind and soul being broadly accepted as synonymous phenomena. Tuke pragmatically stated that *if* insanity was the result of a diseased brain, it could be treated psychologically through the mind's action on the physical brain. Physicians argued that insanity *was* a physical disease of the brain, though they had no evidence for this - the dissected brains of deceased lunatics were not visibly diseased, there was no agreement on types of physical interventions to be administered (often indiscriminately), and some even admitted that moral management worked whilst medical interventions probably did not (Bynum, 1964). Despite these limitations, the strength of this argument was in its political implications: it sidestepped the concept of the soul altogether (satisfying religious and secular critics), and acknowledged the benefits of moral management (satisfying politicians) whilst asserting the fundamental biological underpinning of insanity (satisfying themselves).

Once the asylums were built, they filled up beyond the capacity for which they were originally designed. Individualised moral care was used less, with Psychiatrists acting more as managers than caregivers (Crossley, 2006), and furthermore in an industrialized society the ever-expanding lunatic population was increasingly seen as functionally useless and a burden on the state (Rose, 1986). Psychiatry's task had shifted from treatment to containment, observation and control, and concerns regarding illegal confinement and abusive practices led to the development of the Alleged Lunatics' Friend Society which campaigned for reform (Hervey, 1986).

## ***Twentieth Century Discourses of Mental Health/Illness***

The medical model of mental illness at the turn of the 20<sup>th</sup> Century assumed heritability of tainted genes and provided the theoretical basis for the eugenics movement. This understanding was dealt a severe blow when troops of 'good stock', particularly military officers, returned from the war suffering 'shellshock', and psychotherapeutically oriented approaches provided by, amongst others, Clinical Psychologists, benefitted from a brief boom in the form of outpatient services such as the Tavistock Clinic, and Therapeutic Communities such as Cassel Hospital (Stone, 1985). This bio-determinist strain of the medical understanding of madness became distinctly unpopular and has remained so following the use of eugenics theory to justify genocide in Nazi Germany in the Second World War.

Two important shifts in focus allowed confidence in the medical model to be retained. Neurosis was conceptually separated from psychosis, with the former conceptualised as environmentally caused and amenable to talking therapies and the latter biologically determined and treatable with physical interventions. Furthermore, three new physical interventions were developed in the inter-war years which purported to be effective in treating mental illness – insulin coma therapy, prefrontal leucotomy and ECT (Rogers & Pilgrim, 2005).

## **The Problem of Classification**

Emil Kraepelin (1899) made the first attempts to describe 'dementia praecox' at the turn of the 20<sup>th</sup> Century and Bleuler continued this work, describing what he called 'schizophrenia', though their methods have been criticised for being unscientific (Boyle, 2002). Over time, psychiatric classification extended from simply separating the 'mad' from the 'bad' and the rest of society, to differentially diagnosing *types* of madness, leading to the publication by the American Psychiatric Association of the first Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 1952). The very act of observing and classifying distress is a form of control that separates the object of classification from their social context. It is a system based at best on classifying deviations from societal norms as individual pathologies, thus also reflecting and defining these norms. The centrality of cultural and societal influences on classification is easily observable in the naming then subsequent removal of homosexuality as a psychiatric diagnosis, for example (Wilson, 1993). More recently a



discourse analysis of the DSM-IV (APA, 1994) identified four domains of societal norms against which abnormality was measured – productivity, unitariness, moderation and rationality. The author argues that this system of classification, “provides an image of what individuals could become and helps realign what they are with what they want to be – or what psychiatric discourse decrees that individuals should strive to be,” (Crowe, 2000; p. 76), thus not merely passively reflecting cultural norms but actively dictating them. The situation appears to have deteriorated further since then, with Allen Frances (2012), the chair of the DSM-IV revision committee, voicing concerns about the scientific basis of the recently published DSM-V (APA, 2013), claiming that it further broadens the spectrum of ‘disorder’ or ‘abnormality’, therefore narrowing the spectrum of ‘normality’.

### **Psychiatry and Psychoanalysis**

The neurologist Sigmund Freud’s first endeavours in psychoanalysis were inspired by biological models and contributed to psychiatric systems of classification. Because psychosis was broadly believed to be an organic disorder, psychoanalysis was only considered suitable for ‘neurotics’. Two branches of psychoanalysis developed, loosely defined as: the American school, in which only Psychiatrists could train as Analysts, treatment was based on a medical and individualistic model and analysis was known as ‘the talking *cure*’ (Roudinesco, 1990); and the European school which saw mental distress on a continuum (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995)

With Psychoanalysts treating neurotic patients, Psychiatrists in the early 20<sup>th</sup> century experimented with other treatments for psychosis. Henry Cotton, convinced that psychosis was caused by bodily toxins, removed bodily parts such as teeth and tonsils, though he produced no evidence of its effectiveness and caused immense harm to his patients, sometimes resulting in their death (Scull, 2005). In the 1950s, new psychotropic drugs were developed and marketed as being disorder-specific. These included the ‘anti-psychotic’, chlorpromazine, which was associated with adverse reactions such as tardive dyskinesia and was criticised for being used as a chemical restraint and to threaten and control people (Whittaker, 2002).

## Anti-psychiatry

As a reaction against these dubious psychiatric 'treatments' and as part of a wider culture of political and social unrest of the 1960s, when many marginalised groups fought for liberation and oppressive social and institutional practices were being challenged, a critical eye turned on psychiatry, and mostly from within its own ranks. Anti-psychiatry rejected the very foundations of modern psychiatry, with Fromm (1956) proposing that a culture that dictates that people are valuable for their economic usefulness over their human qualities causes human psychological distress, not individual deficiency or abnormality. The American psychiatrist, Thomas Szasz (1961) pointed out that there was no evidence for a biological basis of 'schizophrenia' and that it can be understood instead as a way of seeking help.

Whilst rejection of the traditional psychiatric system united anti-psychiatrists, political ideologies divided them, and so anti-psychiatry looked very different from country to country. In the USA, the backlash against psychiatry was predominantly from the right wing who argued that it threatened individual rights and moral responsibility. Szasz, for example, believed that being 'treated' as 'patients' by the psychiatric system kept people in a sick role which inhibited their recovery. From his political position in the libertarian right wing, Szasz believed that for somebody to recover they must seek, choose and take responsibility for their treatment. He therefore considered free mental health care provided by the state as anti-therapeutic.

R.D. Laing was arguably the best known and most outspoken of the British anti-psychiatrists. He rejected psychiatric diagnostic categorisations and held a social constructionist view of psychosis that went so far as to propose that "the cracked mind of the schizophrenic may *let in* light which does not enter the intact minds of many sane people whose minds are closed," (1965, p.27, original italics). His work was criticised by traditional Psychiatrists for potentially encouraging people to become 'schizophrenic' (Boyers & Orrill, 1971), despite the inconsistency that willing oneself into such a condition is impossible according to a medical model. Laing and Cooper founded the Philadelphia Association, which set up a number of therapeutic communities – including, most famously, Kingsley Hall - to provide a space for people to follow their psychotic journey with minimal interference from staff (for an account of a patient's journey in Kingsley Hall, see Barnes & Berke, 1973). In San Francisco, Loren Mosher set up Soteria House as a therapeutic community for people

experiencing psychosis, in which residents were seen as people “to *be with* – tolerated, interacted with, indeed appreciated,” by staff (Mosher, Hendrix & Fort, 2004, p.12; original italics).

## **Clinical Psychology**

Whilst Clinical Psychologists in the early 20<sup>th</sup> century predominantly conducted psychological assessments, the growing need resulting from the two world wars led them into the realm of treatment. Since this time, the profession has grown, with Clinical Psychologists now often taking consultant roles in multi-disciplinary teams alongside or in the place of Psychiatrists. This has occurred alongside a wider cultural interest in psychological approaches to human distress (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995).

Psychological approaches have traditionally conceptualised normality and abnormality according to four criteria (Buss, 1966). Behaviours may be considered *statistically* abnormal because they are unusual within social and cultural norms. This conceptualisation relies on value judgements to assign cut-off points and to define unidirectional pathology, i.e. below ‘normal’ intellectual performance is likely prompt intervention from services, whereas performance above the ‘normal’ range is culturally valued. Different psychotherapeutic traditions such as psychoanalysis and humanist psychotherapy value ‘normal’ *ideals*, summarised by Jahoda (1958) as the balance of psychic forces, self-actualization, resistance to stress, autonomy, competence and perception of reality. These criteria have been criticized largely on the grounds of cultural specificity (Rogers & Pilgrim, 2005). The *presence of specific ‘maladaptive’ behaviours* or *‘distorted cognitions’* is an inherently subjective method of categorisation, likely to reflect the cultural values of those with the power to define ‘normality’ and to subjugate those who live beyond it (Rogers & Pilgrim, 2005).

## **Sociology**

There exist a number of ways to explain mental health and ‘illness’ within sociology. *Social causation* accepts the validity of psychiatric diagnoses and seeks to explain the causes of mental illness within the context of social disadvantage. *Critical theory* explores the inter-relatedness of societal structures and the individual psyche, offering social/cultural explanations for individual psychological difficulties. This approach was popular among some Psychoanalysts, such as Fromm (1956) and Bion

(1959) and was associated with Marxist philosophy and the political left-wing (Rogers & Pilgrim, 2005). The tenets of critical theory can also be found in the anti-psychiatry movement (e.g. Laing, 1967). A *social constructionist* approach problematises the concept of reality, viewing it as a product of human interactions inextricably bound in power dynamics. It purports that the nature of 'mental health/illness,' or at least our theories of it, is not a stable entity that will emerge as the result of scientific endeavour, but a complex and dynamic concept developed through human activity. *Critical realism* combines the Durkheimian view that social realities influence individuals' thoughts and behaviour with the Weberian perspective that individual action shapes social reality, in dynamic interplay (Bhaskar, 1989). This approach distinguishes between natural and social structures, and Rogers and Pilgrim (2005), applying critical realism to mental 'health/illness,' state that: 1. mental health services are social structures, so rigid and objective conceptualisations and actions in this context are inappropriate; 2. Different discourses of mental health/illness form part of the conceptual framework within which mental health services operate; 3. Mental health services must be understood within their specific social and cultural context.

## ***Politics of Mental Health Care: The Modern Context***

### **Service User Movement**

Whilst psychiatry's best known critics in the 1960's were Psychiatrists themselves, the movement was also driven by service users, and the UK's first service user group, the Mental Patients' Union, was established in 1972. The successes of other social movements at home (for gay and lesbian, disability and racial equality and rights) and service user movements abroad (such as in the USA and Netherlands), alongside a conservative government that favoured running the health service according to consumerist open market principles provided a culture in which the Service User movement developed (Campbell & Rose, 2011). Whilst the Service User movement had links to anti-psychiatry in its early days (Crossley, 2006; Pilgrim, 2005), service user activists adopted and adapted the aims of other social movements and achieved significant success in a number of domains and on their own terms. The United Kingdom Advocacy Network (UKAN) was a user-run organisation that supported local projects and developed good practice guidelines and training manuals (UKAN, 2001; 2004). The Hearing Voices Network (HVN) provides a forum for Service Users to support one another in exploring the meaning of their unusual sensory experiences. Service User-led research projects included user-focused monitoring (UFM) for evaluating and developing services, and Strategies for Living (S4L) for exploring how people manage their mental distress outside of or alongside services. These projects were well funded and were carried out in non-government organisations.

By the late 1990's, Service User involvement was sought by mental health services in a number of contexts, including national policy-making groups. Service User groups and mental health professionals' organisations formed the Mental Health Alliance to fight for 'Rights not Compulsion' to be enshrined in the most recent Mental Health Act (2007), but their successes were limited. For example, whilst the value of advocacy was recognised, that role was taken from Service Users and professionalized in the form of Independent Mental Health Advocates. The Act emphasized public protection over Service User rights and extended compulsion into people's homes in the form of Compulsory Treatment Orders (CTOs). Furthermore, some users felt that their inclusion in consultation groups was sometimes conditional, often poorly

managed and that they were not given an equal voice as experts by experience (Wallcraft, Read & Sweeney, 2002; Campbell & Rose, 2011).

Hearing voices groups have become more widespread as a result of organisations such as HVN, but are increasingly run by Clinical Psychologists and may involve discussions about medication compliance. Although Service User involvement in research is now a condition of Department of Health funding, there are concerns about the extent to which they can guide research conducted within Universities – powerful institutions with their own research traditions, structural hierarchies and agendas. User researchers continue, however, to deconstruct traditional mental health research philosophies, methodologies and measures in order to promote more user-focused alternatives (Beresford, 2003; Rose, 2009).

National Service User networks have increasingly devolved into disparate local groups and been absorbed into the institutions they seek to challenge, reducing their collective power. Although the rhetoric of Service User involvement has become enshrined in recent mental health policy, in practice this is typically follows a consultation model whereby services provide ready-made solutions rather than working collaboratively to develop new solutions, leaving users feeling ignored and disempowered (Hui & Stickley, 2007; Campbell & Rose, 2011).

### **Care in the Community & the Influence of the Media**

In the 1960's and 1970's psychiatric hospitals gained a public image as outdated and inhumane institutions, an impression fuelled by high profile media exposés. Furthermore psychiatric hospitals were seen as expensive and the Thatcher government of the 1980's set about closing many, replacing them with Community Mental Health Teams (CMHTs) to provide domiciled care for people with enduring mental health needs. This reassured the public that better quality care was being provided, saved the government money and allowed independent providers into the previously nationalised health and social care sector. Deinstitutionalisation made those who had previously been concealed in psychiatric hospitals visible to the public. A number of high-profile cases of violent acts by mental health Service Users were reported in the media, in which the perpetrators were portrayed as both threatening and vulnerable (Joseph & Kearns, 1999; Moon, 2000). The media continue to play an important role in perpetuating stigma against people with 'mental health problems' (Anderson, 2003). Whilst newspaper articles present mental health issues in a variety

of ways (Paterson, 2007), a disproportionate number link perpetrators' violence to their 'mental illness' or history of hospitalisation (Cutcliffe & Hannigan, 2001) and these negative news stories are furthermore disproportionately associated with psychosis (Rogers & Pilgrim, 1996). A recent salient example of this is The Sun's front page headline "1,200 killed by mental patients" (Parry & Moyes, 2013), which has been criticized by mental health charities (Time to Change, 2013).

Following deinstitutionalisation, violence by people with mental health problems was increasingly represented in the media as a social problem, with government policies called into question and services portrayed as having failed in their duty to protect their clients and the public (Joseph & Kearns, 1999; Moon, 2000; Paterson, 2006). Media-fuelled fears about public safety were responded to in government mental health policies, which have increasingly focused on protecting the public from these potentially dangerous people, prioritising secure forensic psychiatric facilities, risk management, and early intervention (Rose, 1998; Moon, 2000; Department of Health, 1998).

## **Recovery**

### **Definitions of Recovery**

Davidson and Roe (2007) define *recovery from* psychosis as a simple reduction or absence of symptoms. *Recovery in* psychosis, however, is a process of "living one's life, pursuing one's personal hopes and aspirations, with dignity and autonomy, in the face of the ongoing presence of an illness and/or vulnerability to relapse," (Davidson & Roe, 2007, p.464) which is similar to Pilgrim's (2008) concept of recovery from impairment, or rehabilitation. Although the personal journey of recovery will be different for each individual, the trans-theoretical model of change provides a useful conceptual framework upon which recovery journeys can be mapped (Leamy, Bird, Le Boutillier, Williams & Slade, 2011).

Recovery in psychosis may also involve overcoming the secondary effects of diagnosis, such as poverty, isolation, loss of valued roles and iatrogenic effects of treatment, which may be termed *emancipatory recovery* (Pilgrim, 2008). These elements of the recovery process may be addressed within services through systemic

efforts to make decisions collaboratively and encourage social inclusion and risk-taking (Lieberman, 2008; Ramon, Healy & Renouf, 2007).

Recovery from psychosis is more easily defined and measured as an *outcome*, and is thus a useful concept for research/outcome monitoring purposes. Lieberman (2008, p. 17) proposes the following *outcome*-focused definition of recovery: “A sustained remission of symptoms ... engagement in an instrumental role activity ... a life independent of supervision by family or other caregivers ... cordial family relations ... recreational activities ... [and] satisfying peer relationships” for a period of at least two years. Whilst this definition incorporates some concepts that may be salient in an individual’s recovery, it is prescriptive and culturally bound – in essence, recovery constitutes behaving ‘normally’. Warner (2010) combines frameworks of process, outcome, individual autonomy and social inclusion in his evidence-based definition of recovery as, “the subjective experience of optimism about the outcome of psychosis ... a belief in the value of the empowerment of people with mental illness, and ... a focus on services in which decisions about treatment are taken collaboratively with the user and which aim to find productive roles for people with mental illness.”

These definitions incorporate elements which appear to originate from other discourses – remission of symptoms sounds distinctly medical and a focus on peer and family relationships would fit with a psychological approach. The elements that remain once these are excluded are pursuit of personal goals, engagement in valued/productive roles and recreational activities, independent living, collaborative decision-making, optimism and empowerment. Tilley, Pollock & Tait (1999) define ‘empowerment’ as “the extent to which the client is involved in defining the problems and setting the targets that constitute the plan of care.”

### **Origins of the modern concept of Recovery**

A meta-analysis of outcome studies from the developed world during the twentieth century shows that 40% of people diagnosed with ‘schizophrenia’ can expect to achieve ‘social recovery’, i.e. to manage their own financial and residential matters with minimal social disruption. Half of this group, or 20% of people diagnosed with ‘schizophrenia’, can expect to recover completely, to be free of psychotic symptoms and to return to their previous level of functioning (Warner, 2004). Subsequent studies have supported these findings in Germany (Lambert et al, 2008), the USA (Harrow & Jobe, 2007) and Ireland (Crumlish et al, 2009), with an international study



across developed and developing countries demonstrating a similar rate of social recovery and a 66.1% level of clinical recovery, a significantly less likely outcome for those living in Northern Europe than elsewhere, interestingly (Haro et al, 2011).

Recovery as a social movement developed in Service User groups in the USA and New Zealand and was brought to popular attention through the publication of first person accounts (Deegan, 1988; Lovejoy, 1982; Leete, 1989; Unzicker, 1989) describing important concepts such as hope for the future, acceptance of the 'condition', empowerment, active coping, social engagement and support, overcoming stigma, meaningful activity and renewed/redefined sense of self (Ridgway, 2001; Davidson, O'Connell, Tondora, Lawless & Evans, 2005). The concept of recovery in mental health has been influenced by recovery in addiction, seen as gaining some control over one's 'condition' and more responsibility for one's life; and in physical disability, in which living a meaningful life in spite of, alongside or as a result of one's 'condition' is considered important. So what is recovery in mental health?

### **Recovery in British Mental Health Services**

Recovery concepts have been filtering in to mental health policy in this country for over ten years. The National Service Framework (DoH, 1999) advocated social inclusion and NIMHE (Morris & Bates, 2003) promoted the strengths approach, encouraging enablement of Service Users to achieve their potential, empowerment and social inclusion. NIMHE (2005) followed this up with detailed process-focused guidelines for services to adopt a recovery focus. The most recent NICE guidance on interventions for 'schizophrenia' (2009), promotes person-centred care and collaborative working with service users and carers. It also endorses an optimistic approach and encourages mental health services to work in partnership with local stakeholders to provide educational, occupational and employment opportunities for Service Users. NICE guidance also emphasises the importance of early intervention, particularly for the first episode of psychosis. The 'recovery star' is now widely used in British mental health care services as a care planning and outcome measurement tool (MacKeith & Burns, 2008). It measures collaboratively-reported change in 10 domains - managing mental health, self-care, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity and self-esteem, trust and hope.

Many tensions arise when incorporating recovery principles into mental health policy and applying it in clinical practice. The hierarchical framework by which health

research is rated (by NICE, for example) values interventions that can be uniformly applied by professionals to a homogeneous group with a predictable outcome. This is incompatible with a model that respects expertise by experience, recognises individual difference, values individual choice and rejects generic outcome measures (Fisher & Happell, 2009). Similarly, the hierarchical structure of mental health services in which 'Doctor knows best' will be challenged, and some within the system have voiced concerns about this (Lodge, 2010).

Some hold the view that the values of personal responsibility and meaningful occupation in recovery have been hijacked by policy-makers to force vulnerable people into the labour market and blame them if they are unable to gain or retain employment (Scanlon & Adlam, 2010). There is also a contradiction between the positive risk-taking and collaborative decision-making required in recovery-based services and the extreme risk-aversion and continued coercion of service users present in current mental health policy (Pilgrim, 2008; Scanlon & Adlam, 2010). An overt focus on individual responsibility may also be used to mask social-political barriers to inclusion and may result in vulnerable people being blamed for societal problems (Pilgrim, 2008; Scanlon & Adlam, 2010).

Stickley and Wright (2011) in a review of British literature on recovery noted that whilst there was an active debate about definitions and discourses of recovery and implications for practice, it "remains to be seen whether it is possible to bring together service users' wishes and service provider obligations into a coherent system for mental health care." The greatest hope for such a system existing is in Early Intervention in Psychosis services.

## **Early Intervention in Psychosis**

When considering early intervention, an important question is: how early? Services have been established to intervene at the pre-psychotic or pro-dromal phase, one of the earliest examples of which was in England (Falloon, 1992). Whilst evaluations of these comparing actual and predicted rates of psychosis showed positive results, there are clear methodological difficulties in evaluating the number of cases of psychosis that were *prevented* as a result of intervention. Furthermore the

ethical implications of treating someone presenting with depression (the most common pro-dromal symptom; Hafner, Loffler, Maurer, Hambrecht, & an der Heiden, 1999) as having psychosis are questionable (Johannessen, 2004).

Although these very early intervention services did not flourish in Britain, the idea of intervening early took hold and by 2000 the government had provided funding for 50 new EIP services. The Department of Health (2001) published a detailed Policy Implementation Guide which outlined EIP services roles as providing assessment and intervention for young people (aged 14-35) experiencing a first episode of psychosis. The interventions that EIP offer range from medication, through psychological therapies (specifically CBT – psychoeducation and service user groups are also specified in this section although they are not therapies as such) to planning for engagement in education or employment. There is also a focus on early and assertive engagement, working with families and carers, planning for crisis (which may include inpatient care) and relapse prevention. Rationale for these services is based on the ‘critical period’ hypothesis, which identified rapid deterioration in the first 2-3 years of the onset of first episode psychosis, poorer symptomatic and functional outcomes for those with longer duration of untreated psychosis (DUP; Marshall et al, 2005), and crucially demonstrated plasticity in the bio-psycho-social influences on the progress of psychosis at this early stage (Birchwood, Todd & Jackson, 1998). The value of EIP services was hotly debated in the early 2000’s. Its advocates argued that the existing system created long delays in treatment, which predicted poor outcomes for service users and precipitated increased use of Mental Health Act (1983) powers (Norman & Malla, 2001). Existing services were criticised for neglecting service users’ psychosocial needs and lacking empathy (McGorry, 2000). Young people found them stigmatising, pessimistic and age-inappropriate (Pelosi & Birchwood, 2003) and quickly disengaged (McGovern, Hemmings and Cope, 1994). Based on this evaluation of the status quo and the finding that functioning at 2-3 years predicts long-term outcome (Harrison et al, 2001), EIP services adopted an assertive outreach approach to intervene during this ‘critical period’ (Birchwood, McGorry & Jackson, 1997; Department of Health 2001) in a way that prioritised service user engagement and satisfaction and promoted recovery principles, as outlined in NICE guidelines for ‘schizophrenia’ (2009).

