

How clinical psychologists experience working in an acute mental health inpatient setting.

Volume 1

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Abstract

The focus of this study was to explore how Clinical Psychologists narrate their experience of working on acute adult inpatient units. Mental health services in the UK are poorly resourced with treatments dominated by medical model perspectives. This model can conflict with the psychological and social models Clinical Psychologists are trained in. The aims of this study were to explore the experience of Clinical Psychologists working in acute adult inpatient units and, through this, develop insight into how the core values for improving inpatient care could be maintained.

This study was guided by Social Constructionist principles. It required a critical stance to be applied on the current system with an understanding that knowledge is co-constructed between and within relationships. Eight individual semi-structured interviews with Clinical Psychologists who work on adult acute inpatient units were conducted and explored using Narrative Analysis. Four dominant narratives were found. These were; 'You can't beat the system', 'I am screaming', 'Connecting with humanity' and 'Someone is screaming'. These narratives related to the Clinical Psychologists themselves in conjunction with the system they were working in which included staff, patients, myself as the interviewer and society in general with the understanding that the interviews were co-constructed and represented multiple voices.

This research confirmed that cuts and lack of resources to NHS services have created a massive strain on the system. The Clinical Psychologists working in this system are attempting to understand and support individuals in acute distress; however, they appear to be doing this in isolation which puts them in danger of burn out. It would seem the system is organised against thinking and feeling, affecting both staff and patients, and leaving their experiences unheard and invalidated. The people who are admitted to wards are likely to have had abusive and invalidating earlier experiences. Wards need to be a safe place where they can have time to express themselves, process this and experience

validation. The opposite seems to be happening, thus, potentially perpetuating their experience of abuse and neglect. Compassion is a Government directive, yet it takes time and space and, thus, is not cost-efficient. To achieve a system, where people who are vulnerable can express their distress and feel heard, provision of ongoing support and resources is required.

Further research could explore the experience of staff who work on inpatient units, for instance health care assistants, nurses, psychiatrists and managers in order to provide further insight into the system that is currently in place and help to develop ways to improve it. It would also give voice to professions that did not have a voice in this research. Experiences of Clinical Psychologists on inpatient units where the medical model is not dominant could also be explored, for instance, where the Open Dialogue approach is dominant. Comparisons between the different approaches could then be explored.

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1. Introduction

1.1 Overview

Residential hospital accommodation for people considered to have acute and severe mental health problems has been in existence since the eighteenth century and has continued to be a source of controversy and debate up to the present day. The institutions of the past have proved pertinent subject matter for the arts and have been represented in painting, poetry, film and literature often depicting disturbing stories (see Appendix 1). Most people are aware of the ‘madhouses’ , as they were commonly known, that existed many decades ago and are appalled at some of the inhumane practices that went on in them. Like our terminology, time has moved on, our understanding has grown and our culture and surroundings have changed. Within the United Kingdom, overcrowded conditions, people being chained to their beds for days and ‘treatments’ such as lobotomies are no longer acceptable, however, the path of history still affects how people are treated today. During this study I will be reflecting on how much we have learnt from our history in the field and how much this informs the present, what do we still tolerate and advocate and what needs to change. I will be focusing specifically on adult acute mental health units and the support and care available within them. This will be considered through the narratives of Clinical Psychologists (CPs) who work within these settings, in addition to how they story their role and position.

Interviews with eight CPs who work or have worked on adult acute mental health inpatient wards in the South East of England will be explored using Critical Narrative Analysis. The research is based on a Social Constructionist theoretical stance asserting that a society shares representations of the world which are determined by its culture and this has implications on how people are treated (Burr, 2003). Therefore, much of this introduction will consider the dominant beliefs around mental health difficulties and inpatient units in today’s society and where they came from. When considering the area I wanted to study for my thesis, it was important for me to step away from creating evidence to support or negate a certain theory or model and look at mental health services from a wider perspective. I believe this is an important

and worthwhile undertaking as looking outside of one's own particular favoured genre may facilitate a wider perspective involving consideration of the values that may be represented within the field of mental health, and any potential domination or manipulation – organisationally or ideologically, by wider forces with different and conflicting agendas.

During the introduction I will attempt to briefly document the history of relevant aspects of mental health in the United Kingdom in order to put both the profession of Clinical Psychology (CP) and acute adult inpatient units into some form of context because

'To describe a world may be the most effective way to change it'

Latour, 2005, p154

I recognise that as the writer I have made decisions about what to include and what to leave out and as I cannot know you, the reader, I can only assume what information may be useful to you in the introduction. As with the CPs I interviewed, you and I have been influenced by our history, society and culture; suffice to say, I can only understand the world through the filter of my culture and society, as can you, the reader. The potential for different interpretations is, therefore, always present. Furthermore, as the interviewer in the eight conversations I recognise that each interview was co-constructed by the interviewee and myself, "the researcher does not find narratives but instead participates in their creation" (Riessman, 2008, p21). Therefore, I have further detailed the context which led me to this study in the 'method' section. Both the interviewee and myself (the interviewer) and you (the reader) are in a particular place and time and, before we arrived there, we had a history of experience that has built up our beliefs about the world and these will influence what we think and do.

I will begin by looking at what is meant by the term 'acute mental health' and how it has been understood in the past. I find myself stumbling over language and terminology, particularly as many terms are used for convenience and ease of understanding rather than my belief in their utility. For example, 'acute mental

health', 'mad', 'lunatics', 'mad houses', 'mentally ill', 'patients' to name but a few. Before defining terms I will outline my literature search strategy.

1.1.1 Literature Search Strategy

The literature which is referenced throughout this study was obtained by inputting into databases key terms relevant to the focus of the project. These included Google Scholar, Psych info, Pubmed and Web of Science. Terms used included: acute mental health, mental illness, inpatient units, psychopathology, psychiatry, psychosis, neuroplasticity, Clinical Psychology, NHS, biopsychosocial, competition, reflective practice, welfare state, cuts, medical model, psychotropic medication, trauma, stigma. Abstracts and references were scanned and, if they were considered relevant, they were downloaded and read. Relevant books were also downloaded or purchased.

1.2 What is meant by the term 'Acute Mental Health'?

'Mental health is defined as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'' (WHO, 2013).

Despite the coherent definition above by the World Health Organisation, the term mental health has become synonymous with mental illness, often people's understanding of being mentally healthy is not being mentally ill. So lies the question, what does it mean to be mentally ill? Perhaps this is dependent on the culture we find ourselves in. Psychiatry in the Western world, and to a smaller extent CP, can be thought of as the domineering factions determining whether someone is mentally ill or not (Newnes, 2014). Psychiatry, over the last 130 years or so (arguably starting with Kraepelin's diagnosis of the disease Dementia Praecox, see Eysenck et al, 1972) has neatly coded various different diseases of the mind into convenient categories which are today assembled in the Diagnostic and Statistical Manual of Mental disorders (5th ed.; DSM-5, American Psychiatric Association, 2013)

and the International Statistical Classification of Diseases and Related Health Problems (ICD-10, World Health Organisation, 1992).

According to these categorisations mental illness can be divided into three types (Gulati et al, 2014). Neuroses includes depression and anxiety which are considered the most common types of illness affecting people to varying degrees. Within this category, people are normally aware they are 'ill'. Psychoses, which include schizophrenia, are considered as the more severe end of mental illness. Here, the person is said to have lost touch with reality and may experience auditory hallucinations (for instance voices of people who are not present) and delusions (bizarre and irrational beliefs). Bipolar disorder is another type of psychosis, sometimes known as manic depression, where the person experiences episodes of profound depression as well as episodes of mania characterised by uncontrollable episodes of excitement and irritability, often accompanied by disordered thinking and delusions. The third type of disorder categorised are personality disorders, which are attributed to people who are considered to have long term dysfunctional patterns of relating to other people. Acute mental health services work with people who 'are either (a) experiencing, (b) at risk of, or (c) recovering from a mental health crisis' (Joint Commissioning Panel for Mental Health, 2013, p5). Those admitted to an acute unit are likely to be experiencing a severe episode of mental illness and are, consequently, diagnosed using the above categories. I will now consider the origins of the classification of mental illnesses in order to help make sense of the system we use today. I shall focus specifically on psychosis, firstly, because this is considered to be one of the more severe mental illnesses resulting in hospitalisation to acute settings and, secondly, because it is beyond the scope of this study to consider the history of all the 'disorders'.

1.2.1 Origins of Classification and Making Sense of Mental Illness

As mentioned, Kraepelin (1856 – 1926, see Kraepelin, 2002), is often considered to be the founder of modern scientific psychiatry (Eysenck et al, 1972). In order to enhance understanding, he believed that psychiatry needed 'a profound and deep union with general medicine' (Jablensky, 2007, p382) which required a detailed examination of patients. As described by Jablensky (2007), Kraepelin observed

thousands of people in order to create meaningful clusters of symptoms. He is most remembered for distinguishing between the two most serious and disabling forms of mental illness, namely dementia praecox (schizophrenia) and manic depression. Kraepelin hoped that his account of schizophrenia would eventually be proved by pathological research, i.e. proof of a cerebral degeneration of the brain caused by toxins in the body. He was disappointed when, on examination of deceased patients brains (performed by his research assistant Alois Alzheimer), no abnormalities were found. Kraepelin based his approach on certain features, namely: mental illnesses are separate, naturally occurring categories, they are inherited conditions which follow a predictable deteriorating course and the symptoms are caused by diseases of the brain or nervous system. It is from Kraepelin's categories that our mental health system is based today, over 100 years later.

There have been some notable opposition to his ideas, for instance, the Swiss psychiatrist Meyer (1866-1950, see Winters & Bowers, 1957) who can be credited with the development of the biopsychosocial approach to mental health. Whilst he accepted the possible role of inheritance in the aetiology of mental health, he also saw mental illnesses as reactions to biographical circumstances and the environment. Szasz (1961), a Hungarian psychiatrist, on the other hand completely disregarded the belief that mental illness is caused by chemical imbalances in the brain. He argued that mental illnesses are socially constructed by the psychiatric profession so that their role, as medical specialists, is maintained. Szasz saw people's distress and 'peculiar' ways of behaving linked with problems of living rather than symptoms of a medical condition (Szasz, 1961).