## Controversies

Critics of EIP cite a number of flaws in the evidence base. Given that an early detection sample will include those 15% who would be expected to experience spontaneous remission of symptoms (WHO, 1979), they would be expected to have better outcomes than a long duration of psychosis sample from which spontaneously recovered people would be excluded. Furthermore, long duration samples may demonstrate detrimental iatrogenic effects of long term *treatment* rather than long term '*illness*' (Warner, 2005). Early intervention in cases of good-prognosis psychosis with anti-psychotic medication may have significant detrimental effects in terms of both the social/psychological effects of labeling somebody 'psychotic' who might not otherwise have warranted mental health service involvement and the worsening of symptoms that can occur upon withdrawal of anti-psychotic medication in this group of people (Warner 2004; 2005). EIP services have also been criticised for discharging clients after (usually) three years, thus neglecting continuity of care and potentially affecting long term outcomes (Yung, 2012). Whilst research into the short-term outcomes for EIP clients in a British service have shown positive results in terms of symptoms and functioning, some of these gains were lost at five year follow-up (Craig et al, 2004). There is however some evidence that early gains can be maintained and improved upon with continued specialist mental health input (Norman et al, 2011).

Despite these concerns, the government's investment in EIP services has continued. Recovery principles are central to these services, which may reflect a cultural, social and political shift in attitudes to psychosis. Recovery however, is a polyvalent concept (Pilgrim, 2008) that can be adopted and adapted by different groups with different motives to very different ends and the focus on service user involvement and empowerment has been linked to a neoliberal discourse of consumerism and individualism that has been politically dominant in Britain since the Thatcher era of the 1980s.

This framework assumes that people experiencing psychosis are capable of recovery and it places the power over and responsibility for this recovery primarily with the individual whilst asserting that services and wider society have a role in empowering individuals. Although these principles resonate with many of the aims of the UK service user movement, recovery was not widely adopted by groups in the UK as it was in the USA and New Zealand (Campbell & Rose, 2011), so it is perhaps

surprising that it has so rapidly become part of mental health policy here (Slade, 2009). Concerns have been raised within the UK service user movement that a focus on recovery in government policy may be linked to cuts in services and pressure for people to engage in paid employment (Campbell & Rose, 2011), and the cost effectiveness of EIP compared to standard care is emphasised in policy documentation (Mental Health Network NHS Confederation, 2011). These concerns are further compounded by Warner's (1994) argument that recovery may be inhibited by poor socioeconomic conditions, in which the stress of cuts to state benefits, unaffordable food and housing and high unemployment may exacerbate people's existing difficulties. The principles of recovery and social inclusion also sit uncomfortably alongside concerns for risk management so prominent in the Mental Health Act (2007; Pilgrim, 2008).

Given this current political context and considering a historical backdrop of institutional power over individuals who defy cultural expectations, what might a recovery-focussed service look like?

## ***Why is talk important?***

### **Social Constructionism**

Social constructionism holds that, “experience, knowledge and practice are constituted through historically specific interpersonal, institutional processes,” (Georgaca, 2013, p. 56), and when applied to mental health, social constructionist research aims to deconstruct the social, cultural and political forces that influence how psychological distress is conceptualised and treated.

People talk to each other in order to try to make sense of their experiences and decide how to behave (Garfinkel, 1967), and talk is in itself behaviour (Austin, 1962). Different people talk about phenomena differently depending on the social context, and through talk they both reflect and construct a version of reality which provides the basis for further action (Potter & Weatherell, 1987; Fairclough, 1995). As illustrated earlier, different conceptualisations of psychosis and their associated treatments have been more or less dominant in social discourse and practice at different points in history (McCranie, 2011). Particular discourses achieve cultural dominance because they fit the social and political climate of the time, to then be challenged by opposing movements gaining power in a rhetorical to-and-fro. Through talk, we have the power to maintain, challenge or transform versions of reality and power relations between individuals or groups of stakeholders within a social structure (Fairclough, 1995).

The discourses described previously have their own supporting bodies of literature and their critics similarly cite contradictory evidence. Often the evidence is inconclusive or contradictory in itself and could be used to support different explanatory frameworks. For example, whilst Warner’s (2004) meta-analysis of outcome studies is often cited in support of the recovery model, it also tells us that around 60% of people diagnosed with ‘schizophrenia’ in the developed world can expect a chronic outcome and to be reliant on some level of continued support. The question of how and the extent to which an individual may recover can only be answered *in* time and may change *over* time. At any point in that person’s journey, the conceptualisation of their way of being may be shaped by talk that draws upon available and salient discourses.

Whilst talk is powerful in constructing versions of reality and positioning stakeholders in relation to one another, people are often unaware of this (Fairclough, 1995). Fairclough (1995) outlines three elements present in talk:

- ⤴ Genres – structures that order social practices, such as ward rounds, clinical supervision, assessment letters.
- ⤴ Styles – the roles people adopt in social interactions, including how they position themselves and others in relation to one another.
- ⤴ Discourses – underlying ideologies that connect and give meaning to identities, understandings and actions.

Analysing these three domains and the relationships between them gives a deeper understanding of the ways in which social action reflects and impacts upon the social context at local, mezzo and macro levels.

Talk as a focus of research is particularly important when the speakers hold power, as in mental health service teams. The language used by mental health professionals can act to reinforce their own powerful position and construct new realities with regards their clients – making new understandings (descriptions, categorisations) possible through language (Rose, 1990b; Mendez, Coddou & Maturana, 1988).

## ***The Current Research Context***

### **Service User Experience of EIP**

Qualitative research has been conducted into Service Users' experience of EIP services. An ethnographic study by Larsen (2007) found that a Danish EIP service was experienced as helpful in helping clients to develop understanding of their difficulties through explanations and support. A focus group evaluation with users of a British EIP service elicited reported positive experiences of a 'human' approach to mental health care and collaborative decision making (O'Toole et al, 2004). The most in depth exploration of service users' experience of a British EIP service is an IPA analysis of interviews with eight participants, which identified themes of stigma, relationships, understanding their experience, sense of agency and impact on sense of self (Harris, Collinson & das Nair, 2012). Although clients reported feeling stigmatised by their 'psychosis' label and by accessing mental health services, they also described their involvement with EIP reducing their experience of stigma. They spoke positively of their relationships with other Service Users and their Care Co-ordinators. They reported understanding their psychosis in terms of their life experiences and finding this to be normalising, also describing involvement with EIP as a necessary part of their journey which afforded them the opportunity for personal development. This linked to the theme of increased self-understanding and self-development as a result of being involved with EIP services. Interestingly, Service Users gave conflicting accounts of feeling powerless and in control of their interventions with EIP and described moving from avoidance to acceptance and control over their psychotic experiences. Finally, Service Users gave conflicting accounts of feeling connected to and part of society, and also continuing to feel disconnected from it. Service Users' accounts were interpreted as representing a non-linear personal journey of recovery and reflected elements of Recovery discourse such as hope.

### **Talk in Clinical Settings**

Examinations of the process whereby clinical interviews are transformed into psychiatric reports found that medical diagnostic understandings are employed and supported by selectively reporting (and selectively ignoring) aspects of clients' perspectives and denying the subjective role of the Psychiatrist as author of the narrative to make the diagnosis appear 'self-evident' (Barrett, 1996; Hak, 1989). This



clinical writing was found to transform people's self-identity from a 'person with schizophrenia' to a 'schizophrenic person', reducing their individual human nature to merely an expression of their 'illness' and reinforcing chronic and medical explanatory discourses (Barrett, 1996). A similar process of medicalisation was described in conversations between ward staff and clients, in which the former coached the latter into explaining their experiences in medical terms (Terkelsen, 2009).

Colombo, Bendelow, Fulford & Williams (2003) interviewed professionals working in a CMHT and found that they conceptualised a case vignette largely according to models commensurate with their professional identity – Psychiatrists constructing models of mental illness, Social Workers constructing a social understanding of difficulties etc. Though they found variability of models within individuals' accounts, the medical model was most commonly used by professionals, Service Users and carers, and participants reported the medical model being dominant in decision-making. A discourse analysis of ward rounds (Platts, 2006) found that 'illness' and 'personality' were dominant discourses and appeared to have different rhetorical functions. 'Illness' discourses were found to privilege medication as the treatment of choice and maintained professionals' credibility, whereas 'personality' discourses were used to identify treatments' limitations including who would receive treatment. Although professionals dominated, Service Users and carers' understandings appeared to mediate the use of discourses about 'illness' and 'personality'. Griffiths (2001) described ways in which CMHTs used subtle discursive techniques to implicitly categorise clients without using openly pejorative language. This categorisation functioned to exclude clients from services on the basis of 'inappropriateness', though Griffiths argued that the narrative sequencing of this discourse with reference to limited resources and 'gatekeeping' suggested that the team were 'rationing' care.

### **Staff Experience of Recovery Principles**

A discourse analysis of interviews with CPNs showed them talking about being willing to work in empowering ways with their clients but identifying a number of organisational, legal and medical barriers to doing so which were typically more salient the more severe and enduring the clients' difficulties (Tilley, Pollock & Tait, 1999).

Discourse analytic research has highlighted the contextually bound and action-oriented nature of discourse in mental health services, and the ways in which it is used to construct clients' experiences, position stakeholders and serve institutional purposes. It has found the medical model to dominate in various mental health service settings, as well as illustrating ways in which it is challenged. Given the particular historical and current cultural-political context of EIP services, I am interesting in exploring the discursive landscape in which they make sense of their clients and make decisions regarding their care.

## **Research Questions**

- What discourses are used in EIP team meetings?
- How do different discourses affect the discussion?
- How are these discourses used to position stakeholders (staff, clients, families, the public)?

# Method

## ***Introduction***

In this chapter I will outline firstly how my research questions led me to collect naturalistic data and how this influenced my choice of research method. I will then go on to outline the process of recruitment, data collection and analysis.

## **Methodology**

### ***Social Constructionism***

Social constructionism holds that there is no single 'knowledge' of reality, but rather 'knowledges' that are mediated by their historical and cultural context as well as the language available to describe them (Burr, 2003). The brief history of mental health conceptualisations outlined in the previous chapter demonstrates some of these 'knowledges'. Social constructionist research, "is concerned with identifying the various ways of constructing social reality that are available in a culture, to explore the conditions of their use and to trace their implications for human experience and social practice," (Willig, 2008, p. 7), which is consistent with the aims of this research.

### ***Naturalistic Data***

I felt the most appropriate and direct method of investigating how staff teams make sense of clients' presentations in clinical practice was to record discussions in which this naturally occurs (Potter & Hepburn, 2005). Whilst other methods, such as interviews or focus groups, could elicit information about *how staff construct* their practice through talk, this would be a step removed from and potentially unrepresentative of *actual clinical practice* (Willig, 2008). Naturalistic data is taken directly from the source of the phenomenon under investigation – EIP staff team meetings – and as such is more likely to accurately capture institutionally situated and action-oriented practices with minimal intrusion of researchers' assumptions (Potter, 2004).

### ***Selecting a Research Method***

Asking *how* EIP teams make sense of service users' lives through conversation is an open-ended research question that invites an investigative approach suited to a

qualitative methodology (Willig, 2008) – I considered a number of potentially suitable methodologies:

**Interpretive Phenomenological Analysis (IPA)** adopts a relativist approach that is compatible with constructionism. It aims to explore the nature and texture of participants' *experience* of events rather than analysing the events themselves. It is suited to analysing transcripts of semi-structured interviews and could be applied for the purposes of this project to interviews with staff about their experiences working in EIP services or attending MDT meetings. I am interested, however, in capturing something of the nature of events *as they occur in practice* and IPA is not a suitable methodology for the analysis of naturally occurring phenomena such as team meetings.

**Grounded Theory (GT)** is a process of deriving theories of contextualised social processes from written material, such as transcriptions of meetings, through a process of coding and constant comparative analysis, thus making it a seemingly appropriate methodology with which to explore my research questions. GT traditionally adopts a positivist approach and views research as a vehicle for discovering existing truth. Whilst more reflexive versions of GT have been developed (Pidgeon & Henwood, 1997; Charmaz, 2006), it has been argued that as it becomes more constructionist and more concerned with discourse, it can no longer be considered a version of GT (Willig, 2008), and it begins to resemble Discourse Analysis.

### **Discourse Analysis (DA)**

DA has epistemological roots in linguistics, which recognises speech as functional (Austin, 1962); ethnomethodology, which recognises the constructionist nature of talk to help people to make sense of the social world (Garfinkel, 1967) and sees it as a valid topic for research in its own right (Zimmerman & Pollner, 1971); and semiology which notes that the meaning of language lies in its complex relational and cultural context (Barthes, 1964; 1972). DA challenges cognitivist assumptions that talk directly represents reality (Willig, 2008), adopting instead a discursive constructionist perspective that views discourse as action oriented, situated in sequence and rhetoric (Billig, 1996), and that is both constructed from and constructing of forms of knowledge (Potter, 1996; 2004).

DA's three main aims are to describe how language is used to communicate; to explore the nature of different categories and varieties of discourse; and to propose

theories to explain communication (Bloor & Bloor, 2007). Although it encompasses a range of approaches with different epistemological origins and theoretical perspectives, there are two dominant branches (Potter & Wetherell, 1987; Burr, 1995).

### **Discursive Psychology (DP) and Foucauldian Discourse Analysis (FDA)**

DP has its roots in semiology, ethnomethodology and conversation analysis (Harper, 2003). It is a relativist approach, so rejects the concept of one true reality and sees all accounts as equally valid; it also adopts a social constructionist standpoint, so sees people as actively constructing their own reality through language (Burr, 1995). It is primarily concerned with discursive practices - how people use language to negotiate and construct meaning (Willig, 2008).

FDA derives from the work of post-structuralist philosophers, and in particular that of Michel Foucault (Potter, 2004). Discourses are defined as “sets of statements that construct objects [e.g. psychosis] and an array of subject positions [e.g. mental health workers, clients and carers in relation to psychosis and to one another],” (Parker, 1994, p. 245). The poststructuralist approach sees the discursive construction of people, objects and phenomena as in constant flux, and recognises that the more enduring and naturalised a discourse becomes, the more powerful it is (Laclau & Mouffe, 1985). FDA is concerned with the historical and cultural context of discourses as phenomena – who they privilege, who they disempower and the ways in which they impose particular ways of being on those subject to them. Although the discourses themselves are the primary concern of FDA, they are examined in terms of how they are used to construct versions of people and position them in relation to one another (Willig, 2008).

### **Combining Discourse Analytic Methodologies**

My research questions require me to examine the available discourses and investigate how people use them to make sense of others’ behaviour and construct their (power) relations to them, thus drawing on elements on DA and FDA. Potter & Wetherell (1995) outlined six theoretical principles of DA that incorporate elements of these two approaches:

1. Practices and Resources. DA is concerned with available discursive resources (such as discourses, categories and rhetorical devices) and how people use these resources in practice.
2. Construction and Description. DA concerns itself with the ways in which people use discourses to construct particular versions of the world, and how these may become established and accepted as 'reality'.
3. Content. Speech is regarded as social action in itself, rather than evidence of other (e.g. cognitive) processes, and is the primary focus of the research.
4. Rhetoric. One discourse may be employed to challenge, counteract or discredit other discourses; this argumentative nature of language (Billig, 1996) and its inherent power dynamics may also be a focus for DA.
5. Stake and Accountability. People use language to manage the presentation of their and others' stake in a situation and their accountability for events.
6. Cognition in Action. DA rejects reductionist cognitive notions that behaviour, including speech, reflects fixed mental schemas. Instead it treats talk as a dynamic social-cognitive process, predicts variation in speech acts as the social context changes and does not assume speech to represent underlying attitudes or opinions of participants.

A methodological approach combining DA and FDA therefore allows me to examine the practices of constructing meaning *within* wider institutional, social and political frameworks (Wetherell, 1998).

## Method

### *Selection and Recruitment*

#### **Selection of EIP Services**

The participating EIP services are both multi-disciplinary teams that work for up to (and occasionally beyond) three years with clients aged 14-35 experiencing first episode psychosis. I have differentiated them by naming them 'NHSEIT' - (NHS Early Intervention Team) and 'Recover'. They were selected primarily for their differences, in order to provide variation in the data and make research outcomes more likely to be applicable to EIP services working in different contexts. The main differences between NHSEIT and Recover are summarised in table 1, with staff demographic information based on consent form responses. The Clinical Psychologists in these teams supported the project as field supervisors.

	<b>NHSEIT</b>	<b>Recover</b>
<b>Location</b>	Town	City
<b>Staff demographics</b>	100% White British Mean age: 39 70% female	81% White British - also Asian, African-Caribbean and mixed Mean age: 35 54% female
<b>Sector</b>	NHS	Independent

Table 1: Differences between participating services

The difference in location is important. Recover, being in a University city is a bigger service with more staff and clients. The service is divided into four separate teams although each has a similar staff mix of predominantly Support Workers and Case Co-ordinators, and performs the same roles. Recover appeared to have a greater proportion of University students as clients and a wider demographic mix of clients from different socio-economic, cultural and ethnic backgrounds. NHSEIT on the other hand has a smaller staff team and client caseload, and functions as one team. NHSEIT is based in a former industrial and mining town with a less ethnically and socio-economically diverse client demographic – this is somewhat reflected in the services' staff demographics. Whilst the skill mix in the two services is similar - consisting of

Support Workers, Nurses, Occupational Therapists, Social Workers, Housing and Employment Specialists and a Clinical Psychologist – Recover employs three Psychiatrists, whilst NHSEIT relies on local liaison psychiatry for this specialist input.

### **Service Level Authorisation**

I initially approached the Clinical Psychologists within the identified services to discuss my research proposal and gauge their interest in being involved with the project. I then circulated a draft research proposal (see appendix 5 for final version) to service managers to seek service level approval for the project. The Clinical Psychologists and I were available to discuss any questions or concerns raised and the protocol was developed with input from Service Managers and local NHS Trust Research and Development (R&D) representatives.

### **Recruitment of staff from the EIP Services**

I presented the research proposal and circulated information sheets and consent forms (see appendices 1 & 6) to staff at the two services at their business meetings. I left extra copies of these documents to be circulated to staff who were not present and both I and the field supervisors were available to answer questions either in person during or after the meetings or via email and telephone. I collected signed consent forms at the meetings and the field supervisors collected the remaining forms before data collection started. An additional anticipated benefit of presenting at team meetings prior to data collection was that staff would be more familiar with me and comfortable with my presence and that the data collected would be more naturalistic as a result.

### **Selection of Meetings to record**

Meetings were selected at which clients are routinely discussed (therefore business meetings were excluded) and according to criteria that aimed to provide variation in the data collected. I sought variation with regards to:

- Length and depth of discussion about clients
- Number of attendees
- Job roles of attendees.

The types of meetings suitable for me to record included large MDT meetings, handovers and - in Recover only - smaller team meetings to discuss particular issues relating to clients (e.g. internal referrals, risk, family work, CBT). Supervision meetings



were excluded due to the heightened sensitivity of information that may have been discussed and the wish for staff not to feel the need to self-censor in this setting.

Six meetings were recorded in total, though only five of these were analysed. Recordings 1 and 2 were made in NHSEIT, and 3, 4 and 5 were made in Recover. The differences between these meetings are outlined in table 2. Meetings 1, 2 and 4 were selected for the number and multi-disciplinary demographics of attendees. Recordings 3 and 5 were selected for having fewer attendees and for the likelihood of clients being discussed in more depth.

<b>Recording</b>	<b>Meeting</b>	<b>Attendees</b>
<b>1</b>	Handover	12: Team Manager (C), Clinical Lead (I), Clinical Psychologist (E), Assistant Psychologist, 2 Occupational Therapists (B,F), 2 Nurses (A, G), 4 STR workers (H)
<b>2</b>	Team meeting	14: Team Manager (C), Clinical Lead (I), Clinical Psychologist (E), Assistant Psychologist, Housing Resettlement worker (T), 2 Occupational Therapists (B, F), 4 Nurses (G, A), 3 STR workers (H)
<b>3</b>	Internal allocations (1 team)	5: Senior Case Co-ordinator & CBT Therapist (O), 2 Case Co-ordinators (M, P), 2 Support Workers (K, N)
<b>4</b>	MDT meeting (2 teams)	9: 2 Psychiatrists (L,V), 4 Case Co-ordinators (M, S, U), 3 Support Workers (K, W, Y)
<b>5</b>	Internal CBT referrals (1 team)	6: 1 Senior Case Co-ordinator, 1 Senior Case Co-ordinator & CBT Therapist (O), 1 Case Co-ordinator (Z), 3 Support Workers (K, N, Q)

Table 2: Differences between analysed meetings

The letters in parentheses refer to the speakers in the transcripts. I have not allocated letters to those who did not speak in the quoted extracts.

Although NHSEIT meetings contained many brief updates on clients, they also allowed for longer discussions about specific difficulties and complex ongoing cases. Recover meetings were generally smaller, with only staff from one or two teams

meeting at once. The staff mix was broader in the larger NHSEIT meetings. Whilst meetings 1, 2 and 4 follow a similar structure and agenda each time they take place, meetings 3 and 5 are focused on specific issues and are scheduled on a rolling timetable in order that a different issue is discussed each week. These meetings were selected to increase variation in the data rather than for their specific topics.

A professionals meeting was recorded, in which representatives from NHSEIT, the Assertive Outreach Team and the Criminal Justice System met to discuss two clients who were involved with these services. This meeting was initially recorded because it was thought that staff would discuss very few clients at greater length than would be possible in other meetings. This meeting was not analysed as EIP had relatively little input, and the inclusion of staff from other services extended beyond the boundaries of the initial research proposal, to examine EIP teams' talk about clients.

### ***Ethical Issues and Approval***

Ethical issues raised by this research and considered in the protocol related predominantly to clients' consent and protecting staff and client-identifiable data.

There is a general acceptance in health care research that if a researcher wishes to use information about clients/patients, they should acquire their informed consent. I argued to not seek client consent for two reasons:

- To seek informed consent from EIP clients who may be acutely distressed and mistrustful of services or others could risk increasing their distress and jeopardising their engagement with the service.
- Not recording discussions about clients who had not given consent would require either 1. For those discussions to be postponed until another meeting, 2. For them to take place at the beginning/end of the meeting, before/after recording takes place or 3. For recording devices to be switched off/on during the meeting according to whether or not consent had been given. These options could impact on client care and affect the organisation and flow of meetings, making them less naturalistic.

As well as affecting the quality of data collected, these protocol options could also have affected the type of data it was possible to collect – discussions about clients who were new to the service, were particularly distressed or had particular issues with trust or

suspiciousness might have been disproportionately excluded from analysis due to difficulties in gaining consent. This would reduce the variety of data available for analysis, potentially introduce bias, and compromise the applicability of research outcomes to EIP services. It was therefore decided not to seek client consent.

This decision increased the importance of anonymising data to protect client's personally identifiable information. The procedures were managed differently in each service, as guided by detailed discussions with the R&D departments of the NHS Trusts responsible for each service. Clients were referred to by a non-identifiable number in NHSEIT and by their first name only in Recover (see participant information sheets, appendix 1 for details). Significant measures were taken to protect participant and client-identifiable information at all stages of data collection and analysis – see appendix 5 (protocol) for details.