1.2.2 Current Paradigms

Szasz's view is supported by a growing number of psychiatrists and psychologists today (e.g. Bentall, 2009, Rapley et al, 2011, Johnstone & Dallos, 2013). These authors view mental illness as a normal response to life events rather than an underlying psychopathology. This is supported by studies looking at the relationship between childhood trauma and psychosis (Read et al, 2012) showing child abuse to be a significant causal factor for psychosis and 'schizophrenia', more specifically for

hallucinations. Read et al (2012) assert that understanding the mechanisms by which child abuse leads to psychosis requires an integration of biological and psychosocial paradigms which acknowledge that adverse events can alter brain functioning. Whilst there is no proof of mental illnesses being caused by diseases in the brain (Bentall, 2009) brain imaging research has shown differences in brain development depending on a person's upbringing and external environment. Shore carried out extensive analyses linking neurological research with attachment theory and trauma (Schore, 2010). His findings suggest that the development of the right side of our brains, where we develop our emotions, is dependent on our early attachment relationships. Since the 1960s, there has also been increasing research looking at our brains ability to change through our lives, known as neuroplasticity, this is in contrast to the previously held position that our brains are a physiologically static organ (Doidge, 2007).

The research on neuroplasticity has enormous implications on our understanding of treatment for mental health disorders and, perhaps, adds credence to the value of therapy as a process for change, thus providing a further reason to avoid negative labels for those with mental health issues. Indeed, context has been considered an important consideration in relation to 'schizophrenia', for example, Read et al (2005) suggest that researchers and clinicians should routinely ask about childhood trauma when trying to understand or assist people diagnosed as psychotic or schizophrenic. Further, Romme and Escher (1993, 2000) based their approach to treatment of people experiencing psychotic symptoms on the principles that, firstly, hearing voices is a normal human experience, secondly, they can be understood in the context of life events and interpersonal narratives, and thirdly, they are often precipitated and maintained by events that overwhelm and disempower the individual. Furthermore, Beavank, Read and Cartwright, (2011) carried out research which indicated that voice-hearing prevalence in the general population may be as high as 13 percent. In contrast, the National Survey of Psychiatric Morbidity in the UK found a population prevalence of a probable psychotic disorder of 0.5 percent (Singleton et al., 2003). This indicates that experiences such as hearing voices can be a common experience and are not necessarily part of a disorder.

This is at odds with psychiatry's traditional view that voice hearing is a bizarre and unusual experience indicating serious psychopathology. In an interview with 'The Irish Examiner' Gijbels (2014) said 'people don't necessarily want to get rid of their voices. Psychiatry tends to diagnose something faulty in the brain, but many famous people heard voices – Ghandi did. So did Joan of Arc'. The National Alliance on Mental Illness points out that the cultural context is also important, for example, in Native American cultures hearing the voice of a deceased relative is part of a healthy grieving process (NAMI, 2014).

In an attempt to reframe understanding of psychosis and to work with extreme distress Longdon, Corstens and Dillon (2013) put forward Janet's (1889/1973) *phase-oriented* model of recovery which stated that distressed individuals need to attain a sense of safety before integration and resolution can take place, wherein trauma is processed and associated losses are mourned for. This is followed by a process of reconnection in which the skills of the previous stages are incorporated into daily life. We will consider current contexts for care in sections 1.5, 1.7 and 1.8. As we will see, these ideas seem far removed from the treatment provided on inpatient units at present. Additionally, the multi-cultural context of Britain is ever changing and perhaps our mental health system needs to rethink how it understands, manages and interacts with the people it aspires to help. We will now consider the context of care for acute issues, and with this the role CP has within the system.

1.3 Where do Clinical Psychologists fit in?

In order to help answer this question I will firstly attempt to provide some context to this profession by detailing its development. I will then discuss the context CPs work in today, and in particular, focus on the NHS as the organisational context CPs work within and acute adult inpatient units as one system of care for those in acute distress.

1.3.1 The Development of Clinical Psychology

The field of CP is often considered to have begun in 1896 with the opening of the first psychological clinic at the University of Pennsylvania by Lightner Witmer (e.g. Kennedy et al, 2009). In the first half of the twentieth century CP focused on psychological assessment, with little attention given to treatment. After the Second World War, the profession emerged in the UK largely shaped within the context of the National Health Service. In its infancy there was an emphasis on psychometrics predominated by intelligence and personality testing. The three centres for CP included the psychometric school at Crichton Royal Hospital in Dumfries under John Raven, the experimental school at the Maudsley and Institute of Psychiatry, and the psychoanalytic school at the Tavistock, both in London. All three set up centres for clinical training and they all emphasised the importance of assessment; the Tavistock favoured projective assessment techniques such as the Rorschach inkblot test. Tensions around whether methods were scientific or not already existed.

With the emergence of this new field came the need to establish a firm grounding for the profession. The Boulder Conference in 1949 set out the aim of the CP programmes which was to produce scientist-practitioners, clinicians who were equally adept at research. Those who completed CP training in the 1950s mainly worked in large institutions dominated by psychiatry. Behaviourism became the central feature of their work. Whilst learning theory was accepted as demonstrating scientific confidence in British CP, a challenge still existed from those committed to interpretive sense making where significance was given to underlying symbolic meanings and scientific proof was less of a feature. In 1980, other approaches to knowledge began to emerge including cognitivism and, to a lesser extent, social constructivism.

1.3.2 Clinical Psychology today

CP training courses now promote a biopsychosocial approach, rather than a biological one. Within this approach, a person's context is recognised as an important aspect of understanding difficulties, this constitutes a positive change in addressing inequalities. Since Schon introduced the concept of reflective practice, this has encouraged practitioners to additionally recognise the influence of their own

experience on their practice (Schon, 1980). Furthermore, over the past two decades new approaches and theories have developed which embrace qualitative evidence (Willig, 2008). This move towards qualitative data has helped practitioners pay attention to the wider influences upon psychological distress and the lived experiences of people in distress (Smith et al, 2009: Andrews et al, 2013).

In 2007 the NHS set up New Ways of Working for Applied Psychologists (BPS, 2007) which extended their traditional roles and focused on team work and leadership. This led to the CP Leadership Development Framework (BPS, 2010) and, although it has always been recognised as a core skill of CPs, good practice guidelines on the use of psychological formulation were published in 2011 (BPS, 2011). These documents have led to clarity around the role of a CP within the NHS which includes effective leadership promoting a psychological approach. I will now move on to a discussion of the wider context in which CPs work in: the NHS.

1.4 The NHS

'Health policy in Britain today is a legacy of decisions taken by public and private agencies over many hundreds of years' (Ham, 2009, p5).

The NHS was established in 1948 and was the first health system in Western society to offer free medical care to the entire population (Klien, 2013). Central government began planning reforms to the whole health and social care system in the middle of World War II. It is notable that these reforms aimed at creating a more equal society came at a time when the country was at war - a time of austerity and hardship. Perhaps a sense of national pride and the pulling together of communities encouraged the people in power to value all sections of society - this became the value base of the proposals that followed. The Labour Government elected in 1945 made it a priority to establish a single national, publicly funded, health service for the entire country. The legislation which authorised this was passed by parliament as the National Health Service Act of 1946 (Speller, 1948) and the National Health Service began in 1948. Funding was provided through taxation, thus workers paid 'national insurance' a tax specifically for the NHS. The fundamental principle of the NHS was that services should be free to everyone at the point of delivery. Health and social

services should be financed, administered, and delivered in the public sector and not for profit.

From 1948 to 1982 the NHS structure remained largely the same, however, with the election of the new Conservative government under Thatcher in 1979 the next fifteen years led to radical changes (Hall, 2013). The White Paper, Working for Patients (1989) was of particular importance as it introduced changes intended to create the conditions for competition between hospitals and other service providers. This was attained through the separation of purchaser and provider responsibilities and the establishment of self-governing NHS trusts and GP fund holders. The implementation of policy feeds back into policy-making (Hall, 2013) and it is clear that Working for Patients has influenced how national policy has developed since. The system is complex with changes being influenced by many internal and external factors. I have attempted to list some of the major changes that have occurred in Appendix 2. I will now focus on key developments that have shifted the value base and shaped the current context of the NHS: the global economic environment, responsibility for care and accountability for what happens.

Since 2001, annual performance ratings have been published for NHS trusts in England (DoH, 1999a) which has contributed to a change in working values, where meeting targets is prioritised over patient care (Francis Report, 2013). Bevan and Hood (2006) have suggested that the use of targets results in *gaming*, for example, extra staff being drafted into accident and emergency departments and operations being cancelled. They stated that when reported performance meets the targets nobody knows how genuine any improvements are. Perhaps the most significant and much disputed change came with Lansley's Health and Social Care Bill which, after a two year fight from opposition groups, became law in 2012 (DoH, 2012a). Lansley's reforms involved reducing government control over the various components of the health system and creating measures to divert NHS funding to the corporate sector. The NHS was becoming a profit based organisation stepping away from its initial value base (Davis & Tallis, 2013). The main administrative system tier through which universality had been assured was abolished after 64 years and the government was no longer responsible for the financial risk of health care. This responsibility was devolved on to Clinical Commissioning Groups (CCGs,

who organise delivery of services), local authorities, providers, the public and ultimately the people using the services. The reform also involved the abolition of Primary Care Trusts which had ensured all people throughout the country were covered and that health services were organised on a geographical basis. CCGs members are no longer based on where you live but according to which GP practice you belong to. Practices and commissioning groups are now able to accept patients regardless of where they live and can reject costly patients. The CCGs determine which services are part of the health service and which are chargeable. They are established as budget holders and can determine which primary and secondary services they contract, from whom and at what cost. The CCGs are only required to provide services that they consider appropriate.