Ethical approval for this project was granted by 'NRES Committee Yorkshire & the Humber - Leeds Central' and local NHS Trust R&D approval was also granted (see appendices 2-4)

## ***Data Collection***

### **Audio Recording**

I decided to audio record meetings rather than video them, because I considered three small digital dictaphones with external microphones distributed around the room less intrusive than video cameras. Although this meant that I could not analyse staff's embodied actions in detail (Potter, 2004), the greater emphasis in this research is on staff's discursive practices, and I considered it most important that they carry these out in the most naturalistic environment possible. I was present throughout the recorded meetings and made notes of some physical gestures that appeared significant to the discussion, such as staff indicating speech marks with their fingers.

### **Recording Protocol**

Prior to meetings starting, I checked that all staff present had given and continued to give consent, and reiterated the protocol for protecting client information

- using only first names or numbers to refer to clients. One member of staff withdrew consent before meeting 4, and we negotiated that I would not transcribe her contributions to the meeting. I asked staff to each state their name in turn, for greater ease of identifying their voices during transcription, then to continue the meeting as usual. Meetings were recorded in their entirety and staff were encouraged to meet me afterwards if there were sections of discussion they wished me to exclude from analysis (see appendix 5 protocol), though this did not occur in practice.

## ***Transcription Process***

### **Transcription protocol**

I transcribed the recordings as soon as possible after they were made. The transcriptions were line-numbered in order to easily link notes, comments and analysis back to the data and to extract quotations (Potter & Hepburn, 2005). I used a simplified version of Jefferson style transcription (Atkinson & Heritage, 1984; see appendix 7) to incorporate the aspects of discourse relevant to my research (words, non-verbal utterances and pauses) without making the transcripts difficult to read (Potter & Wetherell, 1987). Transcribing is necessarily inexact (Deese, 1984) and I limited subjective interpretation as far as possible in the transcription in order that the reader can evaluate my analysis for themselves from excerpts of transcription (Sacks, 1995).

### ***Data Analysis***

The transcription process was the first stage of analysis, and I made notes as I was transcribing the recordings, as well as using the notes made during the meetings themselves to inform my analysis at this early stage to establish a preliminary list of themes derived from the research questions (Potter, 2004). I then colour-coded the resulting themes in the transcripts in order to highlight dominant themes and discourses to make the data more manageable. Sections of transcript were copied and pasted into separate documents according to these themes, and some whole client-discussions were identified as being particularly interesting examples of multiple discourses being used in complex or unexpected ways.

Following this I identified patterns of similarity and variability between accounts using a cyclical process, constantly referring back to the transcripts and where necessary to the original recordings. Once I had identified patterns, I developed hypotheses about the functions and effects of discursive actions on further discussion or decisions made. These were tested and developed by referring again back to the data (Potter & Wetherell, 1987), seeking supportive or contradictory examples that further refined hypotheses. I made analytic notes on copies of transcripts and reflective notes in a research journal, which I reviewed periodically as part of the iterative analytic procedure. Analyses were frequently checked with the academic supervisor, and the process and outcomes of analysis were discussed periodically with the field supervisors. I also discussed preliminary findings with participating staff teams as a validity check and to help develop and refine my hypotheses (see Appendix 8 for notes).

I did not follow a formalised procedure for analysis, but instead adopted an organic approach, allowing my intuition to guide the process (Cooper & Stephenson, 1996) whilst bearing in mind the theoretical principles of DA (Potter & Wetherell, 1995). The recordings were rich with potentially interesting and significant interactions and the scope of the research did not allow for me to explore them all. Through multiple redrafts of the results chapter, cyclical re-analysis of the data and discussions with supervisors and participants, I explored what appeared to be the most common and salient issues that connected to form a meaningful narrative.

### ***Writing Up***

When reporting my findings, I chose extracts pragmatically, using those that illustrated the most clearly the phenomena I was describing. Extracts have not therefore been selected equally from each meeting, with no extracts quoted from meeting one because despite examples of the common themes occurring in this meeting, interactions in other meetings demonstrated them more clearly. I have used a combination of short 'one-off' extracts to illustrate discrete points and extended series of extracts from the same client-discussions to allow exploration of the development of more complex interactions between different discourses.

## **Writing up protocol**

I have identified extended extracts using italics, ending with a reference to the recording and line numbers from the original transcript. I have indicated shorter quotes within the body of the text with speech marks. When these quotes do not originate from the extract to which the text refers, I have referenced them using the recording and line numbers or the extract number if they have been quoted in another section of the chapter in order to allow the reader to situate them in the flow of the discussion.

I have given staff letters and clients pseudonyms as identifiers. I have copied extracts as they appeared in the transcripts, but have included clients' pseudonyms and staff's job titles in square brackets in place of the identifiers used for them in the meeting. I have indicated gaps in the extract (excluded transcript) with the following: [.....].

## Results

The data gathered from EIP meetings was rich and complex, and any attempt to simplify and order it will necessarily compromise this. I have attempted to give the data a sensible structure, whilst cross-referencing between sections of the chapter to illustrate connections and complexities.

I will start this chapter with a brief description of the recorded meetings and will go on to answer the first research question - what discourses are used in EIP team meetings? I will describe and illustrate the three core discourses used by staff – Medical, Psychological and Recovery – as well as exploring how other common institutional and cultural discourses are used to complement these conceptual frameworks. Key to this is how the common cultural discourse of Work Ethic appears to underlie Psychological and Recovery approaches in these meetings. I will go on to answer the second research question - how do different discourses affect the discussion? – with particular reference to how ‘problems’ and ‘solutions’ are constructed through these dominant discourses. I will then answer the third question - how are these discourses used to position stakeholders? – by examining discussions about clients who appear to present challenges to the team’s approach, and exploring how staff and clients are positioned in power-relationships to one another through discursive actions. I will conclude with a summary of my analysis.

### The Meetings

#### *One*

This was a daily handover meeting in NHSEIT. Clients are classified as ‘red’ (high risk/ unwell/ in crisis), ‘amber’ (of concern) or ‘green’ (no immediate concern) - clients considered ‘red’ or ‘amber’ were discussed in this meeting. 18 clients were discussed at this meeting. For 13 of these clients only a brief update was given – that there was nothing significant to report, that they were the responsibility of another service or that they would be discussed at greater length at another meeting. Five clients were discussed in more detail, with planned contact from EIP reported for three clients (one specifically to discuss medication), and decisions made regarding two

clients – to make contact and that a client was currently unsuitable for psychotherapy. I have quoted no extracts from meeting one in this chapter, as whilst many of the issues I will go on to outline were evident in this meeting, they were better illustrated in quotes from other meetings.

Most staff sat in horseshoe formation, facing a screen on which the electronic notes system was projected and updated throughout. Two staff sat on a separate table and contributed little to the meeting. When one spoke, another pointed at the Dictaphone and raised their eyebrows by way of a reminder or warning that they were being recorded. I sat behind the horseshoe, visible to most staff, though they rarely looked at me. Some staff arrived late or left early and occasionally other staff walked through the room which was situated between the offices and main entrance.

It was intended that clients would be referred to by their Rio (electronic notes system) number, but following a discussion before the meeting it was decided that this would be unworkable. With little time to devise another system, staff were asked to refer to clients by their initials. Whilst some staff did this throughout, many forgot and were reminded to do so by other staff, causing some disruption to the natural flow of the meeting.

## ***Two***

This was a weekly team meeting in NHSEIT to problem-solve issues such as risk, onward referrals, or formulation of clients' difficulties. Seven clients were discussed, with very brief updates given for three and lengthier conversations occurring regarding four. One referral letter was read and discussed, with the resulting decision to take her on for assessment. The conversation about one client was dominated by a discussion about the care needs of his relative. Ongoing recovery work was reported for two clients and psychological input for one. I have quoted extensively from one of the longer discussions about 'Jade', which illustrated some of the conflicting pressures which EIP teams manage and which resulted in decisions for two EIP staff to work jointly with her and that she is not currently suitable for family therapy (extracts 20-24).

Again, most staff sat in a horseshoe formation and they contributed most to the meeting. Although there were spare seats in the horseshoe, some staff sat at the table and contributed less, with some occasionally whispering to one another out of range of



the microphones. One person who arrived late sat at the table at first, contributed significantly and later moved into the horseshoe.

I listed all clients' names alphabetically and allocated them numbers in ascending order. Staff were asked to refer to clients by these numbers. As in meeting one, some staff occasionally referred to clients by name, and there were some delays while staff scanned the lists to find the numbers of the clients they wished to discuss. The usual order of the meeting agenda was changed as it was considered by some senior staff that this would benefit the data collection. This was commented on by one member of staff during the meeting and justified to her by the Team Manager.

Despite the discussion in meetings one and two being affected somewhat by the recording in the ways outlined above, staff commented after the meetings that they and their colleagues appeared to act as they would usually. Some staff, when they saw me between meetings asked with humourously exaggerated nervousness, "are you recording?" before speaking to other staff. This may have indicated some degree of anxiety about the recordings being made.

### ***Three***

Team meetings in Recover occur fortnightly, and address different topics each time. The topic of this meeting was internal allocations of clients to other staff, but it started with some members of another team presenting some information about a creative therapy service and a discussion about particular clients' potential suitability for referral. The staff from the other team left following this discussion. Three clients were discussed in relation to creative therapy – I have used two extracts from this discussion (13 and 16). 19 other clients were discussed – one to be discharged, 10 to remain with their current EIP worker (Haroon and John – extracts 7, 8 & 17), seven to be transferred to other staff (Sean, Charlotte and Jim – extracts 2, 5 and 20) and one transfer decision was postponed. Although most of these outcomes were presented as information sharing, four transfers, two non-transfers and the postponed decision were all decisions made within the meeting.

The meeting occurred in a small room in which I sat on the periphery but not entirely outside the circle of staff. Staff looked at me intermittently through the meeting and occasionally appeared to seek my contribution or agreement on a point of discussion, which I did not give verbally. At the end of the meeting one member of staff

asked if anyone had any concluding comments to make, and asked me specifically if I had any feedback, to which I shook my head.

Staff were required by the protocol to refer to clients by their first names only, and as in other meetings they occasionally said full names and were reminded of the protocol by others.

#### ***Four***

This was a weekly multi-disciplinary meeting of two teams in Recover to share information, review and make care decisions about clients who are considered in or at risk of relapse. 25 Clients were discussed, 11 in detailed discussions and 14 in short updates – that there was no further update, they were no longer considered at risk of relapse, contact had already occurred or been planned, they were the responsibility of another service (extract 9 – Kareem), they were soon to be discharged from hospital or they would be discussed at another meeting. It was decided to postpone a decision regarding four clients and medication reviews were decided on for three clients (extract 1 – Adam). Joint working was decided on for two clients and one was to be invited to the women’s group. A referral was discussed and it was decided to gather more information before choosing whether to accept her onto their caseload (extract 19 – Claire).

Most staff sat around a large table and clients’ clinical notes were read from intermittently and updated throughout. The meeting appeared to be led predominantly by one of the Psychiatrists, but all staff contributed. One case co-ordinator withdrew consent for her contributions to be transcribed and analysed at the start of the meeting. She did not contribute often or at great length to the meeting, so this did not require me to omit large sections from analysis. Staff occasionally talked over each other or conducted simultaneous conversations in smaller groups during this meeting, making some short sections of the recordings inaudible or difficult to understand.

The meeting took place in one section of a large open-plan office. I sat on the periphery and staff did not often acknowledge my presence. One member of staff from another team who had been working in another part of the office commented that these meetings were usually, “more raucous,” with, “black humour,” indicating that my presence and the recording of the meeting may have had some effect on staff’s behaviour.

## ***Five***

This was another weekly team meeting in Recover, and the topic was 'CBT referrals'. It started with a brief introduction to the referral criteria by the CBT therapist (O) and there followed a discussion about seven clients' potential suitability for referral for CBT. The meeting was ostensibly led by the CBT therapist, but all staff contributed fairly equally. Three members of staff left after 20 minutes and another arrived after 50 minutes, noticed me and asked if the meeting was being recorded. It was decided that one client was suitable for CBT (extracts 3, 4 and 14 - Tameca), one was not suitable (extract 18 - Yvonne) and four might be suitable at a later date (extracts 10-12 - Chris; extract 15 - Angus).

As in meeting three, I sat on the periphery of the circle of staff, and they occasionally looked at me, but did not invite me to contribute.

## ***Decisions***

Meetings were used predominantly for information sharing rather than decision making. Staff would present their planned next action with a client, and unless they were unsure about how to proceed or others disagreed with their plan of action, this would be unchallenged by others in the team. Decisions were made regarding 25 clients, though the largest number of these decisions (8) was to postpone a decision or "watch and wait". Other decisions were made regarding clients' (un)suitability for therapy (4), to assess clients for therapy (1), accept a referral for assessment (1), keep clients or transfer them to another member of the team (6), do joint work (3), arrange a medical review (3), invite clients to a women's group (1) or otherwise contact clients (2).

## **What Discourses are used in EIP Team Meetings?**

The dominant clinical discourses used in the meetings could be categorised as Medical, Psychological and Recovery. I will refer to these as 'core discourses' as they provide complete conceptual frameworks for identifying problems and clients' and staff's roles in carrying out tasks to achieve goals that address the problems. Other discourses were also identified and are discussed in later sections of the chapter. These include Risk, Legal, Normality, Personality Disorder, Professionalism and Work Ethic, and whilst not complete conceptual frameworks for understanding clients' difficulties, are drawn upon selectively to argue for particular outcomes, complement other discourses or account for particular aspects of clients' presentations.

The core discourses appeared to be more or less dominant at different points in clients' journeys through EIP. Although staff did not often explicitly refer to the length of time clients had been with EIP, they appeared to use Medical discourse early in clients' journeys when they were more likely to be acutely distressed. Psychological and Recovery discourses appeared to be used more later, when clients were more 'stable' and staff knew them better and so could propose psychological formulations of their difficulties and develop plans based on their recovery goals. Clients' journeys did not necessarily follow this linear pattern (as evidenced in discussions about 'relapse', for example) and discourses were drawn upon flexibly. However I have presented the discourses in this order – Medical, Psychological, Recovery – to broadly follow clients' journeys through the service, as well as to reflect the order in which they have emerged as significant conceptual paradigms in the recent history of mental health services, and to allow the discussion to develop from addressing the familiar and specific roles of Medical discourse to the more unique ways in which Recovery discourse is used in EIP.

### ***Medical Discourse***

Medical Discourse was taken broadly to mean the conceptualisation of clients' difficulties as symptoms of illness, to be treated by physical means such as medication. This discourse was the least commonly used of the three dominant discourses, appearing in discussions of 25/80 clients. It appeared in 11 of the 25 client discussions in meeting 4 (the only recorded meeting at which Psychiatrists were

present), in relation to clients considered acutely ‘unwell’ or showing signs of relapse. Interestingly it also occurred in four of the seven client discussions in meeting 5, but here predominantly in relation to diagnosis and categorisation of clients’ difficulties.

This extract is taken from the middle of a conversation about Adam, who was described as “high functioning” and showing “early warning signs” of relapse.

- L: Do you know what his risks are when he’s unwell, is it .. vulnerability associated with the .. mental illness
- S: y- .. vulnerability, yeah, he was wandering around with no shoes on in [city], erm, he’d erm jumped into erm ah, he’d jumped into like a lorry? And erm .. messed up someone’s papers? so he’d, which is kind of a similar thing that he did recently when he clocked in and did a shift didn’t he in [city]? or something or was trying to do a shift in [city]=
- L: =right
- S: He’d clocked in somewhere. He’d gone somewhere and clocked in .. to a centre or something?
- L: What, somewhere he didn’t work?
- S: Somewhere he didn’t work at all.
- L: oh right [laughs] ... yeah.
- S: Erm, so I think he is showing erm displaying quite bizarre behaviour
- L: I don’t think sh- he doesn’t pose a risk to other people particularly does he? Or
- S: No=
- L: =Yeah, to himself it’s more the .. odd .. stuff when he’s unwell

Extract 1: Recording 4, lines 34-50.

Risk discourse concerns references to clients being in danger from or to themselves or others. In this extract, Risk and Medical discourses are linked, with vulnerability (risk to self) characterised as being “associated with the mental illness,” positioning Adam as a passive and non-agentive (McCarthy & Rapley, 2001). S then describes his vulnerability in vague terms of “bizarre behaviour ... odd stuff” which makes him a risk to himself. The bizarreness of his behaviour is emphasized by the extreme case formulation, “Somewhere he didn’t work at all” (Pomerantz, 1986; Edwards & Potter, 1992). The behaviour itself is not directly self-harming, with the

implication being that breaking social conventions is inherently detrimental to Adam or invites harm from others – an interesting socially bound conceptualisation of risk. The vagueness of this description may have the effect of making it difficult to refute (Edwards & Potter, 1992). “Mental illness” and socially unacceptable behaviour are constructed as problematic, with Adam and society (the nameless others that may do harm, if this is what is meant) absolved of responsibility for harm (Gilbert & Mulkey, 1984; Edwards & Potter, 1992). The function of locating the problem in “mental illness” was to render his behaviour meaningless (meaning was not explored in this conversation) and advocate ‘treatment’ through medication – the decision that was reached by the end of the conversation.

The following extract is a brief update on Sean and constitutes all that was said about him at this meeting.

*P: Erm, who I need to transfer is [Sean] .. er he's doing really really well .. er Quetiapine has really really helped him he says. He's he his problems main problems were voices and anxiety .. and they are all at minimal levels. So he was thanking L very very much for the Quetiapine .. er:m but because he's really stable he could go to somebody but I just don't know who really maybe [Support Worker] .. maybe [Support Worker] if [Support Worker]'s got any space=*

Extract 2: Recording 3, 229-133.

P specifies that medication has helped with “voices and anxiety” – successful medical treatment of symptoms. The sequential positioning of the statement “he’s really stable” implies a causal link between medication and stability, and the use of direct reported speech lends weight to the case for medication having been helpful (Edwards & Potter, 1992; Potter, 1996), whilst leaving it unclear whether P shares this view. Referring Sean on for continued input from EIP implies that their role extends beyond managing symptoms and that he is ready to move on the next stage of his EIP journey. That a Case Co-ordinator is transferring Sean to a Support Worker implies that matching professional skills to clients’ perceived recovery needs is prioritised over maintaining a consistent relationship. This draws on a discourse of Professionalism whereby staff are valued according to their professional skills.

The above extracts illustrate how Medical discourse was used to construct the client as a passive medium for meaningless symptoms. The problem was defined as “mental illness” located within the client and associated with Risk discourse. This negated acknowledgement of the client’s responsibility for his behaviour or society’s potential to tolerate a degree of deviation from social norms. The task advocated in this discourse was for staff to offer and client to take medication to reduce symptoms and increase ‘stability’, for which the client was described as humbly grateful. These outcomes led to the client’s transfer to an EIP support worker, suggesting that managing symptoms and creating ‘stability’ is only one part of the EIP’s aims and constitutes a first step towards recovery.

### **Medical ‘Trump’ Cards**

Medical was the least commonly used of the dominant discourses. In a recovery-focused service which explicitly values client empowerment and personal responsibility, Medical discourse served specific functions - to communicate the severity of clients’ problems and to justify solutions to manage risk.

### **Constructing Severity**

The following three extracts are taken from the beginning, middle and end (respectively) of a conversation about O’s client, John. It was presented as an update on John’s progress and no decisions were made regarding his care in the meeting.

O: *[John] erm we just.. do CBT work with me. To be honest we’ve not been meeting much recently because he’s.. he’s done really well he was somebody who’s just sort of sub-threshold delusional paranoia .. but nothing else, I think he would’ve ended up probably with a diagnosis of de-delusional disorder if he’d have carried on*

P: *Oh really?*

Extract 3: Recording 3, 541-546.

The description of John as, “sub-threshold delusional paranoia .. but nothing else,” does not appear to provoke an anxious reaction in others. Mental health is conceptualised here on a scale with a threshold beyond which somebody is





Perhaps a secondary effect of Psychological discourse increasing understanding is that it encourages empathy and a sense of similarity between staff and clients. This reduces the perceived severity of John's difficulties, as reflected in P's comment that "it's hardly ..." This is counteracted by O who uses the power of the Medical discourse in reference to "the brink" of a diagnostic threshold to increase the sense of 'otherness' and perceived severity of John's difficulties to justify EIP input, which is recognised by P, saying, "was it, yeah," in a concerned tone of voice.

### **Responding to 'Risk'**

In extract 1 I proposed a link between Medical and Risk discourses. The following extract occurs at the end of a brief update about Kareem in which no clinical decisions were made. Here Medical, Risk and Legal discourses are drawn upon, with Legal discourse meaning references to the legal framework within which mental health services may be obliged to detain and/or treat clients against their will.

*W: But if somebody's  
unwell and they have to be recalled to hospital it doesn't matter where the bed is, because  
the risk then, I suppose*

*L: I think the family started saying that they were happy to have him at home and to  
keep him at home a bit, but I kn- I agree with you, if someone's that unwell I think you  
have to say to the family actually it doesn't matter where the bed is, it's it's not actually  
their decision, it's about him and his mental health an- and the risk and, th- you know,  
really they shouldn't.. feel that they're in a position where they can say 'oh it's alright,  
we'll hang on to him for a bit longer', but I can understand why they don't want him to go  
out of area, but , I think that was part of it an- .. and also 'cause people don't seem to  
want to get involved with CTOs out of hours, you know.*

*W: 'Cause th- s- that was the Sunday and he'd it went on 'til Wednesday, } that's just*

*L: I know,  
yeah. So they'd been struggling with him for 4 days, and he was really unwell, an- I- he  
was much more hostile when I saw him an- .. was quite threatening, like really invading  
personal space ... anyway, so he's back in, so.*

Extract 6: Recording 4, 282-292.

Mental health services are positioned as being legally responsible for Kareem “and his mental health ... and the risk.” Kareem’s family on the other hand are portrayed as imposing on services’ territory by “feel[ing] that they’re in a position” to make decisions about his care, implying that this should be left to the ‘experts’. The narrative sequence implies a causal relationship between Kareem’s delayed admission and him being “much more hostile.” This serves to justify the earlier statement that if a client is “unwell and they have to be recalled to hospital it doesn’t matter where the bed is,” implying that (unidentified) mental health services lapsed in their legal responsibility to detain Kareem sooner, with a detrimental effect on his mental health and risk. The combination of Medical, Risk and Legal discourses here serve to position mental health services as responsible experts, invalidating the viewpoints of other stakeholders – Kareem and his family.

### ***Psychological Discourse***

Psychological discourse was taken to mean understanding clients’ difficulties as reactions to life events and/or circumstances, to be addressed through a form of psychotherapy. This discourse was frequently used, appearing in 34/80 client discussions. Although at times it was recognisably CBT focused, staff used Psychological discourse more broadly in considering clients’ behaviour in terms of their life history and current social circumstances. Psychological formulation more commonly occurred in longer discussions about clients who were not acutely ‘unwell’.

The following extract is taken from near the beginning of a discussion in which Z is making a case for Tameca’s suitability for CBT with O. Prior to this excerpt Tameca is described as “very proactive” (line 12) with regards her involvement with EIP. It is also stated that she has a job, implying a degree of ‘functioning’ and ‘stability’.

Z: *we’ve talked about core beliefs and things and I think she’s from being a very young age she was sort of in charge of her siblings and wasn’t really allowed to cry: and felt that she’s she used to take her away, she remembers as a child=*

O: *=so she had to .. hold everything together then ... yeah*

Z: *young child, yes, very young child, sort of three or four she remembers taking herself away from the family to cry, ‘cause it wasn’t allowed, so she’s,*

she's not allowed to: express weakness, she has to be strong and she has to be supportive of everyone=

[.....]

Z: No, but mum: went to live abroad and left her with three younger siblings when she was 18 .. 18, 19 and she had her first episode when she was 21 yeah.

Extract 7: Recording 5, 17-30.

The sequential positioning of chronologically ordered statements regarding Tameca's life constructs a developmental narrative that functions as a causal explanation of her "first episode" (Edwards & Potter, 1992). The events described appear to be quite out of her control and thus she is positioned as a victim of her experience. Z uses expert CBT language of "core beliefs" which she emphasises ("she has to be strong and she has to be supportive") and contextualises in Tameca's early experiences.

Tameca's story is brought up to date in the following extract in which her core beliefs are contextualised in her *recent* experiences, thus continuing the narrative thread through her life.

Z: Erm, and so she's got a really good understanding .. of what's going on but while she was away .. she: she was missing home and was starting to feel quite tearful .. wasn't eating properly or drinking properly and in:stead of addressing that, she kind of thought 'right, I can get through this, I can do this' and ended up getting quite unwell. So, at the moment we've done a timeline of when she was away and what happened, so I think it'd be really good for her to and well the whole aim of keeping her on is to help look at, help her look at developing ways of identifying those things which she did

O: Yeah

Z: Like early warning signs but then sh- she stopped herself from doing anything about them because .. it would I don't know, let other people do:wn it would show

O: { weakness, it would .. yeah  
These beliefs were getting in the way, yeah.

Z: Erm .. so: I think she would be .. I think CBT would be really useful for her. { to look at around her beliefs and how she can

O:

so a-

*around looking at these beliefs a- and seeing if we can loosen them up=*

Extract 8: Recording 5, 43-58.

Tameca is constructed as intelligent and capable, with “a really good understanding” based on a psychological formulation of her difficulties. She is also constructed as a responsible adult, in contrast to her ‘victimhood’ as a child - Z describes how her core beliefs *influenced* her decisions, but the statement that “she stopped herself” emphasises her *agency* in choosing whether or not to act on these beliefs, problematising both the beliefs and the behaviour. Z has built a case for Tameca being appropriate for CBT, constructing her as motivated, capable and responsible, and constructing her difficulties as understandable within the CBT conceptual framework of ‘core beliefs’ and behaviour. O responds to Z’s proposal that “CBT would be really useful for her” by stating the therapeutic goal of “seeing if we can loosen [the core beliefs] up” with the implication that this would reduce their power and increase Tameca’s ability to behave in a way that contradicts them, thus potentially preventing future relapses. Medical discourse did not appear in this discussion and the conversation concluded with her being considered suitable for CBT.

Psychological discourse is seen in the above extracts to conceptualise the client’s difficulties as meaningful within her developmental context, and understandable but unhelpful currently. The client is positioned as being a victim of past experiences, but as taking responsibility for her behaviour in the present. CBT was proposed as a way to help the client “loosen” unhelpful beliefs to encourage behaviour change and prevent future relapse.

It is interesting that within this meaning-making narrative, she is described as “getting quite unwell” – a vague and softly medical term that appears incongruous in this context. Clients were described as being “well” or “unwell” 28 times in total within discussions dominated by different discourses, so I did not analyse this as a strictly Medical construction, though it has associations with this discourse. I have explored this issue further in the next chapter, but suffice to say for now that the term “unwell” appears to be a shorthand device drawing on a shared understanding of individual

clients' presentations that (perhaps inadvertently) locates the problem within the client.

### ***Recovery Discourse***

Recovery discourse is defined as pursuit of personal goals, engagement in valued/productive roles and recreational activities, independent living, empowerment, collaborative decision-making and optimism. Recovery discourse occurred most frequently, appearing in 37/80 client discussions. It occurred least frequently in meeting 1, the handover, appearing in 5/18 client discussions, and in all client discussions in meeting 5, the CBT referrals meeting.

Evidence of collaborative decision-making was difficult to identify in the meetings as clients were not present. It was however evident in the number and type of decisions made – decisions were made regarding only 25 of 80 clients and the majority of these decisions were to postpone decision-making. Decisions about suitability for psychotherapy and transferring clients between EIP staff appeared to be made by staff, but otherwise decisions were made to offer services, contact clients or arrange medical reviews to which clients are invited, implying collaboration. Instances of empowerment and optimism are also difficult to count in the data, but are discussed in relation to client responsibility and the positivity with which staff respond to Recovery discourse.

With regards the other, more quantifiable elements of Recovery discourse, productive roles were mentioned in 21 client discussions, with personal goals and independent living reported in relation to less than half this number of clients (10 and 11 respectively) and recreational activities discussed in relation to only three clients. In six discussions, clients were described as more or less “functioning”, without further elaboration. I included “functioning” as an example of Recovery discourse as it implies being able to fulfill a role or engage in an activity.

The following extract is from the middle of a discussion about Charlotte, who is described as “really high-functioning” and “recently coming off her meds” (lines 166-7).

N: =sh-she's reduced it gradually and she's had reviews with L but .. i- it's kind of.. left her feeling quite flat she says? .. and .. she's tried other things that would work through different coping strategies and other things to try and help motivate her like she goes to the gym .. she's looking at doing voluntary work as well, she thinks that might help .. erm, 'cause she said to me she kind of.. feels like her boyfriend's out every day and she she's in studying and going to lectures but she hasn't really got .. much of a .. purpose? she wants to be working or doing some voluntary work?

P: Mm good=

N: She's looking at Samaritans=

P: Oh is she?

N: =yeah, and she was a bit worried she was saying 'oh I might not get on that because half the people don't get on it and I've had mental health problems and that might stop me getting on'

P: but you're more likely

N: but then yeah we had a really good conversation and she was, and then she eventually I hope she went away and she's kind of saying that sh- they know it probably gives me m- more .. experience? and more knowledge? and

Extract 9: Recording 3, 177-191.

Charlotte is described as exploring non-medical ways of managing her “flat” mood, which consist of engaging in occupational and recreational activities, which is constructed as giving her a “purpose”. N’s repeated use of direct reported speech (“she says,” “she thinks,”) positions Charlotte as having power through category entitlement as an ‘expert by experience’ and constructs Charlotte as empowered in her decision making. Doubt about her ability to work due to having experienced mental health problems is expressed in Charlotte’s own words and is related to stigma in wider society, thus distancing N from the discourse. N further reinforces that this is not her personal view by stating that the intended outcome of a conversation with Charlotte was that her mental health history and experience could be considered beneficial to her work, positioning N as supportive and empowering. N’s recovery-focused narrative is responded to positively by P, with, “Oh is she?” said in a tone that conveyed surprised admiration. The decision reached at the end of the conversation was to

continue visiting Charlotte, with her and staff sharing responsibility for telephone contact in between visits.

Recovery discourse can be used to position the client as responsible and capable, and EIP staff as supportive and empowering. Emotional difficulties (“flat” mood) are seen to be addressed actively, through employment and recreational activities. Employment is presented as a positive task that will give the client a “purpose”, and mental health problems are constructed as being *not a barrier* to employment, to the extent of being beneficial to the client.

### **Constructing Value - The Work Ethic**

Having outlined how clients are seen as responsible within Recovery discourse, I will elaborate on how this is constructed as responsibility for fulfilling valued roles. I will firstly demonstrate how staff construct employment and education as valuable. I will then illustrate how the concept of Work Ethic is used alongside Psychological discourse and applied to staff as well as clients. I will conclude the section with an example of how staff privilege the Work Ethic element of Recovery discourse over Psychological discourse. The Work Ethic discourse refers to discussions that allude to a moral judgement of the inherent benefits of hard work.

### **Work**

Extract 9 highlighted how work is constructed as valuable. The following extract sees some types of work as more valuable than others. The extract is taken from near the end of a conversation about Haroon who was described as “being quite paranoid, quite difficult to understand [...] coming across as very confused” (lines 616-7).

*O: Yeah .. so at the moment he se- he seems to have really picked up in about the last .. in the last three or four weeks, he’s working at his family takeaway but he wants to get a proper job so I’ve set him up with [Employment Specialist].*

*N: mm*

*P: Oh good*

Extract 10: Recording 3, 638-642

In this excerpt, a link between 'functioning' and mental health is constructed. References to "when he was unwell" and having "really picked up" suggest that Haroon is now considered (more) well (than previously). Alongside this concept of positive progress regarding his mental health runs the idea of occupational progress – that "he's working at his family takeaway" refers to good enough functioning to fulfil an occupational role, but that "he wants to get a proper job" employs elements of the Recovery discourse (respecting the client's wishes and seeking meaningful occupation) to construct a narrative of positive progress. Stating that Haroon has been referred to the Employment Specialist demonstrates that staff and client are working according to the recovery principles of EIP, and this is recognised as positive by P - "oh good." The assertion that "working at his family takeaway" is not "a proper job" implies a judgement that individual occupational 'success' is more valuable than the family business. This assertion of western cultural values is particularly pertinent in this case as it was earlier stated that Haroon is of British-Asian origin.

## Education

Education is constructed as valuable in the following excerpt, from a discussion about the creative therapy service.

*P: Can she work round scho:ol and stuff like that?*

*K: She can be flexible and I think the group erm, 'cause we have a few s- University students that have done the group and she will make the time suit the group as best as possible, it's normally around 4 o'clock.*

*P: Yeah, that'd be* { *alright*

*K: Erm in town, so it's, she tries to make it as accessible as possible for students .. erm, be more difficult for people that are working, but*

Extract 11: Recording 3, 41-47.

Staff appear keen that creative therapy disrupts education as little as possible, following a Recovery discourse in which education/occupation are seen as important aspects of recovery from psychosis. It goes further to construct them as of *greater* value than psychotherapy in that creative therapy "work[s] round school," with education taking priority. That it would be "be more difficult for people that are



working” again reinforces that work would be expected to take priority over creative therapy.

## **CBT**

### ***A Precious Resource***

This extract follows extracts 7 and 8 in which Tameca’s difficulties are psychologically formulated, and sees O describe her as “suitable” for CBT.

*O: I’m saying yeah, I I’m not making any s- decisions until next week, right [.....] ‘cause I want to give everybody a fair chance to come forward but I’m saying yes she sounds suitable so don’t go and tell her yet.*

Extract 12: Recording 5, 101-105.

Here O appears to construct CBT as a special and limited resource which all candidates must have “a fair chance” of winning. Tameca has apparently been ‘shortlisted’, perhaps on the basis of her earlier construction as being willing (“very proactive” – line 12) and able (“really good understanding” – extract 8, line 43). The special status of CBT as a precious resource is further reinforced in the request not to “go and tell her yet,” as though this might raise her hopes before the final decision is made. O is thereby positioned as a ‘gatekeeper’ for CBT.

### ***The Psychotherapeutic Work Ethic***

As a precious resource, CBT must be rationed. In the following extract, Angus’s potential commitment to therapy is discussed as a factor that may affect whether he will be offered CBT. Q has enquired about whether O would be willing to offer CBT outside the service’s usual working hours to fit around Angus’s work – constructing CBT as valuable but with work taking priority.

*Q: No usually he works ‘til f- er he’s not back ‘til about half five so is that, would he have to go, leave early or something like that?*

*O: [sigh] If he could, that would be ideal, but yeah. Not that I’m trying to shirk working late but better if he could come before 4 the- I’m hap- I’m happy to .. if somebody’s put- putting work in though and er they’re getting something out of it I’m prepared to you know go the extra mile but I’m not gonna keep committing to staying ‘til*

*7 o'clock for someone who's just dragging their heels with it. I don't think I'm being selfish by saying that but erm*

Extract 13: Recording 5, 162-169

The timing of O's sigh implies discomfort at the prospect of offering CBT outside of office hours. The initial disclaimer that he's not "trying to shirk working late" reinforced by the retrospective disclaimer that "I don't think I'm being selfish" indicates that this apparent inflexibility may be unpopular among his colleagues, perhaps because it contradicts recovery principles of prioritizing the client's occupation (Van Dijk, 1993). The specific wording is interesting also – to "shirk working late" implies a responsibility to work beyond contracted hours, which he would be "selfish" not to do. He goes on to position himself and Angus as sharing responsibility for therapeutic work, in that he will "go the extra mile" for somebody who is "putting work in." The sequential positioning of Angus "getting something out of it" implies that if they share responsibility for working hard, the therapy will be effective. This fits a Psychological discourse that collaboration in psychotherapy will achieve positive results for the client, but may also serve to reinforce a wider principle of the moral value of work. This is set in contrast to "someone who's just dragging their heels."

### **Functioning Prioritized over Understanding**

I have illustrated how the Work Ethic discourse was applied to CBT and previously how employment and education were implicitly prioritised over creative therapy. I will go on to discuss how Psychological discourse was 'trumped' by Recovery discourse, when the importance of clients' functioning and stability was explicitly prioritised over potential benefits of psychotherapy. The following extract comes from the middle of a brief conversation about Yvonne in which it was decided not to offer her CBT.

O: *Yeah, you can use CBT model but I [wouldn't feel] confident doing that*

P: *no no, so it it would be ok to  
for her to have it with for things like self esteem self confidence, but y- it's all related to  
the trauma?*

O: *It's gonna come up isn't it and trigger things when she has to think about it*



## How do Different Discourses Affect the Discussion?

I have already outlined the specific ways in which Medical discourse was used functionally to construct severity and justify service input in response to risk. I will now outline how Psychological discourse was used to locate problems within the client whilst ignoring potential environmental contributors to his distress. I will then illustrate how staff use the Work Ethic element of Recovery discourse to construct the solution to clients problems in taking responsibility for pursuing socially and economically valued roles.

### *Locating the Problem in the Client*

In extracts 1, 7 and 8, Psychological and Medical discourses were used to define problems and locate them within clients – in their “mental illness” or “core beliefs”. The following extract occurs in the middle of a long discussion about Chris’s suitability for CBT.

Z: *E:rm .. and, but he just doesn't get, he wears his hood all the time when he's out, not 'cause he can hear people talking about him but because he: he just I think he just doesn't like .. people particularly, and where his mum lives he's he's grown up there and I think there's various hostilities with some neighbours, you know like from being a child*

O: *mm-hmm*

Z: *erm he's never been assaulted while he's been out. Erm .. so it's quite difficult to get an idea of what it is that stops him from going out. He says he just doesn't want to see people .. or doesn't like going out or .. it's quite nondescript*

*[.....]*

Z: *he's got it in his head, he's he's managed to get onto [city]'s housing list .. and in his mind if he moves to [city] everything'll be fine because he feels comfortable in [city], when he goes to [city] he can have his hood down and he's not bothered about being out .*

O: *He can have his hood down*

Z: *It's just doesn't, it's not consistent, which is why I'm struggling I suppose*

*[.....]*

O: *He sounds like he sounds like he's not .. being very open about things*

Z: *No:*

O: Which is the concern really if he's finding it difficult to.. I think there's a lot he's not saying by the sounds of it.

Z: Yeah

O: or do you think it's just he's just not aware of what it is?

Z: I think maybe he's not particularly aware.

Extract 15: Recording 5, 251-291.

The 'problem' in this case appears to be that he "doesn't like going out" and he "wears his hood all the time when he's out." The 'problematic' nature of this is not elaborated on, suggesting that it is self-evident that "going out" is good (versus 'staying in' being bad) and perhaps calls on a common stereotype of 'hoodies' as aggressive young working class men associated with criminal gangs. Z describes a relatively specific example of "hostilities with some [of Chris's mother's] neighbours," which could go some way to explaining why he more generally "doesn't like people particularly." Further evidence that the problem could be conceptualised as external and associated with his local environment or community is given in the statement that "he feels comfortable in [city]." This is effectively disregarded in the statement "in his mind if he moves to [city] everything'll be fine," implying firstly that Z (the mental health expert) does not share that opinion, and potentially that Chris's opinion (located "in his mind") is problematic. That Chris's behaviour is described as "not consistent," despite evidence of it being consistent with regards location (uncomfortable in one place, comfortable in another) suggests that what Z is "struggling" with is that the problem may not be located in the client. It appears that Z and the team conceptualise Chris's difficulties differently to him and that their (expert) view is considered more valid.

Having constructed the reason for Chris's difficulties as within him rather than his environment, staff are left assuming that a psychological understanding will become apparent when he gives them the necessary information to develop a psychological formulation. The extract ends with O and Z discussing whether Chris is unwilling ("not saying") or unable ("not aware") to provide this information, concluding that he is probably unable. The discussion continued with the proposal for Z to conduct some preparatory work with Chris, testing and fostering his ability to use CBT.

Locating the problem within the client gives both client and staff a role – to work together to understand the nature of the difficulty and use the tools they have (CBT) to solve it. That the client is constructed as unable rather than unwilling preserves his image as a ‘good’ client. His inability is treated as a temporary hypothesis not an unchangeable fact, allowing staff and client a role in developing his self-reflective capacity and positioning staff as empowering, consistent with recovery principles.

### ***Locating the Solution in the Client – Ability and Responsibility***

Whilst staff have a role in supporting clients to improve their *ability* to address their problems, clients must ultimately take *responsibility* for their recovery, as I will go on to illustrate.

Extract 16 immediately follows extract 15 in which the problem was constructed as within the client, not the environment.

Z: *What hasn't helped is the employment support allowance are so inconsistent. You get some people who actually can't leave the house and are made to go to these assessments. [Chris] for some reason, I don't know how, his mum spoke to the employment support allowance and he hasn't had to go for an assessment. He's not been asked to, basically he's almost got out of having to do these things which I think would have really helped him. So: [sigh] it's really frustrating.*

O: *hmm*

Z: *Erm and it's he- it's helping his stuckness really*

O: *I mean, the fact .. the fact he's got some goals is a good thing,*

Extract 16: Recording 5, 291-299.

Here, Chris is categorised as ‘able’ in contrast to “people who actually can't leave the house” (Edwards & Potter, 1992; Potter, 1996). That he is described as having “got out of” an employment support allowance assessment implies that he is shirking responsibility for something that he *ought* to do – he ought to be assessed as capable of working and risk losing his benefits if he does not seek employment. That such an assessment “would have really helped him,” and that not doing so is “helping his stuckness” constructs forcing people into work as “helping”. This may function to

absolve Z of responsibility for Chris not achieving recovery-focused goals of employment or education. The Work Ethic discourse that places value on *striving* and *doing* is explicitly reinforced in O's statement that "the fact he's got some goals is a good thing," referring to earlier stated goals "to be able to go out, go to college, do [...] *parcours*" (line 247).

The following extract about Guy occurs later in the discussion about Chris and is given as a self-contained illustrative example.

*Z: there's another guy who also has a questionable diagnosis of bipolar disorder, but he's prog- you know, he's done really well .. and there have been social services involvement with his children which hasn't been positive but actually the outcome's been quite positive in that he's .. he's been really really active to try to prove that you know he can be the father he wants to be whereas a year ago .. he had bipolar disorder and was a patient, his girlfriend was his carer, it was all really patient illnessy, very medical model, but now I can do some some work with him and sort of you know .. motivational stuff about, 'cause he's done really really well,*

Extract 17: Recording 5, 380-387.

Here the "medical model" is explicitly criticised for allowing Guy to adopt the sick role, with his partner taking responsibility for his care. The sequential ordering of events construct negative involvement with Social Services as having prompted Guy to take responsibility for performing valued social roles. Z uses comparing and contrasting ("whereas ... now") to further emphasize the categorisation of the medical model as disabling, compared with recovery principles as empowering (Edwards & Potter, 1992; Potter, 1996). This example serves to reinforce the benefits of recovery principles for all involved – they have allowed staff and client to work together towards a shared goal. That this example is given within the conversation about Chris implies that he too could benefit from being forced to take responsibility for his recovery by having to attend an Employment Support Allowance assessment, in line with the Work Ethic discourse. It may also serve to further position Z as 'doing her best' in difficult circumstances – when the client does not share EIP goals and other services have not forced these goals upon him.

Whilst Chris was constructed as potentially 'unable' to do CBT, the following extract shows staff questioning Ali's ability to engage in creative therapy, due to his fear of threatening voices.

O: *I think [Ali] feels he can't talk about a lot of things due to the threats of the voices.*

K: *OK... OK*

O: *So* { *I don't know whether*

N: { *I think he wan- he wanted to but he said it was too distressing then=*

K: { *=Yeah, yeah*

O: { *=Yeah, yeah. He was too worried about the consequences=*

N: *=yeah=*

K: *=There was [Sarah] who was voice hearing who who engaged with the full group last time and she was having quite distressing experiences but, you know, that was managed and sh- yeah, she seemed to benefit from it. Also I have a client [Dan] who was pretty much erm mute when he came to the service and he identified you know wanting to be able to socialise and talk more and that's why he signed up for creative therapy, he's now done 2 groups and he's now able to kind of.. speak in .. like 2 or 3 sentences all together which was like .. yeah*

[.....]

N: *So might be, it might be good t- with someone, to get in there early really then*

K: *Yeah*

Extract 18: Recording 3, 11-23.

The voices are constructed as agentic and powerful, with Ali positioned as fragile and passive – a victim of his voices. N's use of direct reported speech – "he said it was too distressing" - further reinforces this construction (Potter, 1996). K challenges this construction by giving the example of two clients who, "seemed to benefit," from creative therapy in spite of significant difficulties. Similarly to extract 9, whilst Sarah and Dan's difficulties are acknowledged, they are constructed as no barrier to striving and achieving. Dan is described as agentic *despite* his difficulties, in control of his actions, and on the road to recovery. These examples served to promote creative therapy as an appropriate intervention and again constructed staff as



supporting clients to take responsibility for their recovery in contrast to being seen as victims of psychosis.

## How are These Discourses used to Position Stakeholders?

I have described how Medical discourse was used to position staff as responsible experts in relation to powerless clients and families. Psychological and Recovery discourses on the other hand served to position staff as collaborative and supportive in relation to motivated and active clients. In these examples clients appeared to be playing their roles appropriately, allowing staff to perform their reciprocal roles, but I have also given examples in which these roles are not so straightforward. I will go on to analyse discussions of three further clients who actively resist a client role or otherwise challenge EIP, and explore what this may reveal about staff and client roles.

### ***“Avoiding Services”***

The following extract is from the beginning of a discussion about Claire, who has been referred to EIP.

*S: “Telephone call with ... [Claire]’s mum, she said that [Claire] is doing her second year at [city] Uni on her .. [course]. On further questioning [mum] said [Claire] had been admitted initially on a section 2 and then on section 3 of the Mental Health Act for a period of 6 weeks at the [hospital] in [city] on the [ward] for a stress-related condition .. [Claire] has made it clear that she no longer has any problems and does not want any service involvement. [Mum] rang back to say she had just spoken to her daughter and that she does not want to see services but [mum] passed on her mobile number and also gave the address [address]”*

*[.....]*

*S: There’s quite a lot of information from [other city] EIP. I wonder whether she should just be on our caseload really, and it sounds like she’s avoiding services?*

*[.....]*

*U: I’ll have a look and see what’s what and then bring it back tomorrow morning*

*[.....]*

*M: I- I don’t think that we’re gonna establish whether it’s psychosis by seeing [Claire] because she’s probably not psychotic now. The investigation, the assessment needs to be*

*around gathering the information that's been erm taken from other people involved in her care and, whether she's engaging or not we could've done that. Anyway*  
Extract 19: Recording 4, 600-652.