These changes were made in the midst of a global financial crisis where unemployment was rising, adversely affecting public health (Stuckler et al, 2009). According to the Office of National Statistics (2013) in 2012 there were 6,045 suicides in people aged 15 and over; an increase of 437 compared with 2010. It is perhaps unsurprising that the need for mental health services has risen in the last few years with people struggling to cope with lack of money, jobs and opportunities. Despite this growing pressure on the need for services, mental health services have also been affected by cuts. In October 2013, Care Minister Norman Lamb said that there are 'too many failures' in the treatment of people with mental health conditions calling for an end to 'institutional bias against mental health' within the NHS (Community Care, 2013, online resource). Also in October 2013, Martin Baggeley, the medical director of the South London and Maudsley NHS Trust, claimed that 'the mental health service in England is in crisis and unsafe' (Community Care, 2013, online resource).

1.4.1 NHS Changes and Clinical Psychologists

The combination of the introduction of competition between services and budget costs has created an environment where value is placed on cost effectiveness, and with this the question of who can provide therapeutic interventions. In many ways this change in perspective has created a state of uncertainty and, with this, a sense

of insecurity among CPs. Indeed, as services are restructured many senior CPs have been re-interviewed, salaries have reduced and some have lost their jobs saving the NHS money (BPS, 2012). The Improving Access to Psychological Therapies and Psychological Wellbeing Practitioner programmes (DoH, 2008a; Samuals & Veale, 2009) has resulted in generic training in CBT and other psychological therapies; there is now a growing need for CPs to prove their worth as there are now cheaper alternatives to provide therapeutic interventions. For some CPs and some services this shifting emphasis may have resulted in a shifting professional onus from the people they are treating to their own survival. Targets are to be reached and clinicians must answer to managers and Commissioners in order to remain in post.

These issues go beyond the profession of CP to the NHS as a whole. Indeed, the NHS is under scrutiny with failing reports and critical media coverage. For example, whilst the 2008 Darzi report (DoH, 2008b; Darzi, 2008) detailed the immediate recommendation for improvements in quality, the recent 2013 Francis report (Francis, 2013) detailed the substandard care and mistakes made at Mid-Staffordshire hospital. The conclusions made by the reports are that there is a problem within the very culture of the NHS and it is the culture that needs to be changed. This is an important point yet there are also wider questions that need to be answered regarding what is underlying and influencing the way the current culture is behaving. Is there a need to go back to basics and reconnect with the underlying values of health care and equality for all, particularly for the most vulnerable? NHS staff need support via appropriate staffing levels and basic training. Training in basic values, person-centred care and listening skills are perhaps areas where CPs can demonstrate fundamental skills.

1.5 Acute mental health units

This research project focusses on the experiences of CPs who work within acute mental health inpatient environments. Therefore, I will detail some of the history of inpatient facilities to help create an understanding of the system that exists today.

1.5.1 What is the history of acute inpatient care?

Prior to the eighteenth century people experiencing mental health difficulties were largely left to fend for themselves along with the poor, homeless and physically disabled. There may have been an interrelationship between these contexts, as there is today (WHO, 2001;Kuruvilla & Jacob, 2007). There were no provisions or sense of public responsibility at this time and people had to rely largely on Christian charity. The exception to this was the Bethlem hospital (Chambers, 2009) which was founded in 1247 and whose history reflects the changing social attitudes and perceptions of public responsibility to mental illness over the centuries, vacillating between neglect and cruelty to more humane care. These changes are further detailed in Appendix 3. Of particular note was the introduction of moral treatment by the English Quaker, William Tuke (see Tuke, 1813) who opened the Retreat in York in 1792 and French doctor Philippe Pinel (see Hergenbahn and Henley, 2013) the chief physician at the Bicetre hospital on the outskirts of Paris. Their policies of lessening restraint, providing routine and occupation and compassionate care, resonates with policies in our mental health system today.

By the mid-nineteenth century people with mental health problems were placed in large institutions paid for by the state and charitable organisations. These asylums became larger and larger through the Victorian period and the initial values of treatment, similar to the York Retreat, became lost and replaced by institutional systems of order and efficiency. Perhaps this is where the current context is similar, there is order and efficiency but that may not truly represent the best interests of those living within them. Fagin (2007) cites William Gaskell, who was appointed Medical Superintendent at the Lancaster Lunatic Asylum. Gaskell described the scenes of degradation and squalor that he first witnessed there:

‘The care was predominantly custodial; many patients were in handcuffs, leg-locks or straight jackets. Some of the patients were chained to box-seats in heated rooms over a permanent sewer, removing the need for patients to go to the toilet’.

(Fagin, 2007, p12)

People involved in the care of patients became increasingly disillusioned with this type of care and this, in all likelihood, impacted on their ability to provide quality care. Public expenditure did not increase with the growth of resident numbers which effected standards of care, with order and efficiency likely to be even more valued as a means of managing this growth. Asylums and those within them became stigmatised and increasingly unpopular. With this, steps were made towards morale treatment again, with positive results; however, such changes were unsustainable with the increase in need and the lack of money for training and resources. This clearly resonates with the context of today, with global and local economic issues, and the need for cuts, order and efficiency. The way of managing this unsustainability, in the past, was for wards to contain large dormitories, day rooms and dining areas with each ward being locked. Violence was common and wards were noisy. However, as described by Fagin (2007), with the introduction of the Mental Treatment Act of 1930 some positive changes were made. Residents could accept a voluntary status, request treatment and be offered parole within the hospital grounds or in the local town. They were allowed to use their own clothes, occupational therapy was introduced and recreational activities such as dances became part of life. Hospitals had communities of their own and could exist independently of the outside world.

In 1948, following the introduction of the welfare state and the inception of the NHS, mental hospitals came under the same administration as general hospitals, and as a result, a programme of upgrading was initiated by the new hospital regional boards. However, overcrowding worsened and asylum care was criticised. There were reports of dehumanising behaviour and a call for rehabilitation of chronic residents back into the community was advocated. Various books were published in the 1950s and 1960s which studied the characteristics of asylums including Stanton and Schwartz (1954) and Strauss et al (1964). The most famous of these was by Goffman's (1961) *Asylums* which detailed an observational study he carried out of St. Elizabeth's Hospital in Washington, D.C. Goffman posed as an employee of the hospital for a year gathering ethnographic data on aspects of patient life. His aim was to describe the situation from the point of view of the patient and his conclusions

were disparaging. He discusses an authoritarian system where patients are subjected to humiliation and are forced to define themselves as mentally ill.

Goffman termed the phrase 'total institutions' and he likens mental health hospitals to prisons, monasteries and military organisations. In these 'total institutions' inmates are stripped of their normal identification and normal social roles no longer apply. The staff try to instil in patients that they have behaved incorrectly in society and they need to change in order to function outside of the hospital, hence to leave they need to accept the psychiatric view of themselves. Goffman's criticism of mental health hospitals made an important contribution to the substantial recognition of the need to reform care of people with acute mental health issues. However he has also undergone criticism questioning his analogy that mental health institutions are 'total institutions' like prisons, due to the differences in their goals. Levinson and Gallagher (1964) state that Goffman provides too little attention to the therapeutic and rehabilitative functions of the hospital and has therefore neglected to see the variation in organisations, ultimately providing too narrow a view. Linn (1968) also criticises the inferences Goffman makes about the situation of patients stating that they are weakly supported by any rigorous empirical data. However Linn does concede that Goffman's analysis is both provocative and insightful.

Between 1959 and 1980, due to the introduction of new treatments, such as psychotropic medication and out-patient services, the number of hospital residents fell from 159,000 to 79,000 (Fagin, 2007). A small number of hospitals pioneered 'therapeutic communities' (see Kennard, 2008) and were informed by psychodynamic and sociological perspectives which were beginning to gain merit from psychiatric professionals at the time. Locked wards were opened, hierarchies between staff and residents were reduced, with decisions being made more transparent, and more prominence was given to residents' wishes regarding treatment. According to Clarke (1965), this was 'in some degree a revival of the old principles of moral treatment' (Clarke, 1965, p948). In 1953, this was supported by a report by the World Health Organisation, which stated 'too many psychiatric hospitals give the impression of being an uneasy compromise between a general hospital and

a prison. In fact the role they have to play is different from either: it is that of a therapeutic community' (WHO, 1953, p17-18).

1.5.2 The current context

Unfortunately, due to the demise of the institution itself much of these efforts were short-lived; although some therapeutic communities remain, such as The Cassel Hospital in West London (Day & Pringle, 2001). The introduction of the White Paper, 'Better services for the mentally ill' (1975) raised the profile of community care for patients with mental health problems stating that people are to be treated at home. If they required inpatient admission it would be a brief stay at a psychiatric unit in a district general hospital. However, according to Fagin (2007) financial crises and negative attitudes from the government towards social welfare meant adequate amounts of money were not devoted to community care, and the shortage of residential places in local authority homes delayed the closure programme. The de-institutionalisation continues to this day and now there are very few Victorian asylums in existence, many being prime sites for property developers. Hardcastle (2007) points out that many of the staff who worked in the old institutions moved into the new workplaces within psychiatric wards. Little was done to prepare or train staff for this shift and, unfortunately, they appeared to take their former institutional practices and attitudes with them (Hardcastle, 2007). Those staff teams who had developed a more therapeutic approach as a collective team were broken up and, consequently, their collective skills were lost. As care of acute and severe distress mainly centres within these brief stay units, this becomes the setting for the current study. Before we consider this study in more depth, I will continue to summarise recent developments.

Mental health services have experienced a high level of scrutiny and subsequent reform. A major review in 1998 (Acute problems SCMH) surveyed 38 services and 215 patients were asked about their experiences. The report concluded that:

- There were no clear goals for acute care
- The setting was neither pleasant nor therapeutic

- Staff were not delivering targeted programmes to improve user health or social functioning based on individual needs.
- Acute in-patient care had poor connections with community services.