Medical-Legal discourses (regarding detention under MHA, 1983) and Recovery discourse (University) were both used in the opening statement of this extract, read from Claire's notes. It is emphatically stated twice that Claire "does not want to see services." This is later reframed as "*avoiding services*," suggesting that Medical and Legal discourses 'trumped' Recovery in this case, perhaps due to their function of conveying severity - EIP have the responsibility to be involved and Claire has no choice in the matter. Claire is further excluded from the decision process and rendered effectively insignificant in her own assessment in M's statement that EIP could assess her "whether she's engaging or not." The proposal that "she should just be on our caseload," whilst sounding unintrusive, defies and invalidates Claire's expressed wishes. The decision about whether to take her onto their caseload is postponed in order that a staff member can "look and see what's what and then bring it back tomorrow morning," to another meeting. The vagueness of this statement implies that it draws on a shared understanding of "what's what". The proposal that Claire could become a client despite "probably not [being] psychotic now," may draw upon a shared understanding of psychosis as fluctuating and enduring and positions staff as expert and active.

Having described the potential for somebody to be powerless to resist being made into a client against their will, I will go on to explore how an existing client can have power to reject this role. The following extract is from the beginning of a conversation about Jim.

*O: OK... well I've got [Jim] who I only met at the assessment back in .. September. Erm .. he's very hard to get hold of, he's erm, him and his [relative] are both .. erm sort of ex-travellers and th- they work in [trade] and I think they just wanna keep the system at arms le- length really not interested in engaging .. erm, I tried to contact him several times by phone, sent letters, I sent him a physical health check to do by post and never got that back*

?f: mm

O: a:nd when I- cause he he never gave me a direct mobile phone number for him, I don't know if he actually has one or not but it's always through his [relative] and [relative] says 'oh, I'll ..y'know he's not around at the moment but I'll get him to call you back' and that never happens and then his [relative] said 'oh I think he's gone off with some girl and he's down [in a city] somewhere' .. but it just doesn't ring true.

P: So {are you keeping him or

O: {So ... well .. [sigh] I don't need to really. I mean I'm .. as far as I know as much as we can get from the initial assessment there's not any risk to carry

[.....]

O: But he yeah, he is a potential er .. person I could hand over for somebody else to keep on .. you know banging on his door occasionally [.....]

P: It's just that in my experience .. I th- I don't know if this it might be different in this situation, but I tend to keep people who don't engage? because

O: But I'm under pressure to take people on because we've got a lot of new referrals

P: Aah

O: So I've got to get rid of people somewhere .. and he's somebody who who I'm not doing any active work with

Extract 20: Recording 3, 309-351.

O presents a narrative about Jim and his relative which highlights and draws on common assumptions about people from the traveler community being self-reliant and suspicious of outsiders, and sets the scene for a narrative of non-engagement (Edwards & Potter, 1992). O goes on to give a three-part list of ways in which he has tried to establish contact with Jim, which has the effect of making the information seem complete (Jefferson, 1990). In this way, O appears to have presented a case for him having done all he can to engage Jim. O goes on to build his case for transferring the client to a Support Worker's caseload using a number of powerful discourses – lack of engagement (Psychological), the client not wanting input (client's wishes – Recovery) and lack of risk. Pressure on resources is given as further support for transfer when the proposal is challenged by P, with the implication that this might be considered

unpopular and is used as a 'last resort' argument. That O (a CBT therapist) wishes to transfer Jim to a support worker draws on a Professionalism discourse - that his time is more valuable than that of a Support Worker - which links back to the issues of rationing limited resources for the most deserving clients discussed around extracts 12 and 13. The extensiveness of his argument for transferring the client suggests that he is arguing for something that may contradict others' expectations, as illustrated by P's expressed tendency, "to keep people who don't engage." The argument that O makes reminds me of a rationale for *discharge* - in fact, this is how I remembered this extract in the early stages of analysis and only realised it was an argument for *transfer* upon later re-reading. That O describes having "to get rid of" clients and for somebody "to keep on [...] banging on his door occasionally," seems to indicate irritation, frustration and a lack of hope, as though EIP have to go through the motions of attempting to engage somebody as resistant as Jim without expecting a response, positioning them as relatively powerless in relation to Jim.

### ***The Inappropriate Client***

Whilst people are in some ways powerless and in other ways powerful in deciding whether or not they will be EIP clients, how do staff negotiate whether and what services they will offer clients? I was struck during the analysis that staff did not explicitly construct clients as 'bad', but as 'inappropriate' for services in various ways. I have presented chronologically ordered extended extracts illustrating ways in which staff use different discourses to construct Jade as inappropriate for EIP. I have interspersed shorter quotes illustrating the counter-arguments, for EIP to continue working with her to illustrate the competing pressures staff consider when making difficult decisions regarding clients such as Jade.

### **Personality Disorder**

The following extract is from near the beginning of the discussion about Jade.

G: *it's been a bit hit and miss seeing her, but it's like kind of issues that we've just been talking about. She's at school and .. it's she's the sister of a client that we had under our team that's still seeing [CMHT worker], erm and they were, I think he's got a diagnosis of personality disorder now I'm I don't want to compare brother and sister but it's the lad that erm I think [str] with, he were on Ward - for a long period of time and [Sw] assessed him as an AMHP. Erm, he'd manipulated erm*

*.. he'd been reading all the books and he'd said everything that he w- he needed to know to try and get sectioned and [Sw], he actually admitted that to [Sw] .. at at the time that he were assessed, but obviously he's got loads of problems and issues going off, but he it's it's also the lad that's advised other clients we've und- had under our team what to say to get DLA and stuff, well this is the sister of him. And a lot of stuff that she's saying to me .. erm it's difficult because I'm either seeing her in school or seeing her at home but don't w- she don't want to see me at home when 'cause she don't want mum and brother to hear anything. It's difficult to talk about outdoors in out and about places and she don't really want to come here because her brother were .. on here.*

Extract 21: Recording 2, 133-146.

The, “kind of issues that we’ve just been talking about,” refers to an earlier conversation around EIP referral criteria and so sets the scene for a conversation considering Jade’s appropriateness for involvement from the service. The disclaimer “I don’t want to compare brother and sister” invites the team to consider G’s account of Jade’s brother’s behaviour as pertinent to their understanding whilst pre-emptively denying potential criticism for doing so (Van Dijk, 1993). She describes the brother as having “manipulated ... and ... said everything that he ... needed to know to try and get sectioned,” and then corroborates this argument with a footing in his own admission, leaving little room for debate about this assertion. The implication of him having “manipulated” services is that he wanted to use EIP in a way that it was not intended, with the implicit suggestion that Jade may be behaving similarly. The statement that Jade’s brother is “the lad that’s advised other clients [...] what to say to get DLA and stuff, well this is the sister of him. And a lot of stuff that she’s saying to me .. erm,” proposes a potential link between his behaviour (“advis[ing] other clients ... what to say”) and Jade’s (“saying”) by firstly reiterating their family connection and immediately following this with a reference to her behaviour. This insinuates that he may have tutored her as to how to say, “everything that [she] ... needed to ... to try and get sectioned,” as *he* had. However, she also states that, “obviously he’s got loads of problems and issues going off,” and that “he’s got a diagnosis of personality disorder now,” indicating with the power of Psychological and Medical discourse that he (and therefore *she*) *does* have genuine need for mental health service input, but *not* necessarily from EIP.

## Normality

I define Normality discourse as reference to experiences or behaviours that are considered culturally accepted or common. In the following extract, G goes on to describe the beliefs and experiences of Jade and her mother, which they describe as “spiritual”.

G: Erm .. and and the experience that she's having [telling you and] the things that her mum does see things and hear things and feel things and they were just, it's all about spirituality and they do think there's this other force there and. Like when I looked, when I were sat in the house there were the mirror there and there were, I looked and I looked away and her mum were just telling me that she sees and hears things in the house and I saw this picture in the mirror and I thought [laughs] when I looked it were a pencil drawing of [Jade] in the mirror. But they're describing stuff about seeing people through windows and mirrors and they think they've got this gift. So, like, that that can be what they believe, can't it and loads of people believe that. They've got the most cynical member of the team to [laughter] to work with on that [laughing], but err=

E: =They've still got, still got you believing it

G: } apart from D, yeah [laughing, inaudible].

Extract 22: Recording 2, 155-165.

G's vivid description is notable, and may function to draw listeners into the scene (Potter, 1996) and to argue for the potentially unpopular view that these experiences be considered 'normal' (by way of being 'common') and therefore non-psychotic (Edwards & Potter, 2001). She describes the potentially problematic event of her being momentarily drawn into Jade's 'spiritual' world in the unfinished statement that "I saw this picture in the mirror and I thought." This implies that she started to doubt her own non-belief (a point later picked up on by E and confirmed by G) which develops the argument for these experiences being 'normal'. This is at odds with her description of herself as "the most cynical member of the team," and her laughter may indicate unease at the dissonance between these two positions (Gilbert & Mulkey, 1984; Edwards & Potter, 1992). The statement "that can be what they believe, can't it and loads of people believe that" is difficult to contradict in two ways: firstly it is vague and secondly, it would require making the unpopular argument that these experiences

are 'abnormal', which could be perceived as being disrespectful of her belief system, as analogous to a religious belief system.

That the above discourses were used to argue for Jade to be excluded from EIP services is indicated in G's statement that "I don't know if she's for our team" (line 167).

## **Differential Diagnosis**

In this extract, G relates an experience that Jade described to her.

*G: When you ask her about her her main 3 things that bother her it's her weight .. erm, it's money and that she needs to get out of that house, that she's living in .. and the only s- odd s- sh- there's this seeing things and stuff but she's like a couple of years ago, I'm presuming there's some trauma there I don't know about. Err she had this err two years ago she had this experience where her body were like catatonic and she couldn't move but she could only hear and see things that she believes weren't really there, now I think that's some kind of .. panic, some kind of post-traumatic, I don't know, sh- th- this has only happened once.*

Extract 23: Recording 2, 184-190.

"This seeing things and stuff," refers to the spiritual experiences outlined above and its vague dismissiveness functions to minimise their perceived importance (Edwards & Potter 1992). These experiences are constructed as *not* psychotic by the use of the conjunction "but," before describing an episode that incorporates factors which would otherwise be considered commensurate with psychosis – she was "catatonic," could "hear and see things that she believes weren't really there" and this was constructed as potentially linked to trauma. This episode was attributed to "some kind of panic, some kind of post-traumatic, I don't know," implicitly excluding psychosis as a possible explanation. The word "disorder" is implied but absent from this description, perhaps because it is self-evident or would be unpopular. The statement of this having "only happened once" and "two years ago," is given as justification for her attributing it to "panic" rather than psychosis, drawing on a common understanding of psychosis as enduring.



As the discussion continued, G stated that Jade “don’t want medication, she don’t want to go to CAMHS and I’m, and I think [CAMHS Child Psychiatrist]’s quite .. concerned because she’s mentioned stuff about feeling so low that she wants to harm herself” (line 195-7), drawing on the powerful Risk discourse to argue that she needs support and input from services. That Jade does not wish to take medication (which might relieve staff’s anxiety about risk management) and has rejected input from another mental health service leads to G’s statement that “I feel a bit of pressure from her that if I don’t work with her, nobody’s gonna work with her” (line 219-20). These statements paint a picture that EIP have no choice but to be involved in Jade’s care. G reiterates this pressure in stating that “I feel a bit out of my depth” (line 201), and asks “if somebody could start .. coming out with me” (line 202-3), which another member of staff agrees to do.

### **Playing the System**

At the beginning of the extract 22, G presented Jade’s concerns, which appear to be typical for an adolescent girl and not explicitly related to mental health problems. Whilst ‘making healthier lifestyle choices, seeking employment and independent living’ may have fit with a Recovery discourse (goals that EIP would share), “weight [...] money and that she needs to get out of that house” (extract 22) suggests the lack of a Work Ethic.

*G: dance teacher and this other support worker at school seem to have built up quite a good relationship with her and they seem very caring, you know, sometimes they can be a bit negative with they’re, when they’re talking to you about, ‘cause they don’t understand about mental health but .. they seem to really think that she’s pulling the wool over us eyes and she don’t want to go to school and she’s trying to get out of going to school and she wants a house when she leaves school and [sigh] so ..*

Extract 24: Recording 2, 227-232.

G’s description of the Dance Teacher and Support Worker as “caring” and having “a good relationship” with Jade give weight to the argument, footed in their opinion, that “she’s pulling the wool over us eyes,” whilst simultaneously distancing G from the statement – ‘they’re saying it, not me, and they know and like her’. This is

immediately followed by the statement that “she’s trying to get out of going to school and she wants a house when she leaves school,” drawing on a current political discourse of ‘playing the system’, wanting ‘something for nothing’, being a ‘scrounger’ or a ‘skiver’ – lacking a Work Ethic.

G’s expression of concerns about Jade’s suitability for EIP input whilst arguing that they have no choice but to work with her prompted staff to offer support through joint working, as previously demonstrated, and through making suggestions for potential interventions. In the following extract staff are discussing assessment tools that could be used with Jade.

A: *Well*  
*that young lad that we went to see ev- every single question, you remember, every single question on the KGV he goes yeah I’ve got that. Intensity oh yeah, 10 intensity=*

G: *=That’s why I don’t want to for that reason, for that visit I don’t want to do: that.*

A: *Every single one, just .. yeah.*

E: *But, I suppose if someone answers like that then that gives you information too, doesn’t it.*

Extract 25: Recording 2, 267-272.

The emphasis in A’s initial statement regarding another client and his tone of voice indicate frustration or annoyance that the client was attempting to deceive him. G’s statement that “that’s why I don’t want to” indicates a suspicion that Jade may behave similarly, and that conducting such an assessment would be pointless. E’s statement that “if someone answers like that then that gives you information too” implies that the client is exaggerating their experiences (similar to the ‘malingering’ tests inbuilt in some psychometric assessments). This introduces the idea of playing the client at their own game – using specialist knowledge and the power of scientifically tested assessment tools to justify EIP decisions.

The action orientation of the discourses outlined above appears to be to categorise Jade (as ‘Personality Disordered’, ‘normal’, ‘not psychotic’ or ‘playing the

system') to argue for excluding her from or limiting her access to EIP services (Edwards & Potter, 2001; Griffiths, 2001). The conversation is however far more complex, with these arguments being countered at every turn by G herself, illustrating some of the often opposing pressures EIP services work under.

## Summary

### ***What Discourses are used in EIP Team Meetings?***

Staff predominantly drew upon three core discourses that provided complete conceptual frameworks for identifying problems, roles and tasks – Medical, Psychological and Recovery. Psychological discourse was most recognisably CBT-orientated, though it also appeared more broadly to make sense of clients' current experiences in light of their life history. Recovery discourse most commonly focused on productive roles such as in education, employment and within the family.

Work Ethic discourse was seen to be associated with Psychological and Recovery discourses that placed value on clients taking responsibility for pursuing valued goals. Risk and Legal discourses were also used and were particularly associated with Medical discourse. Staff used a discourse of Professionalism in relation to their own roles and clients' journeys through the service. Other common cultural discourses that were used included Normality (related to age, gender and spiritual beliefs) and Personality Disorder, which were used to argue for excluding clients from services.

### ***How do Different Discourses Affect the Discussion?***

Medical discourse was seen to preclude discussion about the meaning of clients' experiences or behaviour and led to discussion about treatment in the form of medication with the aim of achieving 'stability'. The use of Medical discourse was used to construct severity and 'otherness', and supported arguments for service input.

Psychological discourse appeared to foster a shared understanding of clients' difficulties within the staff team and sometimes led to discussions about suitability for psychological therapy. All core discourses were seen to locate the 'problem' within the client, with Psychological discourse leading to a search for an internal problem whilst ignoring potentially significant environmental factors.

Recovery discourse was responded to positively by staff, diverting discussion from consideration of clients' mental health problems as barriers, towards their pursuit of productive roles despite their ongoing distressing experiences. Recovery was strongly linked to a Work Ethic discourse that prioritised education and

employment ('functioning') over psychological therapies (understanding). Recovery discourse appeared to lead to frustration amongst staff when clients did not share EIP's recovery principles. This sometimes led the discussion towards identifying other services who had the power to force clients to take responsibility for pursuing productive roles.

Professionalism discourse was used to justify moving clients with fewer perceived needs and/or low willingness to engage down the professional hierarchy (to Support Workers). Similarly it was used to argue for moving those with greater need and willingness up the professional hierarchy (for psychological therapy). This was sometimes challenged by a Psychological discourse of maintaining relational stability with staff to beget behavioural stability in clients.

A number of discourses were used to argue for excluding clients from services on the basis of them being 'inappropriate'. These included Personality Disorder, Normality and (lack of) Work Ethic. These were counteracted by discourses of Risk, implying professional responsibility

### ***How are These Discourses used to Position Stakeholders?***

Medical discourse was seen to position clients as passive and non-agentive, and staff as expert. When Medical, Risk and Legal discourses were combined, mental health services were positioned as responsible for intervening regardless of the wishes of clients and their families.

Psychological discourse constructed clients' behaviour as understandable, fostering empathy. Whilst clients were seen as victims of their life history, they were positioned as rational and responsible agents with control over their choices in the present. Psychological discourse positioned staff as expert in developing understanding of clients' difficulties and supporting them to implement solutions. Staff trained in psychological therapies were positioned as gatekeepers for their services, drawing on a Professionalism discourse that positioned staff in a hierarchy within EIP. They constructed clients as (in)appropriate based on their willingness (Work Ethic) and ability to engage in psychological work. If clients were constructed as unable to engage, less qualified staff maintained an empowering role in helping them to develop psychological 'awareness'.

Recovery discourse tended to construct clients as responsible and empowered, and staff as supportive and empowering. Recovery discourse was closely linked to

Work Ethic, and clients who did not appear to be pursuing productive roles were constructed not as unable, but as unwilling, thus positioning clients as powerful and staff as powerless – when clients refused to take responsibility, staff were prevented from fulfilling their empowering role. Staff were seen to distance themselves from Medical discourse at times, sometimes criticising it in relation to Recovery discourse with the effect of positioning themselves as empowering in relation to responsible clients.

In the next chapter I will explore these findings in their wider cultural, institutional and research context.

## Discussion

EIP staff were seen to use dominant cultural discourses functionally to present themselves and others in a particular way and to argue for particular outcomes. I will go on to situate the findings in their historical, political and research context, outlining what they add to our current knowledge. I will frame this with particular reference to the conflicting pressures that EIP face, the anxiety that this generates and the ways by which this anxiety is managed. I will then outline strengths and limitations of the study, implications for clinical practice and future research, and end with some personal reflections on the research process.

### Medical Discourse

There were some similarities between the ways Medical discourse was used in these recorded meetings to the ways they were used in ward rounds, for example constructing the person with 'mental illness' as non-agentive (McCarthy & Rapley, 2001; Platts, 2006). However a medical understanding dominated in ward rounds, whereas it was used fairly infrequently and served specific functions in the EIP meetings analysed. Here it was seen to communicate severity of clients' difficulties, constructing "otherness" and justifying service input. Medical discourse as it was used in EIP meetings conformed to Davidson and Roe's (2007) definition of *Recovery from psychosis* as reduction or absence of symptoms, and reflects the EIP implementation guidance to "focus on management of symptoms" (DoH, 2001, p.45).

It was also used in response to risk and in conjunction with Legal discourse to justify overriding other perspectives such as service user and carer wishes in using legal powers to detain clients and protect stakeholders. Enforcing these restrictions is seen as the responsibility of other services such as the Police and inpatient units. That there are existing frameworks for enforcing stakeholders' immediate physical safety may serve to reduce staff anxiety about risk, and that these are predominantly the responsibility of other services (not EIP) may reduce the dissonance of an EIP client being detained against their will.

## ***Internal Audiences***

The medical model did not appear to be dominant in EIP staff talk, but there did appear to be a perception that it was dominant elsewhere - in other services and in wider society. This section is based not on the original data from recorded meetings, but on a conversation that occurred when I met with participants to discuss preliminary findings, specifically in response to the finding that Risk and Medical discourses appeared to be linked. While I recognise that staff will have used discursive actions to manage their accountability in this setting, I have not analysed their comments from a constructionist standpoint as I have the recorded meetings. I have instead adopted a cognitive positivist perspective, assuming that their comments accurately represent cognitive processes that influence their actions. Treating the data from the participant feedback meetings in this way allows me to make connections between micro-level discursive actions in the recorded meetings and their macro-level institutional, political and cultural context.

Some staff described having been called to give evidence at a serious case review tribunal previously and recalled the experience of their practice being intensely scrutinised and the feeling of being questioned about their role in a client's death as extremely stressful - 'something you will never forget'. Staff from both services described the impact of this being that 'you have the tribunal panel in your head' when dealing with clients presenting with high risk. Consequently they are likely to offer medical interventions such as medication to these clients - whether or not they judge this to be best clinical practice - in order to document that they had done so, thereby protecting themselves in the event of their case notes being used as evidence and scrutinised by a tribunal panel in the future (see Appendix 8).

Another 'internal audience' that staff described bearing in mind when dealing with clients they consider to be high risk is that of wider society and in particular the media. They described 'imagining the headlines', particularly if a client were to physically attack others, and predicted that they would be blamed for having failed to protect their clients and the public (Joseph & Kearns, 1999; Moon, 2000; Paterson, 2006). The constant threat of retrospective scrutiny, punishment, and shame serves to keep staff delivering services in a way that is consistent with what they perceive to be the dominant institutional and social perception of good risk management - medical and legal models. As one participant put it, 'if the worst comes to the worst, you're



called to a tribunal and you tell them that your risk management strategy was based on psycho-social interventions, they're going to ask why you didn't medicate them' (appendix 8). This process is akin to the internalisation of discipline brought about by Jeremy Bentham's 'panopticon', as described by Foucault (1977), in which prisoners (in this case, staff) who know that they *may be* under observation at *any* time behave as though they *are* under observation *all* the time, and so they conform to the rules just in case. This defensive practice pre-emptively protects individual staff and the service as a whole in the event of external scrutiny.

## **Psychological Discourse**

Psychological discourse was used to develop shared understanding of the nature and meaning of clients' difficulties, 'normalising' their experiences and reducing the perceived severity of their difficulties. Psychological formulation was seen to be fairly democratic, in that it was conducted by and between various members of the team with different job titles and (presumably) training backgrounds. This fits with the New Ways of Working for Applied Psychologists, in which psychological knowledge is held by teams rather than being the sole domain of Clinical Psychologists or Psychological Therapists (DoH, 2007).

## ***Individualism***

Psychological discourse was seen to draw on a broader discourse of Individualism in problematising the client and neglecting wider social contributors to their distress (Masson, 1990; Smail, 1993). Whilst the client-environment interaction was recognised as contributing to their difficulties, problems and solutions were predominantly constructed within clients, sometimes in spite of clear indicators - including clients' communications - that the problem was to some extent environmental. This process is similar to that found in the transformation of clinical interviews into psychiatric reports, in which some information was selectively reported and other data ignored to construct a particular understanding of clients' difficulties as self-evident (Barrett, 1996; Hak, 1989).

A demonstration of the pervasiveness of individualism is the frequency with which clients are described as 'unwell'. It is interesting that this ostensibly medical term was used so frequently in the recorded meetings. Participants told me that they use the term 'unwell' as shorthand, relying on the team's shared understanding of

clients' individual presentations. Given the pressure of time during these meetings, particularly the MDT/handovers, it makes sense to use short-cuts. In saying 'unwell', staff were not using the hard medical terminology 'ill', but neither were they saying 'angry', 'distressed', 'unhappy' or any number of other more specific descriptors. These alternative descriptions might invite elaboration on what are they angry at/ distressed by/ unhappy about, potentially opening up avenues of enquiry that implicate social and political injustice, for example, "he is angry because he grew up in a poor and violent household, impacting on his capacity to engage at school, so he has no formal qualifications to prove his worth in a job that would stimulate him and provide for his family, and has been compelled to undertake menial 'voluntary' work in order to continue receiving benefits, perpetuating another generational cycle of poverty and violence."