It would appear that history was repeating itself and the solutions were problematic in themselves. It seems that inpatient units were not therapeutic indicating that only the symptoms of peoples' distress were being addressed rather than the causes. The unpleasant environment and lack of clear goals were also likely to impact negatively on staff's ability to show compassion and empathy for the people they were employed to support and care for, which in turn, was likely to perpetuate feelings of distress.

This report amongst others (Mind, 2000; Standard Nursing and Midwifery Advising Committee, 1999; Royal College of Psychiatrists, 1996, 1998) led to the recognition of poor patient experience and a demoralised work force *and* the need to address these issues through further reform. Significant policies including 'The national framework for mental health' (DoH, 1999b) and more specifically the 'Mental health policy implementation guide: Adult acute inpatient care provision' (DoH, 2002) urged for care that relied on the development of therapeutic cultures, systems and practices which enable user empowerment and evidence-based practice. In support, the National Framework for Mental Health (1999b) launched a number of initiatives. A regional network of 'Development Centres' was formed under the National Institute of Mental Health. These centres set up in-patient collaborative programmes to identify and support improvement in in-patient care. The 1999 'National Service Framework for Mental Health for adults of working age' introduced the ten value-driven guiding principles of the NSF. They were to:

- 1) Involve service users and their carers in the planning and delivery of care
- 2) Deliver high quality treatment and care which is known to be effective and acceptable
- 3) Be well-suited to those who use them and non-discriminatory
- 4) Be accessible so that help can be obtained when and where it is needed
- 5) Promote their safety and that of their careers, staff and the wider public
- 6) Offer choices to promote independence

- 7) Be well-coordinated between all staff and agencies
- 8) Deliver continuity of care for as long as this is needed
- 9) Empower and support staff
- 10) Be properly accountable to the public service users and carers

The NSF was accompanied by Policy Implementation Guides (PIGS, DoH 2001, 2002a,b,c,d, 2003) alongside a series of targets for Trusts to report on. One of the most important of these was the introduction of the Care Programme Approach (CPA) which is a mandatory procedure for recording the needs of those with formally identified mental health problems, and for recording the agreed care plan and the nominated key worker for each service user. Under the CPA, the Department of Health requires all specialist mental health services to carry out a formal assessment of need for all users as they enter the service, this includes a risk assessment. There are two levels of service specified: the standard level and the enhanced level (ECPA) which is applicable to everyone who is deemed to have a 'serious mental disorder' (as stipulated in the DSM-IV, now 5; and the ICD-10). Admittance to an inpatient unit automatically leads to an ECPA classification. In addition to the CPA other relevant policy guidance includes, 'Adult Acute Inpatient Care Provision' (DoH 2002). This provision is to ensure a high standard of nursing practice, environmental design, and meaningful day activities on inpatient units. The call to rekindle those values of compassionate care was stronger than ever, and we will next consider the impact of these initiatives and political agendas on services.

Government policies and initiatives such as Acute Solutions (2006) have all promoted compassionate care, yet conditions on inpatient wards do not seem to have improved as a result (Lloyd-Evans et al, 2010). This has promoted further documentation setting out similar directives which leads one to think that something more than writing policies needs to happen for change to be made. In May 2013, the Joint Commissioning Panel for Mental Health set out guidance for Commissioners of acute care. The paper stated that the aim of inpatient services was:

'to provide a high standard of humane treatment and care in a safe and therapeutic setting'

Joint Commissioning Panel for Mental Health, 2013, p5

However, in a recent investigation by Community Care and BBC News (2014) it was found that a growing number of patients were being sent to more expensive out-of-area hospitals; the numbers rising by 33% last year. Trusts were spending millions buying bed space at private hospitals due to oversubscribed NHS units. This is no doubt linked to the closure of units; since April 2011, Community Care (2013) established that mental health trusts have closed over 1,700 mental health beds. Additionally, they found that cuts to housing and residential placements had led to problems discharging patients. These findings suggest that diminishing mental health services are struggling to cope with a rising demand for crisis care. It is interesting to note the possible drivers underlying this rise in demand, it is possibly related to social issues and lack of adequate support earlier on in people's lives or issues such as lack of housing and unemployment which may, in turn, be related to increases in populations.

In an interview with Community Care (May, 2014, online resource), Paul Farmer, chief executive of the mental health charity Mind, said that;

'Continued cuts to funding for mental health services are taking a significant toll on the quality and availability of services, meaning more and more people are reaching crisis point and need to be hospitalised, meanwhile, some trusts are closing wards and reducing bed numbers at a time when they are seeing increased demand. The cuts are self-evidently a false economy but the real scandal is that services are failing people with mental health problems and putting lives in danger as a result.'

Such a quote is in stark contrast to the aims set out by the Joint Commissioning Panel for Mental Health. Thus, it seems a contradiction that, at the same time as cutting funding, the government are promoting the need for value based care and have launched strategies to help promote this; for instance, the 'Compassion in Practice' (DoH, 2012b) strategy was launched in December 2012 for nurses, midwives and care staff. This includes the '6c's', namely: Care, Compassion, Competence, Communication, Courage and Commitment. This could be thought of

as reminiscent of Tuke's moral therapy at the Retreat in York, however, it would appear the resources are not there to back the policies. As discussed in section 1.5.1, we have seen from history that when services are under increasing pressure, compassion and humane treatment become ideologies rather than realities.

1.6 The Mental Health System

1.6.1. Influences on government policy

Given the number of recent policies for the mental health system it would appear that adhering to decent values in mental health has been the top of the government's agenda. Some would argue that this may be a response to stories in the media (e.g. Mullen, 2005) and the need to be seen to be taking positive action, such that it might be more about saying what the electorate want to hear, rather than any real desire for change.

I discussed in section 1.5.3 the NHS Commissioning Board aimed at ensuring a high standard of nursing practice. Continuing on the theme of good intentions, on 2 February 2011 the Department of Health launched 'No Health without Mental Health' (Department of Health, 2011a), the government's new mental health strategy replacing 'New Horizons' (DoH, 2009) which had similarly aimed 'to work towards a society that values mental well-being as much as physical health'. The new strategy signified a fundamental shift towards a locally-led system wherein local organisations were now accountable to their populations rather than central government. This paralleled a wider shift in public services, towards greater local autonomy and decision-making; holding organisations to account, in line with the governments 'Big Society' initiative (Cabinet Office, 2010). The government's approach was guided by health reforms, such as 'No decision about me without me' (DoH, 2012c) giving people access to support and information in order to make informed decisions about their health. However, this approach sits uncomfortably with the policies around involuntary treatment which will be considered next. One of the overriding features of mental health policy is that of risk, in particular protecting the public from harm of those considered to be suffering from a mental illness. Much of the dominant public

narrative around mental health stigmatise people as violent and dangerous (Corker et al, 2013; Pescosolido et al, 2013; Rethink & Mind, 2008; Smith, 2013) which is perpetuated by stories in the media (McGinty et al, 2014) and is likely to result in reactive policies around mental health care (Corrigan, 2013). We will now consider the process of 'sectioning' that exists in mental health care in order to help further clarify the context in which this study is based.

1.6.2. Sectioning

The 1983 Mental Health Act (amended in 1995 and 2007) permits the restriction, known as 'sectioning', of those who are considered to be a risk to the safety or life of themselves or others due to their mental illness. In order for a person to be 'sectioned' the Act requires that the person is seen by combinations of a general practitioner, a psychiatrist and an 'Approved Social Worker'. It also provides a number of categories of appeal procedures. If a person is deemed appropriate for 'commitment' (which is court ordered) then the individual is confined to an acute inpatient unit for a 72 hour period for evaluation by mental health professionals. Those professionals can then determine whether further commitment is appropriate or necessary.

A Section 2 is an assessment order that lasts up to 28 days and that cannot be renewed. It can be instituted following an assessment under the Act by two doctors and an Approved Mental Health Professional. Under Section 2 assessment orders treatment, such as medication, can be given against the person's wishes. Section 3 is a treatment order and can initially last up to six months. If it is renewed it can last up to a further six months and each subsequent order lasts up to one year. For Section 3 treatment orders, the doctors must be clear about the diagnosis and proposed treatment plan, and be confident that "appropriate medical treatment" is available for the patient. This could constitute basic nursing care alone, injections of psychotropic medication or electroconvulsive therapy. After three months of detention, the person has to either consent to their treatment or an independent doctor has to give a second opinion to confirm that the treatment being given remains in the person's best interests. A similar safeguard is used for electroconvulsive therapy (ECT); although the Consultant can authorise two ECT

treatments in an emergency situation for people detained under Section 3 treatment orders, it may not be given to a refusing patient who has the capacity to refuse it. Capacity (i.e. individuals are deemed able to make decisions for themselves) is considered under the Mental Capacity Act 2005. The CQC (2012) found that the numbers of people being sectioned and detained as inpatients was rising.

As the current routine treatment given or enforced is psychotropic medication, I believe it would be useful to give some consideration to this, including why medication is dominant in the treatment of mental health.

1.7 Medication and the medical model

Given psychotropic medication is the main form of treatment on inpatient units, it is no wonder Clarke (2009, p2) described the inpatient unit as 'the last bastion of the medical model in its pure form'. As Moncrieff (2008) argues, there is no evidence to suggest that medication improves or 'cures' people's mental health. Medication fits with the hypothesis that mental illness is caused by a 'chemical imbalance' in the brain which can be rectified. This is in contrast to other theories which suggest social or psychological causes; as far back as the late 1700s even Pinel suggested these as underlying causes (see Hergenhahn and Henley, 2013).

Moncrieff (2011) suggests that psychiatric drugs are psychoactive substances, in the same way as alcohol or recreational drugs like ecstasy or heroin, which induce abnormal or altered states. The difference between recreational drugs and psychiatric drugs being, that the effects of recreational drugs are usually experienced as more enjoyable, and they are illegal. Therefore, psychiatric drugs can be seen as helpful, not because they reverse an underlying drug abnormality, but because the psychoactive state they induce suppresses the manifestations of emotional or behavioural problems. This drug-induced state is often easier for staff, friends, relatives and the person themselves to cope with than the alternative emotional state they would otherwise be in.

Up until the 1950s, this model, where drugs were used openly as chemical restraints via their sedative properties, was largely accepted. However, with the introduction of drugs such as chlorpromazine, they came to be seen as having disease-specific

actions. They were seen as treating the underlying basis of psychotic symptoms and even schizophrenia itself (NIMH, 1964; Whitaker, 2002). They became known as 'antipsychotics'. 'Antidepressants' emerged at the end of the 1950s. As psychiatric drugs became the norm and were seen to target the underlying disease, the wide range of serious adverse effects induced by these drugs, were relegated to the term 'side effects'. People who have experienced these 'side-effects' may disagree with this terminology. The Care Quality Commission (2013) quoted a patient in their 2011/12 report (p72);

'...twenty-five years from now we'll be looking back at medication use and saying "what the hell were we thinking – look at what we've done to these people"....I got diabetes from olanzapine....I ballooned, put on stones, was drinking all the time and always thirsty...You can't help but feel bitter, it's a serious life-threatening illness, it shortens your life'.

Most research on the history of psychiatry has accepted the portrayal of modern psychiatric drugs as targeting the specific disease being treated. Further, drugs are credited with revolutionizing psychiatry by bringing it in line with medical science and breaking the influence of psychoanalysis and social psychiatry (Shorter, 1997). However, there is still little evidence that supports this assertion (Moncrieff and Cohen, 2005, 2006). Evidence via meta-analyses has shown that, in the case of anti-depressants, their advantage over placebo is small and possibly clinically meaningless (Kirsch, 2011; NICE, 2004) and it has never been demonstrated that they have consistently superior effects to other drugs with psychoactive properties. Moncrieff & Cohen (2006) also state that it has not been demonstrated that depression is associated with an abnormality or imbalance of serotonin, or any other brain chemical, or that drugs act by reversing the problem.

As mentioned, psychotropic drugs are the dominant form of treatment on inpatient units with electroconvulsive therapy often resorted to if medication does not have the desired effects. Convulsive therapy was introduced in the 1930's and by the 1940's electro-convulsive therapy (ECT) was widespread in psychiatric hospitals. It was initially viewed as a treatment for schizophrenia but gradually came to be seen as having best effects in depression. There is still no agreement about how ECT induces its effects but it is generally regarded as acting to rectify an assumed

neuropathological basis for depression. The largest group receiving ECT are older people (Newnes, 2014). Indeed, the majority of persons over the age of 65 and labelled as depressed receive drug treatment or ECT rather than therapy.

It is important to consider the context of Psychiatrists working on inpatient units, as like CP they also have a history and context. They work under immense pressure and, when it comes to risk, hold ultimate responsibility. When someone with a diagnosed mental illness is involved in a tragedy (for instance, in the case of John Barrett who was given leave from an inpatient unit and killed a man in Richmond Park in 2004, see Robinson, 2006) the psychiatrist is often vilified by the media for actions they did or did not take, even when an enquiry concludes that it is the whole system that is at fault. A study by Green et al (2001) considered the ethical quandaries of psychiatrists when working in systems that are 'flawed' and their options for response. The results showed that the principle of fidelity to the patient is compromised along with professional integrity. The authors conclude it is likely that premature retirement and poor recruitment to psychiatry is influenced by these quandaries.

Further considering the pressures Psychiatrists work under, on an acute ward they generally have approximately ten minutes a week with each patient leaving them little time to discuss all the relevant factors involved. Therefore, communication with staff is vital but information can get lost with other staff being under pressure, changing shifts and the often unpredictable nature of the wards. Whilst CPs can be critical of the medical model, they too work in places where the dominant forms of treatment are restraint, ECT and heavy doses of medication with sometimes devastating side-effects. Newnes (2014) suggests that this puts them in a compliant position and, consequently, they too are supporting the diagnostic system and upholding such procedures. It is clear, inpatient settings are a complex system with a complex history, involving complex reasons for the distress. Clinicians have conflicting underlying rationales creating different beliefs around interventions and the very structure of the services.

1.8 Clinical Psychology on inpatient units

The benefits and costs of medication are controversial and debatable, however, if alternative and effective treatments exist then these should be provided and utilised or, at the very least, be an option. Over the last ten years it has been evidenced that therapy for people with severe mental health issues can be useful, particularly Cognitive Behavioural Therapy (CBT, e.g. Freeman & Garety, 2006) and NICE guidelines have made recommendations for the delivery of therapeutic interventions for individuals diagnosed with the dominant labels given to people on inpatient wards (NICE; 2004a, 2004b, 2004c, 2005, 2006, 2009, 2010). No Health without Mental Health's supporting document 'Talking therapies: a four year plan of action' (2011b) is backed by an investment of around £400 million over four years to 2015. The main body of this document explains that more IAPT services are being rolled out but also that talking therapies are expanding access for people with severe mental illness with the provision of CBT for people with schizophrenia (NICE, 2014).

However, the evidence that has led to this action plan has been contested by Jauhar et al (2014) in a meta-analysis of CBT in the treatment of schizophrenia which found only a small therapeutic effect of CBT on psychotic symptoms. The study, therefore, questions the evidence supporting the NICE guidelines for CBT therapy and schizophrenia. The main crux of traditional CBT considers individuals maladaptive thoughts with therapists helping people work towards altering them. An inpatient unit houses people who are homeless, with addiction problems, suffering from intense grief, loneliness, people who have been abused, neglected, and who have suffered trauma. Perhaps what 'therapy' can offer over medication is a space for people to be heard, for their life experiences to be acknowledged and a place to consider alternative ways of managing distress or in Janet's (1889/1973) *phase-oriented* model, to attain a sense of safety.

In December 2012, the British Psychological Society published 'Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care' which sets out clear guidelines of how to deliver better access to psychology on inpatient wards. The document states that all professions have a role to play in delivering psychological interventions and the role of a CP extends far beyond that of a therapist on an adult acute ward. These guidelines claim to provide a toolkit to

demonstrate how psychological expertise can support key areas, such as advocating skills based approaches and staff training, and contributing to staff morale and the 'ward milieu'. The guidelines name CBT and DBT as the therapies of choice but also accentuate formulation and reflective practice. The document states its intention to inform commissioners and managers about the contribution CPs can make to the acute care pathway. Baguley et al (2007) state that the delivery of effective person centred care requires support for system change from all acute inpatient staff. CPs have the knowledge and expertise to train and support staff to adopt a psychological approach which adheres to formulations, allowing staff to see the person rather than the label.

1.9 This Study

In an attempt to gain a greater and more detailed understanding of CPs role in acute mental health inpatient units, this study aims to explore the experiences of CPs working within them. Previous studies have considered aspects of a CPs role on an inpatient unit and their effectiveness, for instance looking at the therapeutic value of patient groups (Heriot-Maitland et al, 2014) and reflective staff groups (Heneghan et al, 2013). However, in terms of addressing the wider context, and the system that exist within and outside of an inpatient unit, there is a gap in the literature. I believe this is particularly important to address at present when we have come full circle back to a mental health system under pressure with a need to improve patient care. As demonstrated within the introduction, there is a complex historical and societal context to the care of acute psychological distress. Underlying this is a fundamental value base that can at times get lost within the complexity. Politicians, administrators, care planners and providers are all navigating the complexities of the mental health care system, and to facilitate this navigation it is important that mental health issues, services and the experience of those currently working within them is comprehensively understood to facilitate this process and meet this gap. I will be using Critical Narrative Analysis which privileges the individual's story but also recognises that it is 'entwined' (Frosh, 2003) with society and the context they are in. Inpatient wards represent an intensified microcosm of the whole mental health system and, therefore, findings from this research can be applied to the wider context.

It is hoped that this study will increase understanding around the impact of change in mental health care enabling more informed decisions when it comes to wider changes resulting in social transformation or smaller more direct changes such as target setting. Experiences of those working in the field are an important element of this and can facilitate decision making processes when allocating resources and planning programmes. I am hopeful that this study will also help develop insight into the individual experiences of those who choose to become CPs and work on acute mental health units. Finally, I hope to help inform how, and in what way, services could be developed resulting in improved patient experience and outcomes.

The main research question is:

How do Clinical Psychologists narrate their experience of working within adult inpatient mental health settings over time?

This will include the following aims:

- To explore the experience of Clinical Psychologists working in acute adult inpatient units.
- To develop an understanding of the core values underlying effective inpatient care.
- To consider how Clinical Psychologists experiences might facilitate the application of the core values in acute mental health services.

2. Method

This section has been divided into three subsections. Firstly, explicit attention is paid to the assumptions that underlie this research and how they fit with the methods used. This is followed by a description of the design of the study and finally, ethical implications are considered.

2.1 UNDERLYING ASSUMPTIONS

As all research is undertaken in conjunction with differing underlying philosophies, in accordance with Bentz and Shapiro (1998) it is important that the assumptions which form the foundation of a study are made explicit.

2.1.1 The focus of the study

The focus of this study was to explore how CPs narrate their experience of working on acute adult inpatient units. The fundamental interest came from a recognition that mental health services in the UK are poorly resourced and treatments on acute adult inpatient units are dominated by medical model perspectives. This model can conflict with the psychological and social models CPs are trained in.

2.1.2 Guiding principles and epistemological position

This study was guided by Social Constructionist principles which require a critical stance to be applied to the taken-for-granted world around us and an understanding that knowledge is constructed between, and in coordination with, others (Burr, 2003). From this perspective it is acknowledged that individual ideas, understandings and meanings about the world are a result of history and culture and people cannot separate themselves from this. It is discourses between people which help us to construct meaning, shape behaviour and uphold structural inequalities (Burr, 2003). Our understandings about the world are not products of objective observations but of social processes which are fluid and ever changing. This is in contrast to the more traditional realist scientific approach which asserts that we can gain knowledge of the

world that is objective and separate from our own interpretations (McNamee & Hosking). The realist approach sees objects as existing independently of their connections or ways of relating. From this position there is one 'real reality' and it is available for science to know. Gergen (2001, p157) stated that movement from empirical methods to social construction reflects a recognition that "our understanding of phenomena are themselves theory laden, as are the methods used in their illumination".