The ways in which staff talk about the environment in relation to clients' difficulties represents a simultaneous acceptance and denial of reality (Long, 2008). Given the potentially wide-ranging implications of a socio-political discussion of individual difficulties, staff might easily feel overwhelmed and powerless – how are they to effect change in deeply entrenched problems controlled by powerful institutions, for example? Engaging in a meaningful way with such issues may be experienced as an intolerable threat to staff's professional identity, and so may be defensively denied.

Describing clients as 'unwell' is one way in which staff were seen to demonstrate this denial – it provides a non-specific and simplistic explanation that locates the problem within the client. When discussing individualism with participants, they asserted that they *do* recognise problems within clients' environments and provide interventions to address these in the form of Family Therapy. Staff here are acting according to their proscribed remit according to government policy (NICE, 2009; DoH, 2001) and constructing problems which they have the tools to solve. Their professional training and identity is based on understanding individuals' minds and applying individual and family-based therapeutic interventions, so constructing problems and solutions within this framework serves to maintain their expert position and protect them from a feared state of uncertainty (Long, 2008). That this approach neglects wider community, social and political factors that impact on people's wellbeing, at least insofar as interventions

are concerned, serves to maintain the status quo (Boyle, 2011). As such, I would argue that they risk only partially addressing the causes of clients' distress and may miss opportunities for collaborative working with clients in which they could be genuinely empowered to address social injustices.

### ***Psychological Discourse Reinforcing Recovery Principles***

Whilst psychological therapy may quite reasonably be seen as a *limited* resource not available to all clients, given the staff mix within EIP teams, its construction as a *precious* resource may serve to maintain the status of Psychological Therapists and Clinical Psychologists in a hierarchical structure within EIP. Another effect of this discourse was that it positioned staff as 'gatekeepers' for psychological therapy, and they in turn constructed clients as '(un)deserving' and '(in)appropriate' for this intervention in order to decide who would be offered therapy. CMHTs were seen to use a similar discursive technique to exclude clients from services on the basis of them being 'inappropriate' without using openly pejorative language (Griffiths, 2001). Clients were constructed as 'deserving' based on evidence of their 'Work Ethic', and 'inappropriate' in response to constructions of them as 'functioning' and of CBT as potentially 'destabilising'.

An arena in which one might expect Psychological discourse to play a significant role is in providing psychotherapy as a reflective space in which clients may explore the meaning of their unusual experiences. The idea of psychotic experience as an opportunity for personal understanding and development is not new – engagement with the personal journey of psychosis has long been seen as central to recovery (Laing, 1965). This concept continues in the work of the Hearing Voices Network and in therapeutic approaches that see understanding people's unusual experiences as essential to recovery (May, 2004; Romme & Escher, 2000; Beavan & Read, 2010; Dillon, 2011). A striking omission from many recent definitions of Recovery from psychosis, however, is psychosis itself – when interventions focus on reducing the DUP, making sense of clients' subjective experience can be overlooked (Tranulis, Park, Delano & Good, 2009). Recovery principles are based on "living one's life ... in the face of the ongoing presence of an illness and/or vulnerability to relapse" (Davidson & Roe, 2007, p.464), and the extent of acknowledgement that psychosis itself warrants any attention is in the aim of symptom reduction (Davidson & Roe, 2007; Liberman, 2008). According to this interpretation of recovery principles, one's life is viewed as somehow

separate from one's experience (of psychosis), and the value of exploring the experience and seeking meaning within it is significantly sidelined.

This bias in Recovery discourse was reflected in the recorded meetings and feedback from staff regarding the initial analyses. Staff talk of clients understanding the origins and nature of their difficulties, and the number of decisions to delay decisions or 'watch and wait' *may* indicate allowing clients space to work through their problems with some support, though this conclusion is speculative. Psychological formulation of clients' presentations was common in these meetings, and in a feedback session, staff described the EIP team holding psychological formulations which they may share with the clients or may otherwise use to inform their work without explicitly discussing their rationale, suggesting that for some clients at least, client understanding was not prioritised.

Rationing of psychological therapy indicates that this particular type of reflective space was not available to most clients. Furthermore, the concept of psychotherapy as a space for client-led exploration of their experiences may not be a fair representation of CBT, the predominant therapeutic model *named* in the meetings. In describing CBT to the teams at the beginning of meeting 5, O stated, "*If they haven't got any goals, that's where therapy tends to drift. But if there's something tangible that they want, say they would like to be able to get a job or something but their experiences are stopping them, then that could be something that can be used as a carrot to bring them back on track when it's drifting. That'll keep it focused,*" (no line numbers available – not initially transcribed for analysis). Interventions that focus predominantly on functional outcomes in this way have been criticised for not affording clients the reflective space necessary for deep understanding and personal growth (Lysaker, Glynn, Wilkniss & Silverstein, 2010). It is also striking that the particular functional outcome mentioned in the above description was "to get a job" – perhaps a further indicator of the prioritisation of employment as a valued outcome in EIP.

The implicit values in these judgments –the importance of the 'Work Ethic' and the prioritisation of 'functioning' over the potential benefits of psychotherapy for other forms of personal growth – are consistent with EIP recovery goals, and thus Psychological discourse is seen to be annexed by or secondary to recovery principles. That EIP are constructed as psychologically informed may also serve to justify their

expert position alongside other more medically focused mental health services, and project an image of scientific and clinical rationale for recovery principles as they are used in EIP.

## **Recovery Discourse**

Recovery discourse was seen to create a good impression of stakeholders, with staff responding to it positively. This chimes with “the subjective feeling of optimism” described in Warner’s (2010) definition of recovery. Recovery has been described as a polyvalent concept that is vague enough to be used in a number of ways (Pilgrim, 2008) – in theory, two services could both make a valid claim to be ‘recovery focused’ whilst operating very differently. NHSEIT and Recover are in many ways quite different services, but they appear to draw from a very similar concept of recovery – one that values clients taking responsibility for pursuing education and employment as a path to individual fulfillment.

### ***Empowerment or Responsibility to Conform?***

The Recovery concept of ‘empowerment’ has positive connotations consistent with Pilgrim’s (2008) definition of emancipatory recovery and inherent in Warner’s (2010) definition. It has been defined as “the extent to which the client is involved in defining the problems and setting the targets that constitute the plan of care,” and is linked to a wider discourse of consumerism within mental health care policy, including service user involvement and choice (Tilley, Pollock & Tait, 1999; p.56). Service user ‘empowerment’ by this definition may conflict with other expressed EIP aims. For example, a client may not want “an education or training plan/pathway to valued employment [to be] produced,” as the policy implementation guide stipulates (DoH, 2001, p.50) – they may consider other activities or roles to be more personally valuable. This demonstrates an organisational barrier to working in a genuinely empowering way with clients, as has previously been noted in interviews with CPNs (Tilley, Pollock & Tait, 1999).

Clients were seen to be constructed as ‘empowered’ when they made choices consistent with the EIP service aims of recovery (education or employment). Achieving these aims is reliant on clients’ ‘functioning’ – a term that was used frequently in the recorded meetings. To function is defined as, “to work or operate” (Cambridge Dictionaries Online, 2013). The use of this mechanistic term to describe behaviour has been linked to medical models of understanding and it serves to objectify the client (Barglow, 1994). In the context of EIP policy guidelines’ focus on occupation and education, ‘functioning’ carries the implication of being useful to

society in economic terms. This is reminiscent of 18<sup>th</sup>-19<sup>th</sup> Century concerns that lunatics in the asylums were a burden on the state, that occupation was a vital part of moral management and that early identification and treatment of lunacy was also considered a priority (Rose, 1986; Scull, 1979).

A grounded theory analysis of health and social care staff's constructions of non-compliance found that they spoke of clients as either 'unwilling' or 'unable' to comply with agreed care plans (Fineman, 1991). In this study, although clients were constructed as either unable or (potentially) unwilling to engage in *psychotherapy*, when clients' stated goals or behaviour did not comply with the EIP version of *recovery*, they were constructed solely as "unwilling" in terms of "playing the system" by "seeking undeserved services" – irresponsible rather than irresponsible (Fineman, 1991; p.359). That clients who did not wish to pursue employment or education were constructed similarly to clients who were non-compliant with mutually agreed contracts of care suggests that this recovery aim is not a *choice* so much as a *rule* with which they are expected to comply. The aim that "every effort must be made to provide an effective pathway to valued education and occupation" (DoH, 2001, p.52) is explicit in the EIP policy implementation guide, but I saw no evidence in the data of staff communicating this to clients. Instead, clients were apparently expected to make this choice for themselves and when they did not this was met not with curiosity, but with incredulity and frustration.

This policy contradicts the recovery values of client empowerment to pursue personally valued goals and staff's reaction could be understood as an anxious response to these conflicting demands – they are stuck in a double-bind scenario in which they are unable to fulfill both their duty to the client and to the service. To effectively address this at an institutional level would mean challenging one of the fundamental tenets of EIP. Since this institution is more powerful than the individual staff or clients, it may be safer for them to project the irresponsibility they feel into the clients (Lyth, 1990; Jaques, 1955).

Although EIP are a part of the system being played by such clients, this was seen to be a wider game to play the benefits system. In Fineman's (1991, p. 360) study, staff described "working the system" as "a client who maximizes the gains from the system but does not take responsibility ... the person is unwilling to work for themselves," which is how clients who did not conform to EIP recovery goals were

constructed in meetings and how the unemployed are increasingly portrayed in sections of the British press. Employment has been conceptualised as a social contract between the state and individuals in which both have obligations – the former to adopt policies that provide employment opportunities and support those who are out of work, and the latter to be motivated and flexible in seeking and retaining employment (Marsden & Duff, 1975). According to these recovery principles, which are consistent with Szasz' (1961) right-wing libertarian view, the medical model's sick role in which clients can be too ill or disabled to work is no longer acceptable - individuals who are not productively occupied are seen as 'shirking' their responsibility up uphold their side of the social contract. This is consistent with the image constructed in some of the popular press of the workless as 'scroungers' and it serves to stigmatise unemployment, making the state of being workless and receiving benefits *personally* shameful, with clients internalising the political pressure to find employment (Campbell & Rose, 2011). Whilst recovery focused work may reduce self-stigma around mental health problems (Harris, Collinson & das Nair, 2012), it may also serve to reinforce stigma around unemployment and deflect attention away from the state's responsibilities within the social contract - *political and societal* causes of poverty and unemployment - as predicted by other writers on the subject (Pilgrim, 2008; Scanlon & Adam, 2010). The workless person with a mental health problem in the current political climate may therefore find themselves doubly stigmatised.



## **The Game of Life**

Thomas Szasz (1963, p.205) talks of, “mental health [as] the ability to play the game of social living, and to play it well. Conversely, mental illness is the refusal to play or the inability to play it well.” According to this definition, the responsibility of recovery-focused mental health services is to support clients in learning to play the game of life according to current cultural norms and expectations and within social and political restraints, which is what EIP appear to be doing. This approach however appears to have two main drawbacks – 1. that EIP cannot force clients to play the game and 2. that the rules of the game may in themselves perpetuate the problems that EIP seek to solve.

### ***EIP have Responsibility Without Control***

I have illustrated the frustration and anxiety generated in staff when clients’ goals or behaviour are not consistent with EIP policy prioritising employment and education. In these circumstances, staff identified other services (such as Employment Support Allowance assessors) who had the power to exert pressure on clients to seek employment, although they did not speak of jointly working with such services.

Another situation in which EIP were seen to have a responsibility to achieve an impossible outcome is in seeking to work with clients who refuse to engage with the service. The policy implementation guide states that “failure to engage in treatment should not lead to case closure,” (DoH, 2001, p.47). This may draw on the common assumption that it is rational to recognise unusual experiences as pathological and accept mental health service provision (Tranulis, Park, Delano & Good, 2009), thus providing a circular rationale for the assertive outreach approach – refusal of services is reframed as avoidance of services and may provide evidence of a need for service input. This assertive outreach approach was described in practice as amounting to “banging on [clients’] door occasionally”, a practice that may be ineffectual (it did not appear to inspire optimism in EIP staff) and still worse might be considered institutional harassment. It is certainly not concordant with Davidson & Roe’s (2007) definition of recovery in psychosis as “living one’s life ... with dignity and autonomy” (p. 464).

## ***Pressure to Conform to a Sickening Society***

EIP policy shapes service provision based on a narrow definition of recovery that focuses heavily on clients undertaking employment or education. Belief in the benefits of occupation for people with mental health problems is not a new concept – it was one of the founding principles of the moral management approach of the York Retreat (Scull, 1979) – and there is some research evidence to support it (Warner, 1994). Alongside this research however, is the accumulated evidence for the social causation of psychosis, which is more prevalent in the lower classes in the developed world (Warner, 1994). Furthermore, when comparing developed countries the prevalence of mental health problems is found to be significantly positively correlated with income inequality, with the UK being the among the *most* unequal societies with among the *highest* rates of mental health problems (Wilkinson & Pickett, 2010). Work (especially mundane and routine work) and unemployment have both been linked to increased psychological stress and mental health problems, indicating that current workforce dynamics may be damaging to all (Warner, 1994; Warr, Jackson & Banks, 1988).

A proposed mechanism by which the modern economic and political climate contributes to mental distress is the process of alienation whereby people feel disconnected from their work and the products of their work, the measurement of human value is reduced to individuals' productivity and relationships are objectified as people are increasingly alienated from their own and others' humanity (Marx, 1990). This view is also reflected in Fromm's (1956) assertion that valuing economic productivity over humanity causes psychological distress. The socio-political landscape of the industrial era of the late 19<sup>th</sup> Century which Marx critiqued in *Das Kapital* (1990) has been likened to the contemporary globalization, and parallels have been drawn between each economic system's impact on individuals (Harvey, 2000). In more unequal societies it has been proposed that alienation presents as 'status anxiety' whereby people place more value on material possessions and outward appearance than relationships (de Botton, 2004; Layard, 2005).

EIP's focus on employment and education as recovery goals is an example of clients' economic productivity being important to their (EIP's and clients') perceived success, and this value judgment was not limited to clients. Staff talked in the results feedback meeting about appreciating the value of having a consistent, supportive

relationship with clients during their time with EIP, however in the analysed meetings they appeared to prioritise their own instrumental roles over human relationships with clients in their decisions to transfer clients to other members of the team to better suit their (clients') practical needs through a discourse of Professionalism.

## **Implications for Clinical Practice**

### ***Reflective Practice***

EIP services and staff are subject to considerable conflicting pressures, and it appeared that some of the anxiety and frustration that arose as a result may have sometimes been felt towards clients. It was not clear in the data the extent to which this was acknowledged and discussed within teams. A forum for reflection on the wider social and political context and consequences of EIP's work, whilst potentially anxiety-provoking, may reduce the likelihood of negative emotion being displaced towards clients. This may also allow space for staff to consider clients' experience of the service

### ***Transparency***

One of the greatest conflicts was that between respecting client choice and working collaboratively whilst being obliged by policy to develop plans centred on education or employment. This conflict could be reduced by staff being explicit about EIP policy with clients from early in their involvement with the service. Although this may risk jeopardizing the engagement of clients who do not share EIP goals, it would create greater transparency and may offer the opportunity for genuine collaboration with clients to work creatively within the policy guidelines. Furthermore, since knowledge is intrinsically linked to power, it may offer a more genuinely empowering experience for clients – to develop better understanding of the system of which they are a part.

### ***Preventative Measures***

Davies and Burdett (2004) outlined measures that could be implemented at a government policy level that would address some of the known psycho-social predisposing factors for psychosis and other forms of psychological distress. They are primarily aimed at children and families, but would benefit society as a whole, and consist of: reducing child abuse and poverty, and creating more equal and just social structures through welfare, education, health and social care; and strengthening support networks for families with children to foster self esteem and healthy coping skills, as in the Sure Start scheme. Although reforming social structures and institutions is a formidable task and beyond the current remit of EIP, the principles of

strengthening support networks and creating equal and just social structures can begin within the service, using an Open Dialogue Approach. In addition, as mental health professionals in collaboration with service users we could use the collective power of our expert positions to campaign for greater awareness of these issues and lobby the government for changes in policy to promote mental wellbeing for all.

### ***Open Dialogue***

Open Dialogue is an integrated social approach to EIP which is well established in the national healthcare system in the Western Lapland region of Finland. Outcome studies have consistently shown that over 80% of clients report no psychotic experiences at two year follow-up, with a similar number of clients in full time employment or education (Seikkula, Alakare & Aaltonen, 2011). Open Dialogue is based on principles of collaborative working between a consistent group of psychotherapeutically trained professionals, the person presenting with difficulties and their family and social network. This group of stakeholders is involved in the process from the very first meeting, which is arranged within 24 hours of a referral, for as long as required. This consistency aims to promote a sense of safety within which uncertainty can be tolerated and the group's resources can be nurtured. Interventions are collaboratively negotiated and adapted to the needs of the group of stakeholders, with the aim of generating a shared language with which to explore their experiences.

The practice of Open Dialogue addresses many of the conflicts and anxieties observed in the meetings analysed in this study. With all staff therapeutically trained, psychotherapy is no longer a limited or precious resource. The security of consistent relationships is explicitly valued and not restricted by predetermined time limits, allowing anxiety to be effectively managed within the group. Working with stakeholders in a group setting may reduce the need for staff to carry the 'internal audiences' that they described, since some of the potential audiences will be present externally. The collaborative and flexible nature of the approach will likely eliminate the potential dissonance between clients' and EIP's recovery goals. The inclusion of family and other members of clients' social circles increases the likelihood of social bonds being strengthened. This also offers the potential for clients' social environments to adapt somewhat to their needs rather than the onus being predominantly on clients to change.

## **Strengths and Limitations**

My intention to record a range of meetings across the two participating services in order to maximise variation in the data collected was balanced against time constraints. Two of the five recorded meetings were explicitly focused on 'high risk' ('red and 'amber') clients, which may have led to a disproportionate recording of risk and associated Medical and Legal discourses. Discussions about psychotherapy may also have been disproportionately related to CBT as a result of recording a meeting focused specifically on CBT referrals. Linked to this is the point raised at a results feedback meeting regarding the lack of analysed discussion about Family Therapy (see appendix 8) due to not recording a team meeting focused on this topic. Two of the meetings (3 & 5) were of the same team, and so may have resulted in some undue bias.

The naturalism of staff interactions may have been affected by my presence at the recorded meetings. I noted some evidence for this being the case, with other staff commenting that meeting four was 'less raucous' than usual, and with staff in all meetings occasionally looking at or talking to me during the meeting. This effect may have been reduced had I attended some meetings without recording them prior to data collection for staff to become more familiar with and comfortable in my presence. Another factor that affected the natural flow of meetings was the protocol for protecting clients' anonymity. When the procedure was adhered to, it was a repeated reminder that the meeting was being recorded. Staff sometimes lapsed into referring to clients in their habitual way, suggesting that the meeting may have been flowing more naturally, however when another participant reminded them of the protocol, this again interrupted the natural progression of the meeting. The disruption was particularly noticeable in meeting 2, in which staff were required to refer to clients using a number and it often took some time for the speaker and then the listeners to associate the correct client to their number.

I noticed during data collection that more of the attendees at Recover's meetings spoke, whilst there were some staff in NHSEIT who did not speak at all, or only in whispers to their neighbours which could not be heard on recordings. I was told by staff after the meetings that this was not unusual, and that it was not likely to be due to the meeting being recorded.

I made notes about visual information such as facial expressions and gestures during meetings, but by audio (rather than video) recording meetings I may have

missed some such data that may have informed the analysis. Transcription data was omitted from meeting 4 due to a member of staff withdrawing their consent. Although the staff member did not speak for a large proportion of the meeting, this did contribute to the data being somewhat incomplete.

### ***Reflexivity and Quality Evaluation***

I shall outline below the ways in which I endeavoured to meet established criteria for quality in qualitative health research and discourse analysis (Elliott, Fischer & Rennie, 1999; Yardley, 2000; Antaki, Billig, Edwards & Potter, 2003).

### **Sensitivity to Context**

I have set my findings in the context of theoretical literature related to the methodology and topic, and linked particular interactions in a specific context to wider philosophical concepts. I have not triangulated my data collection or analysis by using multiple data sources or methodologies, due to the specificity of the research questions, (Johnson, 1997), though I have situated my findings in the context of mental health policy, analysing discourses and particular terms in the data that were also present in policy documents. I situated the sample in its historical and current cultural and political setting, as well as more specifically describing the two participating EIP services and the particular meetings recorded (Elliott, Fischer & Rennie, 1999). This contextual awareness helped me to problematise taken-for-granted assumptions based on naturalised discourses (Harding & Gantley, 1998). My analysis was guided by discussions with my thesis supervisors, two of whom have worked in the participating teams, providing a credibility check on my analysis (Elliott, Fischer & Rennie, 1999).

### **Commitment, Rigour, Transparency and Coherence**

I have described some of the personal and professional experiences that inspired my interest in the research topic and methodology. Throughout the process I have kept a reflective journal to inform my analysis and challenge my presuppositions about discourses and discursive actions. I have outlined in detail the process of data collection and analysis and included transcript extracts to demonstrate participants' orientation and for readers to evaluate my analysis for themselves (Potter, 2004). I have aimed to balance inclusivity of the variation in the data with offering a coherent narrative thread that recognises my role as 'author of a version of reality' rather than 'discoverer of ultimate truth' (Elliott, Fischer & Rennie, 1999). I have attempted to

present a thorough, balanced, and thoughtful analysis that makes clear and justified links between discourses, discursive practices and wider cultural, political and philosophical issues (Antaki, Billig, Edwards & Potter, 2003). I found that alternating extended periods of time analysing the data with breaks from analysis allowed the reflective space (distance) for broad narrative threads to become apparent and the immersion (proximity) to develop a more nuanced understanding and check hypotheses.

### **Impact and Importance**

I have outlined how this project develops the theoretical understanding of the topic and made recommendations for service delivery based on my findings that may be practically useful to EIP and potentially other mental health services, though the limitations of generalisability have been noted (Antaki, Billing, Edwards & Potter, 2003). I hope that I have presented this narrative in such a way as to engage the reader and that its' themes resonate with those familiar with EIP or other mental health services (Elliott, Fischer & Rennie, 1999). I have fed back the preliminary results to the participating teams in order that they may benefit professionally from having been involved in the project, and plan also to circulate a summary of the findings to participants. It is further hoped that such a detailed analysis of discourses and discursive practices related to people with psychosis or severe mental health problems may contribute to changes in the way they are conceptualised in other services and more generally.



## **Implications for Future Research**

This study has added to the evidence base pertaining to the ways in which mental health professionals make sense of their clients' presentations and shown how discursive practices are used functionally to manage staff's anxiety arising from the many conflicting pressures they are subject to. EIP services were specifically developed in accordance with a particular version of recovery principles, but these principles have also been incorporated into existing British inpatient and community services operating within the same wider culture but with their own local and institutional histories. The evidence base on the application of recovery principles would benefit from more qualitative research into the ways in which these are enacted in these different settings. My impression from conversations with other professionals is that interest in alternatives to dominant existing models of service delivery is growing in the UK. Soteria Network and Open Dialogue UK are two examples of organizations that support and promote the development of such alternatives, and whilst they are in their infancy, quantitative and qualitative research into their clinical practices and effectiveness would be of great benefit.