I align my epistemology with the Social Constructionist stance. As the researcher in this study I, therefore, consider myself to be a collaborator rather than an expert and the participants are recognised as co-constructors. I entered into this research accepting that I cannot separate myself from my own view of the world and this will, therefore, influence any interpretations of the data that I put forward. Frank (2000) stated that initial interest proceeds from a standpoint and, therefore, in order to promote some understanding of how my view of this research project has been constructed, I will attempt to explain what drew me to this area of inquiry.

I believe my interest in this area of research came from my long standing interest in the role of CPs and from personal experience as a member of staff on acute adult inpatient units. This included work as a Health Care Assistant, an Assistant Psychologist and a Trainee CP. In 1996 I completed a psychology degree with a vague ambition of studying CP, but I was intimidated by the stiff competition for places on a course and spent the next six years experiencing life without a clear direction. I had my first child in 2002 and began to find deeper meaning in life and accept some personal responsibility. After having my third child I became seriously ill and decided that if I recovered I would pursue my CP ambitions with more vigour. I did recover and looked into getting an Assistant Psychology post in my local NHS Trust but was told that only people who already worked in the Trust could apply for these positions. Therefore, I got a job as a health care assistant on an adult acute inpatient ward with the hope of gaining experience of psychological interventions. I was surprised to find, apart from one part-time psychotherapist, there was no psychological input on the wards. In my position, as a health care assistant, I was able to spend most of my time with people who had been admitted. This was in

contrast to the nurses who seemed to have an insurmountable amount of work to do in the office and interactions with people on the ward tended to be brief.

Many of the residents would self-harm which was something I became accustomed to and much of my role consisted of attempting to prevent this, largely by 'observing' people. One evening, towards the end of my shift, a young man came staggering towards me. He was extremely pale and had a deep cut in his arm. I helped the charge nurse to get him into the small cubical room where medication was kept. The floor of his bedroom was covered in a seemingly impossible quantity of congealing blood and Mozart was playing at a high level on his ghetto blaster. The only other nurse on duty came out of the office, I assumed to offer assistance, but he observed what was happening, rolled his eyes and said he was leaving as it was the end of his shift. I was stunned that he left the Charge nurse and me in this situation.

This experience, along with many others, led me to question the treatment available to patients in acute inpatient settings, and the impact that working in this environment has on staff. By coincidence, in 2012 I worked as a Trainee CP in the same unit where a full time CP was now in post. My experience as a Trainee was very different to my experience as a health care assistant but no less concerning. My relationships with staff, some of whom I had worked closely with before, were notably more strained and it seemed that the stories that accompanied the different roles had an effect on the interactions between us. Although there were aspects about the placement I enjoyed, I was relieved when it came to an end. However, my interest regarding the inpatient unit remained and I found myself curious to find out the stories of qualified CPs who work on inpatient units for longer than six months. I wondered how they were able to construe and sustain themselves in this environment.

2.1.3 Rationale for using a Narrative Approach

As I was keen to gain a rich understanding of individuals' experiences I used the qualitative approach of Narrative Analysis rather than a quantitative approach to this research. This involved exploration rather than testing of pre-existing hypotheses.

There are various different types of qualitative analysis and the choice of method tends to depend on the research's underlying epistemological position (Willig, 2008). Narrative Analysis fits well with Social Constructionist ideologies because, as well as exploring the individual experience, it also considers the wider cultural context which, given the historical and social contexts of these situations, I considered to be a vital contingent in this research. I also wanted to explore the co-construction of the dialogue in order to gain an understanding of the multiple voices that find expression within a single voice (Frank, 2012). This is with the understanding that the narratives that the participants choose to tell have been constructed with and between others, including myself as the interviewer. Therefore, these narratives help to gain understanding of the wider social influences as well as the individual participant.

In recent years, the narrative approach has become a popular method of inquiry in many of the human sciences. This popularity has been described as 'the narrative turn' (Reissman, 2008). Hinchman and Hinchman (1997) see a narrative as a story of events, placed in a sequential order, which conveys meaning to a particular audience. Squire (2008) adds to this by describing narratives as a way in which individuals make sense of themselves and the world. The narrative approach asserts that in order to create a story, certain events are selected out and privileged over other events (Bamberg, 2004). Once privileged, they are linked with other events across time, to form a story about a particular issue. Narrative analysis takes stories as its primary source of data and examines the content, structure, performance or the context of such narratives.

2.1.4 Introducing Narrative Research

Where the emphasis of the analysis lies will determine which methodological approach of narrative analysis is used. As Squire et al (2008) point out, there are few rules for framing inquiries, obtaining and analysing data or presenting narrative findings. Navigating the history of narrative inquiry and the different approaches that have been developed is complex and has been described in different ways. Squire et al (2008) considers narrative inquiry originating from two parallel academic traditions. Firstly, post-war humanist approaches within western sociology and psychology, which put forward holistic and person-centred lines of enquiry often attending to

individual case studies, biographies and life histories (Polkinghorne, 1988; Bruner, 1990). Secondly, structuralist, and later poststructuralist (Barthes, 1977; Todorov, 1990), post-modern (Foucault, 1972; Lyotard, 1984), psychoanalytic (Lacan, 1977), and deconstructionist (Derrida, 1977) approaches to narrative which were concerned with narrative fluidity and contradiction, with both conscious and unconscious meanings. This divided history of narrative analysis accounts for its variability in approaches. However, Squire et al (2008) states that the two traditions are brought together by their shared tendency to treat narratives as modes of resistance to existing structures of power.

Perhaps the most recognised difference between narrative approaches is between event-focused analysis (Labov and Waletzky, 1967) and experience-centred work (Squire, 2008). Both approaches assume there to be individual, internal representations of events, thoughts and feelings to which narratives give external expression. However, event-focused work assumes these phenomena remain constant, whereas experience-centred research stresses that they vary over time and across circumstances. As Squire et al (2008) explain, experience-centred research recognises that the meaning we give to the narratives is always in a process of transformation. Our positioning is never constant, in the course of our lives things that we thought we knew well will become strange to us and the objects of our affection will grow closer, or further away. A third form of narrative research considers narratives as being co-constructed, viewing them as forms of social code (Bakhtin, 1981). Language is considered an important aspect of all narrative research; however, this can be approached in various ways. For instance, language used can be analysed in great detail at a micro-level or it can be seen as a 'transparent window' (Salmon, 1985) giving insight into the human significance of an individual and social life.

Reissman (2003) detailed four specific types of analysis. Firstly, thematic analysis where the emphasis is on the content of a text looking at what is 'told' rather than exploring the 'telling'. Secondly, structural analysis considers the way a story is told (i.e. the 'telling'), with language as the main focus. Thirdly, interactional analysis considers the dialogic process between the teller and the listener and the collaborative meaning gained from the co-construction of a narrative. Lastly,

performative analysis is an extension of the interactional approach where interest moves beyond the spoken word to consider how and why the storyteller is communicating in the way they are and how that involves the audience.

2.1.5 My Approach.

The Narrative Approach I used for this research was based on the principles of performative analysis. This is similar to Frosh and Emerson's (2004) critical narrative analysis and Franks (2012) dialogical narrative analysis which all consider narrative in context. The research also follows the experienced-centred approach which places importance on change over time (Brockmeier, 1993; Ricoeur, 1984) and 'transformation' which is assumed to be integral to the story told, the lives of those telling it and the researchers understandings of it (Andrews, 2008). Finally my approach considers the co-construction of the narratives. Reissman (2008) said narrative analysis is useful when the interest is in how and why a story is constructed as it is, what it accomplishes, and how the audience affects what may be told. Frank (2012) put forward four questions which I tried to keep in mind through the analysis. They are as follows:

- 1) What multiple voices can be heard in any single speaker's voice?
- 2) What counts as a story and what does not?
- 3) Why is someone choosing to tell a story?
- 4) What stakes does the storyteller have riding on telling this story, at this time, to these listeners?

2.2 DESIGN

A qualitative design was used using eight individual semi-structured interviews with CPs who work on adult acute inpatient units. The resulting data was explored using narrative analysis.

2.2.1 Participants

The participants recruited needed to closely match the criteria of the study; therefore, a purposive sampling approach was employed. The participants needed to be qualified CPs who were currently working on, or supervising other CPs, on adult acute inpatient wards.

Josselson and Lieblich (2003) have suggested that narrative analysis requires between 5 and 30 participants. They state it is usually agreed that data should be collected until a 'saturation' point is reached, however, in their research they recognise that they have stopped interviewing when 'we already have learned more than we will ever be able to contain and communicate' (p267); intimating that it is their practical limits that determine numbers rather than the data becoming replete. In Emerson and Frosh's (2004) guide to Critical Narrative Analysis they based their research on one participant. With the criteria for numbers of participants not clearly set, I decided to recruit between six and ten participants to help ensure the number was large enough to be able to consider differences and similarities in individual narratives and in order to carry out analysis within the time scale of the study.

To initiate recruitment I contacted the CP who had supervised me when I worked as a Trainee CP on an adult acute inpatient ward and informed her of my research proposal. She agreed to contact her colleagues in the NHS Trust where she worked and ask if they would be willing for their email addresses to be given to me. I received eight email addresses (including my ex-supervisors). The CPs were contacted via email and were asked if they would like to take part in the study. The email had a 'participant information sheet' which they could read in order to help them make an informed decision of whether or not to take part (see Appendix 4). Seven people agreed to be interviewed and one of them gave me details of a CP in another Trust who I contacted and he also agreed. Seven of the CPs worked on or supervised people who worked on adult acute inpatient wards, however, one of the CPs worked on a low-secure inpatient ward. I made the decision to interview this person to provide an opportunity to consider how experience in this context may differ from experiences in acute inpatient units.