## **Conclusions**

The aim of this research was to investigate the ways in which EIP staff teams used different discourses to make sense of their clients' presentations. I found that staff used three core discourses – Medical, Psychological and Recovery – along with other dominant cultural discourses to achieve particular outcomes and position themselves in relation to others. EIP teams appeared to negotiate a number of sometimes conflicting institutional, clinical and societal pressures. They appeared to have particular difficulty in resolving the conflict arising from clients holding different recovery goals to those stipulated in EIP policy guidance, which are based on seeking employment or education. The dissonance of these conflicting pressures generated anxiety that was managed in various ways including locating problems within clients. As a result, staff were seen to neglect potential environmental contributors to clients' difficulties and the inherent contradictions in their own roles. I proposed Open Dialogue as an alternative service delivery model which has the potential to address some of the difficulties EIP currently experience.

## ***Personal Reflections***

An early driver in my choice to pursue Clinical Psychology as a career was reading a service user's account of her 'treatment' in psychiatric institutions in the 1960s and 1970s (Hart, 1995). I remember being appalled at her inhumane treatment, astonished that this could have happened so recently and inspired by the way she rebuilt her life and managed her distressing experiences with the support of an understanding Psychiatrist. Although I have worked with Psychiatrists I respect very much, I maintained the broad belief that Psychiatry (as an institution) was oppressive and inhumane, whilst Clinical Psychology was compassionate and empowering. The Consultant Psychiatrist I encountered on clinical placement (see chapter one – 'Declaration of Interest') was the embodiment of all that I believed was *bad* about Psychiatry, and motivated me to explore the practices of a recovery-focused, psychology-based service in the expectation that this would enact all that I believed was *good* about Clinical Psychology.

On first impressions, this appeared to be the case, but the more I deconstructed the transcripts, the more I felt that EIP were the 'bad guys' too. I found myself perceiving them as being more interested in achieving service outcomes and protecting themselves than providing the non-judgmental care that clients needed. I think this anger reflected two parallel processes – 1. that I was under pressure to complete this project and felt that I (like the clients) was being reduced to an outcome measure in the form of this document, and 2. that I (like EIP staff) was misattributing wider institutional and political problems to individuals or teams.

Reflecting on these processes allowed me to recognise that I, EIP staff, and perhaps even the aforementioned Consultant Psychiatrist were doing our best with the resources available to us and within the constraints of the systems we are part of. This reflection afforded me the wider perspective that allowed me to be more compassionate towards EIP staff, as I hope we all as mental health professionals and human beings can be towards our clients and one another.

## References

American Psychiatric Association (1952). *Diagnostic and Statistical Manual of Mental Disorders*. Washington DC: APA.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental health disorders (4th ed.)*. Washington DC: APA.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Arlington, VA: APA.

Anderson, M. (2003). 'One flew over the psychiatric unit': Mental illness and the media. *Journal of Psychiatric and Mental Health Nursing*, 10(3), 297-306.

Antaki, C., Billig, M., Edwards, D. & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*, 1. Retrieved from: <https://dspace.lboro.ac.uk/2134/633>, 20<sup>th</sup> May, 2013.

Atkinson, J.M. and Heritage, J.C. (eds.) (1984). *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press.

Austin, J. (1962). *How to do Things with Words*. London: Oxford University Press.

Barglow, R. (1994). *The Crisis of the Self in the Age of Information: Computers, dolphins, and dreams*. London: Routledge.

Barnes, M. & Berke, J. (1973). *Mary Barnes: Two Accounts of a Journey Through Madness*. Harmondsworth: Penguin.

Barrett, R. (1996). *The psychiatric team and the social definition of schizophrenia*. Cambridge: Cambridge University Press.

Barthes, R. (1964). *Elements of Semiology*. New York: Hill and Wang.

Barthes, R. (1972). *Mythologies*. London: Paladin.

Beavan, V., & Read, J. (2010). Hearing voices and listening to what they say: The importance of voice content in understanding and working with distressing voices. *Journal of Nervous and Mental Disease*, 198(3), 201-205.

Beresford, P. (2003). *It's Our Lives: A Short Theory of Knowledge, Distance and Experience*. London: Citizen Press.

Bhaskar, R. (1989). *Reclaiming Reality*. London: Verso.

Billig, M. (1996). *Arguing and Thinking: A Rhetorical Approach to Social Psychology* (2nd edition). Cambridge: Cambridge University Press.

Bion, W.E.R. (1959). *Experiences in Groups*. New York: Basic Books.

Birchwood, M., McGorry, P., & Jackson, H. (1997). Early intervention in schizophrenia. *British Journal of Psychiatry*, 170, 2-5.

Birchwood, M., Todd, P., & Jackson, H. (1998). Early intervention in psychosis: The critical period hypothesis. *British Journal of Psychiatry*, 172(33), 53-59.

Bloor, M., & Bloor, T. (2007). *The Practice of Critical Discourse Analysis: An Introduction*. London: Hodder Arnold.

Boyers, R. & Orrill, R. (Eds.) (1971). *R.D. Laing and Anti-Psychiatry*. Harmondsworth: Penguin.

Boyle, M. (1999). Diagnosis. In C. Newnes, G. Holmes & C. Dunn (Eds.), *This is Madness: A critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books.

Boyle, M. (2002). *Schizophrenia: A Scientific Delusion?* Hove: Routledge.

Boyle, M. (2011). Making the world go away, and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff, & J. Dillon (Eds), *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*. Basingstoke: Palgrave MacMillan.

Burr, V. (1995). *An Introduction to Social Constructionism*. London: Routledge.

Burr, V. (2003). *Social Constructionism*. London: Routledge.

Buss, A.H. (1966). *Psychopathology*. New York: Wiley.

Bynum, W.F. (1964). Rationales for therapy in British psychiatry: 1780-1835. *Medical History*. 18, 317-335.

Cambridge Dictionaries Online (2013). [Internet resource] Available from <[http://dictionary.cambridge.org/dictionary/british/function\\_7?q=functioning](http://dictionary.cambridge.org/dictionary/british/function_7?q=functioning)> [Accessed on 5<sup>th</sup> October 2013]

Campbell, P., & Rose, D. (2011). Action for change in the UK: Thirty years of the user/survivor movement. In D. Pilgrim, A. Rogers, A. & B. Pescosolido (Eds.), *The SAGE Handbook of Mental Health and Illness*. London: Sage Publications.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Research*. London: Sage.

Colombo, A., Bendelow, G., Fulford, B. & Williams, S. (2003). Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Social Science and Medicine*, 56, 1557-1570.

Cooper, N. & Stevenson, C. (1996). Health research. In N. Cooper, C. Stevenson, & G. Hale (Eds.), *Integrating Perspectives on Health*. Buckingham: Open University Press.

Craig, T.J.K., Garety, P., Power, P., Rahaman, N., Colbert, S., Fornells-Ambrojo, M. & and Dunn, G. (2004). The Lambeth Early Onset (LEO) Team: Randomised controlled trial of the effectiveness of specialised care for early psychosis. *British Medical Journal*, 329(7474), 1067.

Crossley, N. (2006). *Contesting Psychiatry: Social movements in mental health*. Abingdon: Routledge.

Crowe, M. (2000). Constructing normality: a discourse analysis of the DSM-IV. *Journal of Psychiatric Mental Health Nursing*, 7(1), 69-77.

Crumlish, N., Whitty, P., Clarke, M., Browne, S., Kamali, M., Gervin, M., McYigue, O., Kinsella, A., Waddington, J.L., Larkin, C. and O'Callaghan, E. (2009). Beyond the critical period: longitudinal study of 8-year outcome in first-episode non-affective psychosis. *British Journal of Psychiatry*, 194(1), 18-24.

Cutcliffe, J.R. & Hannigan, B. (2001). Mass media, 'monsters' and mental health clients: The need for increased lobbying. *Journal of Psychiatric and Mental Health Nursing*, 8(4), 315-321.

Danziger, K. (1990). Generative metaphor and the history of psychological discourse, in Leary, D.E. (Ed.), *Metaphors in the History of Psychology*. New York: Cambridge University Press.

Davidson, L. & Roe, D (2007). Recovery from versus recovery in serious mental illness: one strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16 (4), 459-470.

Davidson, L., O'Connell, M.J., Tondora, J., Lawless, M. & Evans, A.C. (2005). Recovery in serious mental illness: a new wine or just a new bottle? *Professional Psychology: Research and Practice*, 36(5), 480-487.

Davies, E. & Burdett, J. (2004). Preventing 'schizophrenia': creating the conditions for saner societies. In J. Read, L.R. Mosher, & R. Bentall (Eds.). *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*. Routledge: Hove.

de Botton, A. (2004). *Status Anxiety*. London: Hamish Hamilton.

Deegan, P.E. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11, 11-19.

Deese, J. (1984). *Thought into speech: The psychology of a language*. Englewood Cliffs, NJ: Prentice-Hall.

Department of Health (1998). *Modernising Mental Health Services: Safe, Sound and Supportive*. London: The Stationary Office.

Department of Health (1999). *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Department of Health Publications.

Department of Health (2001). *Mental health policy implementation guide*. London: Department of Health Publications.

Department of Health (2007). *New Ways of Working for Applied Psychologists in Health and Social Care – Working Psychologically in Teams*. Leicester: BPS.

Dillon, J. (2011). The personal is the political. In M. Rapley, J. Moncrieff, & J. Dillon (Eds), *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*. Basingstoke: Palgrave MacMillan.

Edwards, D. & Potter, J. (1992). *Discursive Psychology*. London: Sage.

Edwards, D. & Potter, J. (2001). Discursive psychology. In A. McHoul & M. Rapley (Eds.), *How to Analyse Talk in Institutional Settings: A Casebook of Methods*. London: Continuum.

Elliott, R., Fischer, C.T., & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Fairclough, N. (1995). *Critical Discourse Analysis: The Critical Study of Language (2<sup>nd</sup> Ed)*. Harlow: Pearson.

Falloon, I. (1992). Early intervention for first episode of schizophrenia. *Psychiatry*, 10, 40-44.

Fineman, N. (1991). The social construction of noncompliance: a study of health care and social service providers in everyday practice. *Sociology of Health and Illness*, 13(3), 354-374.

Fisher, J.E. & Happell, B. (2009). Implications of evidence-based practice for mental health nursing. *International Journal of Mental Health Nursing*, 18, 179-185.

Foucault, M. (1967). *Madness and Civilization: A History of Insanity in the Age of Reason*. London: Tavistock Publications Ltd.

Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*. London: Allen Lane.

Frances, A. (2012). DSM 5 Is Guide Not Bible—Ignore Its Ten Worst Changes. [Internet resource] Available from <<http://www.psychologytoday.com/blog/dsm5-in-distress/201212/dsm-5-is-guide-not-bible-ignore-its-ten-worst-changes>> [Accessed on 1<sup>st</sup> May 2013].

Fromm, E. (1956). *The Sane Society*. London: Routledge & Kegan Paul Ltd.



- Garfinkel, H. (1967). *Studies in Ethnomethodology*. Englewood Cliffs: Prentice Hall.
- Georgaca, E. (2013). Social constructionist contributions to critiques of psychiatric diagnosis and classification. *Feminism and Psychology, 23*(1), 56-62.
- Gilbert, G.N. & Mulkay, M. (1984). *Opening Pandora's Box: a Sociological Study of Scientists' Discourse*. Cambridge: Cambridge University Press.
- Griffiths, L. (2001). Categorising to exclude: the discursive construction of cases in community mental health teams. *Sociology of Health and Illness, 23*(5), 678-700.
- Hafner, H., Loffler, W, Maurer, K., Hambrecht, M., & an der Heiden, W. (1999). Depression, negative symptoms, social stagnation and social decline in the early course of schizophrenia. *Acta Psychiatrica Scandinavica, 100*, 105-118.
- Hak, T. (1989). Constructing a psychiatric case. In B Torode (Ed.), *Text and Talk as Social Practice: Discourse Difference and Division in Speech and Writing*. Dordrecht, Holland: Foris Publications.
- Harding, G. & Gantley, M. (1998). Qualitative methods: beyond the cookbook. *Family Practice, 15*, 76-79.
- Haro, J.M., Novick, D., Bertsch, J., Karagianis, J., Dossenbach, M., & Jones, P.B. (2011). Cross-national clinical and functional remission rates: worldwide schizophrenia outpatient health outcomes (W-SOHO) study. *The British Journal of Psychiatry, 199*, 194-201.
- Harper, D.J. (2003). Discourse Analysis. In M. Slade & S. Priebe (Eds.), *What Works for What?* London: Brunner-Routledge.

Harris, K., Collinson, C., & das Nair, R. (2012). Service-users' experiences of an early intervention in psychosis service: An interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 85, 456-469.

Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., Dube, K.C., Ganey, K., Giel, R., An Der Heiden, W., Holmberg, S.K., Janca, A., P. Lee, W.H., Leon, C.A., Malhotra, S., Marsella, A. J., Nakane, Y., Sartorius, N., Shen, Y. Skoda, C., Thara, R., Tsirkin, S.J., Varma, V.K., Walsh, D. & D. Wiersma (2001). Recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry*, 178, 506-517.

Harrow, M. & Jobe, T.H. (2007). Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: a 15-year multi follow-up study. *The Journal of Nervous and Mental Disease*, 195, 406-414.

Hart, L. (1995). *Phone at Nine Just to Say You're Alive*. London: Douglas Elliot Press.

Harvey, D. (2000). *Spaces of Hope*. Edinburgh: Edinburgh University Press.

Hervey, N. (1986). Advocacy or folly: The Alleged Lunatics' Friend Society, 1845-63. *Medical History*, 30(3), 245-275.

Hui, A. & Stickley, T. (2007). Mental health policy and mental health service user perspectives on involvement: a discourse analysis. *Journal of Advanced Nursing*, 59(4), 416-426.

Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.

Jaques, E. (1955). Social systems as a defence against persecutory and depressive anxiety. In M. Klein, P. Heimann, & R.E. Money-Kyrle (Eds.). *New Directions in Psychoanalysis*. London: Tavistock.

Jefferson, G. (1990). List-construction as a task and a resource. In G. Psathas (Ed), *Interaction competence*, Washington, DC: University Press of America.

Johannessen, J. O. (2004). The development of early intervention services. In J. Read, L.R. Moshier, & R. Bentall (Eds.). *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*. Routledge: Hove.

Johnson, J.L. (1997). Generalizability in qualitative research: excavating the discourse. In J.M. Morse (Ed.), *Completing a Qualitative Project: Details and Dialogue*. Thousand Oaks, CA: Sage.

Johnstone, L. (2000). Users and abusers of psychiatry: a critical look at psychiatric practice. (2<sup>nd</sup> Ed.) London: Routledge.

Joseph, A. & Kearns, R. (1999). Unhealthy acts: interpreting narratives of community mental health care in Waikato, New Zealand. *Health and Social Care in the Community*, 7, 1-8.

Kraepelin, E. (1899) *Psychiatrie: ein Lehrbuch für Studierende und Aertze* (6th edn). Leipzig: Barth Verlag. Reprinted (1990) as *Psychiatry: A Textbook for Students and Physicians* (ed. J. M. Quen; trans. H. Metoiu & S. Ayed). Canton, MA: Science History Publications.

Laclau, E. and Mouffe, C. (1985). *Hegemony and the Socialist Strategy*. London: Verso.

Laing, R.D. (1965). *The Divided Self: An Existential Study in Sanity and Madness*. Harmondsworth: Penguin.

Laing, R.D. (1967). *The Politics of Experience and the Bird of Paradise*. Harmondsworth: Penguin.

Lambert, M., Naber, D., Schacht, A., Wagner, T., Hundemer, H.P., Karow, A., Huber, C.G., Suarez, D., Haro, J.M., Novick, D., Dittmann, R.W. and Schimmelmann, B.G. (2008). Rates

and predictors of remission and recovery during 3 years in 392 never-treated patients with schizophrenia. *Acta Psychiatrica Scandinavica*, 118(3), 220-229.

Larsen, J.A. (2007). Understanding a complex intervention: Person-centred ethnography in early psychosis. *Journal of Mental Health*, 16(6), 333-345.

Layard, R. (2005). *Happiness*. London: Allen Lane.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199, 445-452.

Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin*, 15, 197-200.

Liberman, R.P. (2008). *Recovery from Disability: Manual of Psychiatric Rehabilitation*. Washington DC: American Psychiatric Publishing.

Lodge, G. (2010). Empowerment and the recovery model. *The Psychiatrist Online*, 34, 116-117. London: Addison Wesley Publishing Company.

Long, S. (2008). *The Perverse Organization and its Deadly Sins*. London: Karnac.

Lovejoy, M. (1982). Expectations and the recovery process. *Schizophrenia Bulletin*, 9, 604-609.

Lysaker, P.H., Glynn, S.M., Wilkniss, S.M. & Silverstein, S.M. (2010). Psychotherapy and recovery from schizophrenia: A review of potential applications and need for future study. *Psychological Services*, 7(2), 75-91.

Lyth, I. M. (1990). Social systems as a defense against anxiety. In E. L. Trist and H. Murray (Eds.) *The social engagement of social science, Vol. 1: The socio-psychological perspective*. London: Free Association Books.

MacKeith, J. & Burns, S. (2008). *Mental Health Recovery Star*. Mental Health Providers Forum and Triangle Consulting.

Marsden, D. & Duff, E. (1975). *Workless: Some Unemployed Men and their Families*. Harmondsworth: Penguin.

Marshall, M., Lewis, S., Lockwood, A., Drake, R., Jones, P. & Croudace, T. (2005). Association between duration of untreated psychosis and outcome in cohorts of first-episode patients. *Archives of General Psychiatry*, 62(9), 975-983.

Marx, K. (1990). *Capital: A Critique of Political Economy*. Harmondsworth: Penguin in association with New Left Review.

Masson, J. (1990). *Against Therapy*. London: Fontana.

May, R. (2004). Making sense of psychotic experiences and working towards recovery. In J. Gleeson, & P. McGorry (Eds.), *Psychological Interventions in Early Psychosis*. London: Wiley.

McCarthy, D. & Rapley, M. (2001). Far from the madding crowd: psychiatric diagnosis as the management of moral accountability. In A. McHoul & M. Rapley (Eds.), *How to Analyse Talk in Institutional Settings: A Casebook of Methods*. London: Continuum.

McCranie, A. (2011). Recovery in mental illness: the roots, meanings, and implementations of a “new” services movement. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE Handbook of Mental Health and Illness*. London: Sage Publications.

McGorry, P. (2000). The scope for preventative strategies in early psychosis. Logic, evidence and momentum. In M. Birchwood, D. Fowler, & C. Jackson (Eds.) *Early Intervention in Psychosis. A Guide to Concepts, Evidence and Interventions*. Chichester: John Wiley & sons.

McGovern, D., Hemmings, P. & Cope, R. (1994). Long-term follow-up of young Afro-Caribbean Britons and white Britons with a first admission diagnosis of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 29, 8-19.

Mendez, C.L., Coddou, F. & Maturana, H.R. (1988). The bringing forth of pathology. *Irish Journal of Psychology*, 9, 144-172.

Mental Health Network NHS Confederation (2011). *Briefing 219: Early Intervention in Psychosis Services*. London: NHS Confederation Events and Publishing.

Moon, G. (2000). Risk and protection: the discourse of confinement in contemporary mental health policy. *Health and Place*, 6, 239-250.

Morris, D. & Bates, P. (2003). *Making Inclusion Work: Social Inclusion Resource Pack on Service Mapping and Outcome Measurement*. Leeds: NIMHE.

Mosher, L.R., Hendrix, V. & Fort, D. (2004). *Soteria: Through Madness to Deliverance*. Philadelphia: Xlibris Corporation.

National Institute for Health and Clinical Excellence (NICE) (2009). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care*. London: NICE.

National Institute for Mental Health in England (NIMHE) (2005). *NIMHE Guiding Statement on Recovery*. London: NIMHE.

Norman, R.M., Manchanda, R., Malla, A.K., Windell, D., Harricharan, R. & Northcott, S. (2011). Symptom and functional outcomes for a 5 year early intervention program for psychoses. *Schizophrenia Research*, 129(2-3), 111-5.

Norman, R.M.G., & Malla, A.K. (2001). Duration of untreated psychosis: a critical examination of the concept and its importance. *Psychological Medicine*. 31, 381-400.

O'Toole, M.S., Ohlsen, R. I., Taylor, T.M., Purvis, R., Walters, J. & Pilowsky, L.S. (2004). Treating first episode psychosis – the service users' perspective: A focus group evaluation. *Journal of Psychiatric and Mental Health Nursing*, 11, 319-326.

Parker, I. (1994). Reflexive research and the grounding of analysis: social psychology and the psy-complex. *Journal of Community and Applied Social Psychology*, 4(4), 239-52.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T. & Stowell Smith, M. (1995). *Deconstructing Psychopathology*. London: Sage.

Parry, R. & Moyes, S. (2013, October 7). 1,200 killed by mental patients. *The Sun*, p.1.

Paterson, B. (2006). Newspaper representations of mental illness and the impact of the reporting of 'events' on social policy: The 'framing' of Isabel Schwarz and Jonathan Zito. *Psychiatric and Mental Health Nursing*, 13(3), 294-300.

Paterson, B. (2007). A discourse analysis of the construction of mental illness in two UK newspapers from 1985-2000. *Issues in Mental Health Nursing*, 28, 1087-1103.

Pelosi, A & Birchwood, M. (2003). Is early intervention for psychosis a waste of valuable resources? *British Journal of Psychiatry*. 182, 196-198.

Pidgeon, N. & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.) *Doing Qualitative Analysis in Psychology*. Hove: Psychology Press.

Pilgrim, D. (2005). *Key Concepts in Mental Health*. London: Sage.

Pilgrim, D. (2008). 'Recovery' and current mental health policy. *Chronic Illness*, 4, 295-304.

Platts, S. (2006). *How are different perspectives managed in multidisciplinary psychiatric ward rounds?* Unpublished thesis.

Pomerantz, A. (1986). Extreme case formulations: a way of legitimizing claims. *Human Studies*, 9, 219 – 229.

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology*, 2, 281 – 307.

Potter, J. & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage.

Potter, J. & Wetherell, M. (1995). Discourse analysis. In J.A. Smith, R. Harre, & L. Van Langenhove (eds.), *Rethinking Methods in Psychology*. London: Sage.

Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage.

Potter, J. (2004). Discourse Analysis. In M. Hardy & A. Bryman (Eds.), *Handbook of Data Analysis*. London: SAGE.

Prilleltensky, I. & Nelson, G. (2009). Community Psychology: Advancing Social Justice. In Fox, D., Prilleltensky, I. & Austin, S. *Critical Psychology: An Introduction* (2<sup>nd</sup> Ed.) London: Sage.

Ramon, S., Healy, B. & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*, 53, 108-122.

Ridgway, P. (2001). Restorying psychiatric disability: learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 335-343.

Roberts, A. (1981). *The Lunacy Commission*. [Internet resource] Available from <<http://studymore.org.uk/01.htm>> [Accessed on 21<sup>st</sup> June 2012]



Rogers, A. & Pilgrim, D (2005). *A Sociology of Mental Health and Illness (3<sup>rd</sup> Ed)*. Maidenhead: Open University Press.

Rogers, A. & Pilgrim, D. (1996). *Mental Health Policy in Britain: A Critical Introduction*. Houndmills: MacMillan.

Romme, M., & Escher, S. (2000). *Making Sense of Voices*. London: MIND Publications.

Rose, D. (2009). Survivor produced knowledge. In A. Sweeney, P. Beresford, A. Faulkner, M. Nettle, & D. Rose, (Eds.) *This is Survivor Research*. Ross-on-Wye: PPCS Books.