Each CP who was interviewed had a professional or personal relationship with at least one of the other participants and they were aware that each other had been approached to take part. I had also met or worked with seven out of the eight participants. These relationships are made explicit in this research as they form an essential part of the analysis. I have, therefore, detailed aspects of the relationships that I was aware of in Figure 1 below.

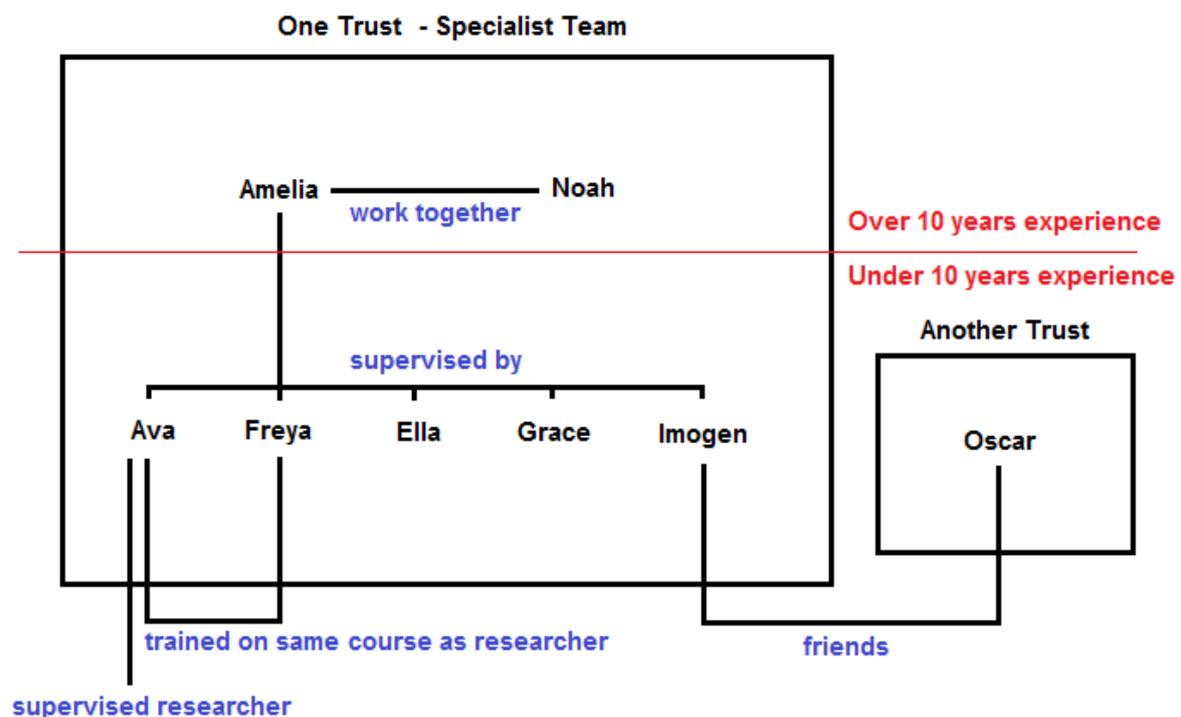


Figure 1: Diagram to show relationships between participants

2.2.2 Interviews

Individual interviews were used for this research with the understanding that when narratives are spoken, the time, the place, the occasion, the narrator, the audience, and the narrative become immediately intertwined (Chamberlin and Thompson, 1998, p10) and can be understood as 'purposeful social actions' in a way that written narratives cannot. The narratives were considered in relation to their co-construction between the interviewer and the research participant (Mishler, 1997) as well as in relation to how they were shaped by the audience to whom they were told; namely, the interviewer, the reader and the wider societal discourses. Narrative analysis

requires a relatively open form of interviewing which allows participants to thoughtfully talk about issues which are of interest to both the research and themselves.

The interviews were designed to encourage development of narratives, with the understanding that narratives may also emerge spontaneously. The interviews consisted of two major orientating questions and question prompts were used appropriately to further participant's narratives. The two orientating questions and a sample of the prompts used can be found in Appendix 5.

2.2.3 Procedure

Before carrying out the interview the information regarding the study was reiterated and the participant was asked to sign a consent form (Appendix 6). The interviews were carried out by one researcher (myself) with the intention of showing respect and empathy for the interviewee but conveying a non-judgmental attitude toward the content of the interviewee's speech (Patton, 2002). The aim was to leave space for the participant to tell their story in relation to a broad question (McNamee & Hosking, 2013). All the interviews were recorded and stored securely on a password protected electronic file.

2.2.4 Transcription

Interviews were transcribed verbatim with pauses and non-verbal expressions (such as sighs and laughter) added in brackets. All the interviews were recorded and transcribed by me (the interviewer). Excerpts of the interviews, particularly areas which were hard to understand, were listened to by a qualified speech and language therapist (who signed a confidentiality agreement, see Appendix 7) and the corresponding transcription was checked for accuracy. An example of a full transcription can be found in Appendix 8.

2.2.5 Data analysis

Following Emerson and Frosh's (2004) critical narrative approach texts were analysed in a series of steps, moving from a micro- to macro-levels of analysis. The exact course that the steps of the analysis took emerged over time in response to outcomes of previous steps. However, the central question which guided the analysis throughout was:

How does this person, in this context, come to give the account he/she does?

The steps of the analysis took place over two phases and were as follows:

PHASE ONE

- 1) Interviews were audio-recorded and transcribed verbatim.
- 2) Each interview was listened to and storylines from the interviews were noted down as well as feelings that were perceived by the interviewer (See Appendix 9).
- 3) The transcripts were read through and the narrative text was separated from the non-narrative text as described by Labov (1972). The non-narrative text contains any material that is irrelevant to the narrative for instance descriptions or reports. The narratives that were left included (Labov, 1972, p363);
 - a. The abstract: what the story is about.
 - b. The orientation: who was involved, what and where.
 - c. The complicating action: what happened
 - d. The evaluation: what is the point
 - e. The resolution: what finally happened
- 4) Storylines in the revised texts were underlined in different colours in order to explore how they presented through the text.

- 5) The revised texts were read through and an attempt was made to represent the different storylines in writing. However, after reflecting on the writing with my supervisors, I recognised that I needed to return to the analysis. Frank (2012) pointed out 'reports emerge in multiple drafts that progressively discover what is to be included and how those stories hang together' (pg43). More thought needed to be given to which narratives should be included, what the contextual issues were and how the narratives were co-constructed and why. My desire to complete the task had meant I temporarily lost sight of the meaning behind what I was doing. This experience seemed to parallel some of the stories within the narratives I was analysing.

PHASE TWO

- 1) The original interviews were listened to again while notes were taken in response to specific questions. The questions which helped to guide the way I listened to the interviews and were as follows:
 - a. What are the main narratives?
 - b. What are the narratives that run counter to these?
 - c. What is not said?
 - d. What are the contextual issues, e.g. social, political, cultural discourses?
 - e. How have I as the interviewer/researcher influenced what has been said, what stories have I given power to, what stories have I closed down?
 - f. What other voices can you hear?
 - g. Who is the audience, and how does that effect what is being said?
- 2) In the final stage dominant narratives were considered and re-explored. The narratives considered to be 'dominant' included stories that were repeated throughout the interviews and incorporated smaller stories within them. Frank (2012) describes how stories 'call out as needing to be written down' (pg43) and he sees judgement as dependent on the researcher's experience in the context. The dominant narratives that were chosen to be written down were

co-constructed by the researcher and it is recognised that multiple other narratives exist (Reissman, 2008). These narratives were explored using Frank's (2012) technique of imagining stories horizontally, vertically and from the perspective of a child. This required,

- a. Imagining horizontally, using Labov's (1972) technique as detailed above.
- b. Imagining vertically, referring to what leads a person to tell the story, considering characters, point of view, genre, suspense and imagination. Frank explains his inclusion of imagination as:

'Storytellers construct stories in recognizable, generally sequential segments, but stories have their distinctive effects - whether to instruct, to explain oneself, to enrol others in a cause, or simply to entertain – because they engage imagination'.

Frank (2012, p42)

- c. From the perspective of a child, Frank (2012) concludes that what a story is can be defined by 'the bedtime test'. He suggests that if a child wants to hear a story before bed, as well as a complicating action, the story has to have suspense and usually hinges on strengths and flaws of the characters who deal with the complication. A child will ask for the same story repeatedly, therefore, he also states that to pass 'the bedtime test', a story should be recognisable across multiple retellings.

I recognise that the course of my analysis was dependent on my own experience and decisions I made from moment to moment. These decisions may well have been different at different times. The analysis undertaken was limited as meanings change and do not stay the same. The analysis, therefore, could go on forever. As the researcher I have had to decide an end point but I recognise further analysis by someone else, or myself, would bring forth other ideas.

2.2.6 Credibility

Yardley (2008) put forward four core principles to demonstrate the validity of a qualitative research project. I will now consider decisions that were made with reference to these principles in order to elucidate the credibility of this study.

The first principle was 'sensitivity to context'. This represented a central component of this study as it was vital that as the researcher and interviewer I was aware of the context the participants were situated in to ensure understanding. In order to demonstrate this I have detailed relevant theoretical and empirical literature in the introduction paying close attention to some of the meanings and concepts that have evolved around mental health, mental health services and CP. Additionally, relationships between the participants and between the researcher and the participants have been detailed in Figure 1 in order to achieve transparency as it is recognised that these relationships were likely to have influenced the narratives. The research interviews were designed to encourage participants to respond freely during the interviews by using open-ended questions.

To demonstrate sensitivity and validity in the analysis stage I used triangulation through regular meetings with my two supervisors to ensure consistency and coherence. A paper trail of all the analysis has been kept in order to provide evidence which links the raw data with the final report. Participant validation was considered however it was thought to be inappropriate due to the relationships between the participants and the complexity of the analysis, for instance the consideration of the narratives that were suppressed.