Rose, N. (1986). Psychiatry: the discipline of mental health. In P. Miller, & N. Rose (eds.), *The Power of Psychiatry*. Cambridge: Polity Press.

Rose, N. (1990a). Psychology as a “social” science. In I. Parker, & J. Shotter, (Eds), *Deconstructing Social Psychology*. London: Routledge.

Rose, N. (1990b). *Governing the Soul: the Shaping of the Private Self*. London: Routledge.

Rose, N. (1998). Television, madness and community care. *Journal of Community and Applied Social Psychology*, 8(3), 213-228.

Roudinesco, E, (1990). *Jacques Lacan & Co.: a History of Psychoanalysis in France, 1925-1985*. London: Free Association Books.

Sacks, H. (1995). *Lectures on Conversation*. Edited by G. Jefferson, Oxford: Blackwell.

Scanlon, C. and Adlam, J. (2010). The recovery model or the modeling of a cover-up? *Groupwork*, 20(3), 100-114.

Scull, A.T. (1979). *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*. New York: St Martin's Press.

Scull, A.T. (2005). *Madhouse: A Tragic Tale of Megalomania and Modern Medicine*. Cambridge: University Press.

Sedgwick, P. (1982). *Psychopolitics*. London: Pluto Press.

Seikkula, J., Alakare, B. & Aaltonen, J. (2011). The comprehensive open-dialogue approach in western Lapland: II. Long term stability of acute psychosis outcomes in advanced community care. *Psychosis*, 3(3), 192-204.

Slade, M. (2009). *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge: Cambridge University Press.

Smail, D. (1993). *The Origins of Unhappiness*. London: Harper Collins.

Stickley, T. & Wright, N. (2011). The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part one: a review of the peer-reviewed literature using a systematic approach. *Journal of Psychiatric and Mental Health Nursing*, 18, 247-256.

Stone, M. (1985). Shellshock and the psychologists, In W.F. Bynum, R. Porter, & M. Shepherd (Eds). *The Anatomy of Madness*, Vol. 2. London: Tavistock.

Szasz, T. (1961). The Myth of Mental Illness. *American Psychologist*, 15, 113-118.

Szasz, T. (1963). *Law, Liberty and Psychiatry*. New York: MacMillan.

Terkelsen, T. B. (2009). Transforming subjectivities in psychiatric care. *Subjectivity*, 27, 195-216.

- Tilley, S., Pollock, L., & Tait, L. (1999). Discourses on empowerment. *Journal of Psychiatric Mental Health Nursing*, 6(1), 53-60.
- Time to Change (2013). Commenting on The Sun's 'Mental Patient' Front Page. [Internet resource] Available from <<http://www.time-to-change.org.uk/news/comment-the-sun-mental-patient-front-page>> [Accessed on 16<sup>th</sup> October 2013].
- Tranulis, C., Park, L., Delano, L. & Good, B. (2009). Early intervention in psychosis: A case study on normal and pathological. *Culture, Medicine and Psychiatry*, 33, 608-622.
- UKAN (2001). *A Clear Voice, A Clear Vision: An Advocacy Reader*. Sheffield: UKAN.
- UKAN (2004). *Advocacy Today and Tomorrow: UKAN Training Tool*. Sheffield: UKAN.
- Unzicker, R. (1989). On my own: A personal journey through madness and re-emergence. *Psychosocial Rehabilitation Journal*, 13, 71-77.
- Van Dijk, T. A. (1993). *Elite Discourse and Racism*. Newbury Park, CA: Sage Publications.
- Wallcraft, J., Read, J. & Sweeney, S. (2002). *On Our Own Terms*. London: The Sainsbury Centre for Mental Health.
- Warner, R. (1994). *Recovery From Schizophrenia: Psychiatry and Political Economy*. New York: Routledge.
- Warner, R. (2004). *Recovery from Schizophrenia: Psychiatry and Political Economy (3<sup>rd</sup> Edition)*. Hove: Brunner-Routledge.
- Warner, R. (2005). Problems with early and very early intervention in psychosis. *The British Journal of Psychiatry*, 187, s104-s107.

- Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist*, 34, 3-5.
- Warr, P., Jackson, P. & Banks, M. (1988). Unemployment and mental health: some British studies. *Journal of Social Issues*, 44, 47-68.
- Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society*, 9(3), 387-412.
- Whittaker, R. (2002). *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill*. Cambridge MA: Perseus Publishing.
- Willig, C. (2008). *Introducing Qualitative Research in Psychology (2<sup>nd</sup> Ed.)*. Maidenhead: Open University Press.
- Wilkinson, R. & Pickett, K. (2010). *The Spirit Level: Why Equality is Better for Everyone*. London: Penguin.
- Wilson, M. (1993). DSM-III and the transformation of American psychiatry: a history. *American Journal of Psychiatry*, 150, 399-410.
- World Health Organisation (1979). *Schizophrenia: An International Follow-up Study*. Chichester: Wiley.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15, 215 – 228.
- Yung, A. (2012). Early intervention in psychosis: evidence, evidence gaps, criticism, and confusion. *Australian and New Zealand Journal of Psychiatry*, 46, 7-9.
- Zimmerman, D. & Pollner, M. (1971). The everyday world as a phenomenon. In J. Douglas (ed.), *Understanding Everyday Life*. London: Routledge and Kegan Paul.



## Appendix 1: Participant Information Sheet

**Leeds Institute of  
Health Sciences**

FACULTY OF MEDICINE AND HEALTH



**UNIVERSITY OF LEEDS**

### **How do Early Intervention in Psychosis Teams Think and Talk about Service Users?**

I am a Psychologist in Clinical Training at Leeds University and I would like to invite you to take part in a research project I am conducting in aspires which forms part of my doctoral training. This project has been reviewed by NRES Committee Yorkshire & The Humber - Leeds Central. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you would like to take part.

### **What is the purpose of the project?**

The aim of the research is to find out how EIP teams discuss service users and make decisions about their care. To do this I would like to audio record up to 12 hours of team meetings, such as professionals' meetings, team meetings or handovers, to explore how service users' presentations and their care are talked about. I would like to return to discuss some of the early findings with you and ask you for feedback which will be used to guide further analysis.

### **Do I have to take part?**

It is your choice whether or not to take part. If you do decide to take part you will be asked to sign a consent form at least 24 hours before the meeting and you can still withdraw at any time until the recording is made. You do not have to give a reason. If there are parts of the meeting that you are uncomfortable about being included in the analysis, please approach me to discuss this after the meeting. If you decide during this discussion that you would like parts of the meeting or your contribution to the meeting to be excluded from analysis, this will be done.

### **What do I have to do?**

At the start of the recorded meetings you will be asked to introduce yourself to make it easier to identify different speakers on the recording. You will be required to refer to service users by their *first names only* (Recover) or *unit numbers* (NHSEIT) during recorded meetings in order to protect their confidentiality. Within a few months of recording the meetings I will invite you to discuss preliminary findings of the analysis in a group with other participants in order for you to have your say and help me with my analysis.

### **What are the possible risks of taking part?**

There is a risk that this analysis will reveal some practices that go against the expressed values of the service. This is to be expected and will be analysed non-judgementally against individuals or teams. Instead I aim to explore team practices in their cultural and political context.

**What are the possible benefits of taking part?**

This project offers a unique opportunity to reflect as a team on your professional practice in some detail. I will arrange to return to the service once the analysis is complete in order to report back the findings and facilitate a discussion about potential implications for the team's practice. This is likely to include strengths that have been identified and potential areas for development.

**Will my taking part in this project be anonymised?**

All the information that we collect about you during the course of the research will be kept strictly confidential. All identifiable electronic information (written and audio) will be encrypted for security whilst the analysis is ongoing. Audio recordings will be destroyed before October 2013 and other identifiable information will be destroyed three years after that, according to Leeds University policy. The audio recordings made during this research will be made into anonymised transcripts, used only for analysis. Sections of this anonymised dialogue will be quoted in the thesis and subsequent publications and/or conference presentations. Neither you nor anybody discussed in the recorded meetings will be personally identifiable in any reports or publications. No other use will be made of them and no one outside the project will have access to the original recordings. The meeting to discuss preliminary findings will not be recorded, though I will make some written notes.

**What will happen to the results of the research project?**

I will report back the outcomes of this research to the team in person once the analysis is complete (as outlined above). In addition, it is intended that the study will be written up for publication within a year of completion and a copy of the published article will be sent to each participating team.

**Finally ...**

Please feel free to contact the research team if you have any questions. We are:

chief investigator, Ellen Duff: (email, telephone); research supervisor, Dr Carol Martin: (email); and your local collaborator Dr Anjula Gupta: (email) or Dr Alex Perry (email).

Should you wish to make a complaint about this research, please contact: Clare Skinner, Faculty Head of Research Support, Faculty of Medicine and Health Research Office, Room 10.110, Worsley Building, University of Leeds, Clarendon Road, Leeds. LS2 9NL.

You may keep this information sheet for your records. Please complete and return the attached consent form if you would like to participate in this study.

Many thanks for taking the time to read this information and consider being a part of this research project.

## Appendix 2: NRES Approval Letter



### Health Research Authority

#### NRES Committee Yorkshire & The Humber - Leeds Central

Yorkshire and Humber REC Office  
First Floor, Millside  
Mill Pond Lane  
Meanwood  
Leeds  
LS6 4RA

Telephone: 0113 3050127  
Facsimile: 0113 8556191

14 January 2013

Miss Ellen Duff  
Leeds Institute of Health Sciences, Charles Thackrah Building,  
University of Leeds, 101 Clarendon Road,  
Leeds, West Yorkshire  
LS2 9LJ

Dear Miss Duff

**Study title:** How do Early Intervention in Psychosis Teams Think  
and Talk about Service Users?  
**REC reference:** 12/YH/0508  
**Protocol number:** N/A  
**IRAS project ID:** 101828

Thank you for your email received on 11 January 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 26 November 2012

#### Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Participant Consent Form	3	11 January 2013
Participant Information Sheet: Aspire	3	09 January 2013
Participant Information Sheet: Barnsley	3	09 January 2013
Protocol	6	11 January 2013

#### Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		16 October 2012

A Research Ethics Committee established by the Health Research Authority



Evidence of insurance or indemnity		29 September 2012
Investigator CV		31 July 2012
Letter from Sponsor		02 August 2012
Other: CV - C Martin (Supervisor)		25 May 2012
Other: Information letter about the Trainee Clinical Psychology Research		13 July 2012
Other: Research Panel Constitution		25 May 2012
Other: Aspire Service Level Agreement		21 September 2012
Participant Consent Form	3	11 January 2013
Participant Information Sheet: Aspire	3	09 January 2013
Participant Information Sheet: Barnsley	3	09 January 2013
Protocol	6	11 January 2013
REC application		16 October 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

**12/YH/0508** **Please quote this number on all correspondence**

Yours sincerely



**Mrs Nicola Mallender-Ward**  
**Committee Co-ordinator**

E-mail: [nrescommittee.yorkandhumber-leedscentral@nhs.net](mailto:nrescommittee.yorkandhumber-leedscentral@nhs.net)

Copy to: *Research Governance and Ethics Administrator, University of Leeds*  
*Ms Sinead Audsley, Leeds and York Partnership NHS Foundation Trust*

# Appendix 3: R&D Approval Letter 1



Leeds and York Partnership   
NHS Foundation Trust

Our Ref: 2012/379/L

Research & Innovation  
North Wing, St Mary's House,  
St Mary's Road  
Leeds LS7 3JX

E-mail: [sinead.audsley@nhs.net](mailto:sinead.audsley@nhs.net)  
Direct Line: 0113 295 2387  
FAX: 0113 2954466

Miss Ellen Duff  
Leeds Institute of Health Sciences  
Charles Thackrah Building  
University of Leeds  
101 Clarendon Road  
Leeds  
LS2 9LJ

15 January 2013

Dear Miss Duff

**Project Title: How do Early Intervention in Psychosis Teams think and Talk about Service Users**  
**REC Reference: 12/YH/0508**

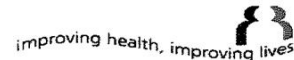
Following the recent review of the revised documents for the above project I am pleased to inform you that updated versions comply with Research Governance standards, and NHS Permission has been granted on behalf of Trust management.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	6	11 January 2013
Participant Consent Form	3	09 January 2013
Participant Information sheet	3	09 January 2013
REC Approval Letter		14 January 2013

The revised versions of these documents should therefore be immediately employed at this site under the existing NHS Permission dated 05 December 2012. Please note that you may only implement changes that were described in the amendment notice or letter.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

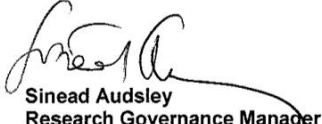


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Leeds and York Partnership   
NHS Foundation Trust

Yours sincerely



**Sinead Audsley**  
Research Governance Manager

Cc. Dr Anjula Gupta, Dr Carol Martin

improving health, improving lives 

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## Appendix 4: R&D Approval Letter 2



South West Yorkshire Partnership **NHS**  
NHS Foundation Trust

8<sup>th</sup> January 2013

Miss Ellen Duff  
Leeds Institute of Health Sciences  
Charles Thackrah Building  
University of Leeds  
101 Clarendon Road  
Leeds  
LS2 9LJ

**Research Department**  
**Ward 2**  
**Castleford & Normanton District Hospital**  
**Lumley Street**  
**Castleford**  
**WF10 5LT**  
**Tel: 01977 605285**  
**Tel: 01977 605298**

**Ref: APPROVAL Letter**  
**Email address: [helen.carter@swyt.nhs.uk](mailto:helen.carter@swyt.nhs.uk)**  
**[research@swyt.nhs.uk](mailto:research@swyt.nhs.uk)**

Dear Miss Duff

**Re: How do Early Intervention in Psychosis Teams Think and Talk about Service Users?**

**REC ref: 12/YH/0508**

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within South West Yorkshire NHS Foundation Trust.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	6	09.01.2013
Evidence of Insurance or indemnity		29.09.2012
Investigator CV: Ellen Duff		
Other CV: Carol Martin Supervisor		
Letter from Sponsor		02.08.2012
Participant Consent Form	3	09.01.2013
Participant Information Sheet	3	09.01.2013

This approval is granted subject to the following conditions:

- You must comply with the terms of your approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform us immediately.
- You must comply with the procedures on project monitoring and audit<sup>1</sup>.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care<sup>2</sup>(RGF). Failure to do this could lead to permission to carry out this research being withdrawn.

<sup>2</sup> Details from:

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4108962&chk=Wde1Ty](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Ty)

- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator**<sup>3</sup>.

They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study (if applicable)
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

**Changes to the agreed documents MUST be approved by in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.**

Projects sponsored by organisations other than the Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

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<sup>3</sup> SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely



Dr Nisreen Booya  
**Medical Director**

## **How do Early Intervention in Psychosis Teams Think and Talk about Service Users?**

### **Abstract/summary**

Early Intervention in Psychosis (EIP) teams aim to offer person-centred and recovery-focussed services for people experiencing early stages of a first episode of psychosis. Service users' care is discussed by EIP teams in meetings at which service users are not usually present. I will record and critically analyse the content of these meetings and invite the participants to contribute to the analysis in order to investigate how service users' presentations and care are conceptualised. The outcomes will be used to make recommendations for service development.

### **Background or rationale of the project**

People talk in order to make sense of their experience, and in so doing they construct versions of the world that can inform their subsequent behaviour. Psychosis can be conceptualised in a number of different ways, including professional (e.g. psychological or psychiatric) frameworks and according to other understandings, including spiritual and idiosyncratic viewpoints. The dominance of these different discourses may vary according to broad social and political trends and they may be employed for particular purposes and with social consequences in the context of a discussion (Potter and Weatherell, 1987). A discourse analysis of ward rounds found that the medical model dominated, as might be expected in a hospital setting, but that the service users' and carers' voices were also present and could hold power (Platts, 2006). Since the early 2000's, mental health policy has become increasingly recovery-orientated and it is in this context that EIP services were developed. EIP teams are community-based and aim to be person-centred and recovery-focussed, offering an alternative to more traditional services. EIP teams meet regularly to discuss service users' care, so what are these meetings like and how do they differ from traditional services?

### **Aims / objectives**

The research aim is to investigate how EIP teams discuss the current care and future expectations of service users.

- What language is used? (e.g. medical, psychological, social models)
- How does the language used shape the team's understanding of service users?
- How are different stakeholders (e.g. service users, families and carers, members of staff) empowered/disempowered in relation to one another through the use of this language?

### **Experimental design and methods**

Two services, Recover (non-NHS) and NHSEIT (NHS) have been approached to participate in this study. Following the recruitment of services and NHS ethical approval, informed consent will be sought from all staff who could be expected to attend the target meetings. Up to 12 hours of team meetings - including general reviews of cases and discussions of fewer cases in greater detail - in each of the two EIP teams will be identified and audio recorded. Sections of these meetings in which the nature of service users' presentations and care are discussed will be transcribed. A discourse analysis will be conducted on the transcriptions according to the principles outlined by Potter and Weatherell (1987). This will allow analysis of the types of discourses used and the ways in which they are used to construct a version of reality. The teams involved will be invited to discuss the outcomes of the initial stages of analysis and their input will be used to inform further analysis.

### **Ethical considerations**

Informed consent will be sought from all staff. Information sheets summarising the research and consent forms will be distributed to all staff who may reasonably attend the meetings I wish to record. Additionally, I will attend some team meetings prior to data collection in order to introduce the research, and answer questions. I will also answer staff queries via email at any other time during the research process in order to ensure that consent is as fully informed as possible. Recordings will not be made of anybody who does not consent. Meetings will be recorded in their entirety. Should participants have concerns about sections of the meeting being included in the analysis, I will discuss their concerns after the meeting. If participants wish for sections to be excluded from the analysis following this discussion, then this will be upheld.

Staff will be asked not to use service users' names, and instead refer to them using their unit numbers (NHSEIT) or first names only (Recover). Identifying information about participants and other stakeholders will be removed from the transcriptions and subsequent write-ups. Transcription will be conducted predominantly by me, but some may be carried out by transcribers who have signed a confidentiality agreement. Stakeholder-identifiable written information (codes to identify the anonymised participants from the transcripts) will be stored in a password protected format on the M drive of the Leeds University server. Audio recordings of team meetings will be stored securely on SWYPFT property (for NHSEIT) and at Recover offices (for Recover) on encrypted 'safesticks' and signed out/in for the purposes of transcription. Consent forms will be stored in a locked cabinet at Leeds University. The audio recordings will be securely destroyed after the final submission of the research has been accepted by the University of Leeds (by October 2013). The transcripts and all participant-identifiable information will be destroyed 3 years after the final submission of the project, as per Leeds University policy.



**Benefits of the study**

Participation in the study will offer teams a unique opportunity to reflect on their practice in detail. The research team will offer to facilitate two opportunities for this. Firstly, the consultation outlined above whereby the initial analysis is discussed with the staff team and their feedback is sought to inform further analysis. Secondly, the final outcomes will be disseminated to the teams involved and members of the research team will offer to facilitate a discussion of the findings and their implications for practice, including identifying strengths and opportunities for service development. The findings will also be submitted for publication and possibly conference presentation upon completion.

**Resources and costs**

- Printing/photocopying of material including information sheets, consent forms, transcriptions.
- Travel costs will be incurred to visit NHSEIT and Recover sites for the purposes of liaising with staff, disseminating information, seeking consent and data collection.
- Specialist recorders and/or microphones.
- I intend to transcribe much of the data but may pay for some to be professionally transcribed.

## Appendix 6: Consent Form

Consent to take part in **“How do Early Intervention in Psychosis Teams Think and Talk about Service Users?”**

	Add your initials next to the statements you agree with
I confirm that I have read and understand the information sheet dated 09.01.2013 explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time prior to data collection without giving any reason and without there being any negative consequences. In addition, should I have concerns about the data collected I may approach the chief investigator to negotiate the exclusion of parts of the recording from analysis.	
I give permission for members of the research team to have access to the audio recordings of meetings and the anonymised transcripts of these. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of participant	
Job Title	
Ethnic origin	
Age	
Gender	
Participant's signature	
Date	
Member of research team taking consent	
Signature	
Date*	

\*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

## Appendix 7: Transcription protocol

- [ Overlap between utterances
- = an indiscernible gap between utterances, such as when one speaker interrupts another
- .. short pause
- ... long pause
- : extension of the preceding vowel sound

Underlining added emphasis in the speaker's tone

() words within rounded brackets were partially audible and/or there is doubt about their accuracy

[...] a section of transcript has been deliberately omitted.

Words within square brackets indicate what the omitted information is, e.g. "[city]" in place of "London" or indicate a para-verbal utterance, e.g. "[laughs]".

## **Appendix 8: Notes from Discussions with Participants about Preliminary Findings**

Clients & staff having different conceptual frameworks for understanding difficulties can be called a “construct clash”. If client has medical model of understanding difficulties, EIP must respect that. They are person-*centred*, not person-*led*, so may act in person’s best interest but against their wishes. Psychological understanding can pervade any other way of working – only met 1 client who had a purely medical understanding. Staff work with whatever (sometimes little) psychological understanding a client has. Sometimes it’s too challenging for clients & families to think psychologically.

EIP uses an assertive outreach approach – once a problem is named (given a psychiatric or psychological label), EIP have to be involved. EIP are inherently more powerful than clients. Problems located within individual: because Amber/Red clients discussed (biased sample) & I didn’t record a family therapy referral meeting.

When performing any action, EIP staff have an “imagined audience” in their head – the client/ family/colleagues/tribunal panel. What would they think? If you tell the tribunal you managed risk through psychosocial interventions, they’ll question why you didn’t medicate. When risk is high a medical review may be offered (even if it may be considered inappropriate or undesired) in order that it can be documented in case of serious case review – defensive practice, reduces staff anxiety. Staff may also take a case to psychology for more in-depth conversations/formulation regarding risk.

Activities (e.g. walks, football) are used as opportunities for therapeutic interventions by staff – are not labelled as such & may not be seen as such by clients.

I reflected that whilst social factors were considered in understanding the development of clients’ difficulties, I didn’t see evidence of social interventions. Staff responded that they offer family work & that perhaps I didn’t attend meetings at which this was discussed.

Psychotherapy as a limited resource – clients have to be ready, able & robust to undertake therapy. Not often offered in first 3 years of service involvement. Meeting with professionals (psychiatrists, psychologists) holds weight in the clients' eyes. Regular, consistent contact with e.g. support workers is valued by clients, but they may not realise it immediately.

When 1 staff member first started working in EIP he was frustrated that they often did nothing – “why aren't you doing something?!” – now he realises the value of not jumping in and doing, and the importance of being alongside the client, watching & waiting. Requires staff managing their anxiety about not doing. whether people 'willing and able'? (strivers/skivers): in CMHT, discharge people who not 'willing'

Team to start trialling an Open Dialogue approach, but expect it to be difficult to work in this way in isolation, without other services adopting it too.

“Unwell” is shorthand – not intended to medicalise clients' difficulties.

When are decisions made, or are they made? Recovery orientated so decisions made with service users. NHSEIT have no medic who may create more 'plans' from expert position and may take charge in teams.

EIP are not set up for understanding clients' difficulties spiritually/religiously. EIP promote secular, individualistic, western values. EIT is countercultural bit also consumes ideas/values of wider culture (e.g. about people on benefits). Part of their work is to get clients to conform to societal norms. We all have madness in us, and we hide it in such a way to be socially acceptable – this is what we aim for our clients too. Clients are often “stuck” in a particular area of their life. EIP work pragmatically to shift them out of stuckness.