The second principle put forward by Yardley (2008) was 'commitment and rigour'. The aim of this research was to provide an in-depth understanding of the experience of CPs on acute adult inpatient units which required an empathic awareness of the context. In section 2.1.2 I detailed an account of my own experience working in acute adult inpatient units and my experience as a Trainee CP which demonstrates commitment to this area of research. The data was engaged in extensively and in great detail with regular discussions with supervisors. The third principle to ensure credibility of qualitative research was 'coherence and transparency'. I have detailed

in section 2.1.3 the rationale for using narrative analysis and the commitment to a social constructionist approach. I have also been clear that I have been flexible in my approach, detailed above in section 2.1.6, which is appropriate within narrative research. The final principle pertains to the 'impact and importance' of the research. Recent government and news reports, as detailed in sections 1.4, 1.5 and 1.6, have detailed poor care in mental health services, particularly acute adult inpatient units. For this to change it is vital that research considers experience of those working within the system in order to develop an in-depth understanding of the issues which can influence future policies and procedures implemented to improve the current situation and provide good quality care.

2.3 Ethical Considerations

Ethical approval was gained from the University of Hertfordshire Research Ethics Board on 9th July 2013; reference number LMS/PG/UH/00090 (see Appendix 10)

2.3.1 Informed consent

The participants were provided with an information sheet (Appendix 4) detailing the aims of the project and details of confidentiality prior to the interview. All participants were asked to sign consent forms to identify they understood the information (Appendix 6). Participants were offered a debriefing session once the research was complete.

2.3.2 Confidentiality

All the interviews were transcribed by myself and these were partially checked by a third party who signed a confidentiality agreement (Appendix 7). The transcripts were downloaded from a Dictaphone and kept in a password protected electronic file. As far as possible, all identifying information was anonymised in the transcriptions. Pseudonyms (which were identified using the most popular baby names of 2013) have been used throughout the project including in the analysis and report. Furthermore, to further ensure confidentiality, I have used the term 'Participant X' rather than a pseudonym to represent participants or quotes in the text

where I believed information may be sensitive or lead to identification of an individual.

2.3.4 Emotional Impact

The participants were warned of the possible emotional impact of in-depth interviews prior to the interview. They all gave assurance of regular supervision and were given the choice to pull out of the study up until four weeks after the interview.

2.3.5 Interpretation of the interviews

The co-construction of the data was regularly discussed and closely observed by my supervisory team. This enabled me to move towards a critical reflection of the interviews and analysis, encouraging examination from multiple positions and to use reflexivity in order to expand my understanding (Gergen & Gergen, 1991).

3. Results and Discussion

I have chosen to write the results and discussion together in an attempt to avoid repetition and promote clarity and understanding.

3.1 Overview

In this section I will present the dominant co-constructed narratives that transpired from the analysis. These narratives will be considered firstly, from a societal perspective and, secondly, from the individual participant's perspective. I do this with the knowledge that I have privileged these narratives and there are other narratives that I have chosen to leave out or I have not been open to. What I have included is a result of my own frame of understanding and I am aware that the data could have been assembled in multiple ways generating different analysis (Frank, 2012). Throughout this process I have changed my understanding of the interviews and altered my decisions as to what to include and I acknowledge that what I have written today may well be different to what I would have written yesterday or would write tomorrow.

Table 1 shows the structure of how I will present the dominant narratives. The framework was achieved through looking within and between the narratives at both their similarities and differences. Section A will be presented under the heading 'Stories of Restraint'. Firstly, this includes the dominant narrative 'you can't beat the system' representing the impossibility of change due to the strength of the culture that exists on an inpatient unit and in the wider system of the NHS. The two response storylines which are included in this section are 'learning to accept' and 'intimidation and power'. This is followed by the counter narrative (Bamberg, 2004) which the participants alluded to but did not directly speak of which highlights their individual distress. I have named this narrative 'screaming inside.' This section has no response storylines as the narrative was unspoken but demonstrated through the way narratives were told and organised.

Section B is presented under the heading ‘Stories of Release’. The first dominant narrative in this section has been named ‘connecting with humanity’ which contains stories about people feeling heard by others and includes the response storylines of ‘understanding mental illness’ and ‘needing validation’. The final dominant narrative features people expressing their distress but this being left unheard by others, others being both individuals and society in general. I have called this ‘someone is screaming’ and included the response storylines of ‘treating the patients’ and ‘stopping to think and feel’.

Each section includes quotations taken from the interviews. The quotations are referenced using the name of the participant followed by the page number on the typed transcriptions. Quotations from ‘Patient X’ (see section 2.3.2.) are not referenced.

Table 1: Table to show the structure of the results.

| | | Dominant Narratives | Response Storylines |
|----------------------------------|--------------|---------------------------|---|
| A Stories of Restraint | The Spoken | You can't beat the system | Learning to accept. Intimidation and power. |
| | The Unspoken | Screaming Inside | |
| B Stories of Release | The Heard | Connecting with humanity | Understanding mental illness. Needing validation. |
| | The Unheard | Someone is screaming | Treating the patients. Stopping to think and feel. |

3.1.1 'Stories of Restraint' and 'Stories of Release'

I have entitled Section A 'Stories of Restraint' as this represents a dominant narrative that encompasses inpatient units (The Lancet, 2013) and the stories which the participants told. When people are admitted to an inpatient unit, and during their stay, various methods of restraint are often used. This could be physical restraint from the staff, chemical restraint from medication, legal restraint from being 'sectioned', psychological restraint regarding speaking about their past and present experiences, or environmental restraint from locked doors. When nurses are employed on an inpatient ward they participate in mandatory training which includes learning how to safely physically restrain someone. Restraint is a part of daily life on an inpatient unit. The spoken stories that came out of the analysis centred on how the approaches to care preferred by the Clinical Psychologists conflict with the dominate approaches used on the units. The stories that were explicitly told articulated the participants' restraint in their actions, thoughts and feelings, rationalised as a necessity in order to survive on an inpatient unit.

In contrast, section B is entitled 'Stories of Release'. This is to encompass the stories which demonstrate ways of working where people have ceased to feel restrained and have been able to connect with themselves and others (the heard). This section also includes stories of people expressing their distress and how this is or is not responded to by others (the unheard).

3.2 Considering the Results in Context

Before considering the individual narratives it is important to consider what has shaped how the stories have been told. Frank (2012, p44) said:

'the primary resources for telling a new story are the stories that are already circulating in the setting'

In the introduction I detailed some of the broad historical, political and cultural influences on adult acute inpatient units. I shall now go on to look more specifically at

the dominant narratives named in Table 1 and the context from which they were likely to have been derived from. The first narrative to be considered is, 'you can't beat the system'.

3.2.1 'You can't beat the system'

'I think we're really starting to see now something post-2010 post-economic difficulties filter through clinically, staff wise, training wise, all those kind of things, I think we're seeing it probably now. David Cameron's fault'

Imogen, p15

It is important to acknowledge the time in history that these interviews took place. In the quote above Imogen is referring to the global recession that began with the financial crash in 2007. This led to a deficit reduction programme by the Coalition government in 2010 (LSE, 2014) and economic policies which enforced cuts to health care and the service industries with the closure of many mental health inpatient beds (see section 1.5.3.). As mentioned in section 1.4.1, people in the NHS have been made redundant as a result of the cuts (HSCIC, 2014; Keogh, 2014) and some have been downgraded from their previous positions. This narrative is very apparent in the interviews.

'I'm working in an NHS which is likely to make me and most of my psychology colleagues redundant in the next few years because they're going to be training nurses up in CBT and various other things that they'll call psychological, that will be able to tick the NICE guidelines box and that's what people's psychology interventions will be'

Amelia, p13

This view of the future for CPs in the NHS is under scrutiny at the moment and with different professions and agencies competing for contracts, CPs can be seen as an expensive resource. The participants in this research discuss this changing view of CP and the need for CP to promote skills which extend beyond therapy and are

possibly more in line with recent guidelines (see section 1.3.2.) which accentuate leadership, working in teams and formulation. Additionally there is scepticism regarding the usefulness of CBT interventions carried out by nurses beyond fulfilling NICE guideline requirements. A CBT training course does not necessarily mean expertise in an intervention, further, this training often enables interventions with straightforward cases. Cases with greater complexity require greater skill, derived from more specialist intensive training. As discussed in section 1.8 the evidence supporting CBT for psychosis has also been called into question (Jauhar, 2014) which could have the potential to discredit the system that informs which treatment is the most effective. Perhaps the need for evidence which promotes time-limited, cost effective therapy (Hall & Iqbal, 2010) relates to the narrative of order and efficiency (1.5.1.) overriding core values of compassion and care. Distinctions need to be made between straightforward clinical work and working with complexity.

Simultaneously to the financial situation, following investigations highly publicised reports have been written over the last few years revealing bad practice in the NHS. The most notable of these is the Francis Report (2013) which details poor care in the Mid Staffordshire Foundation NHS Trust between 2005 and 2009 reportedly resulting in hundreds of avoidable deaths. This, understandably, has led to a loss of public confidence in the NHS (King's Fund, 2012). The Francis report identified numerous warning signs to this and considered why they were not acted upon, including:

'A culture focused on doing the system's business – not that of the patients'.

The Francis Report (p4)

The report possibly reflects on the results of a target-driven culture in the NHS (see section 1.4.) where the principles of business have become the focus. In Oscar's interview he comments that he has been lucky as he has experienced autonomy in his job role, however, he said this was beginning to change,

'we're currently in the process of having more tighter targets and data...activity monitoring which might make it more contact based in the future'

Oscar, p5

Since the investigation into Mid-Staffordshire Hospital, the government has been calling for more compassionate care in the NHS. However, compassion takes time and, therefore, costs money. If people like Oscar have to meet contact targets they will have less time. There seems to be a contradiction between the call for compassionate care and the cuts to resources accompanied by target setting (see section 1.4). This more negative narrative around the changes in the NHS are present in the narratives of the participants. For example,

'I feel like the NHS is being systematically dismantled by the government, this government and the previous labour government'

Imogen, p26

Narratives within Western society are guided by the media (Croteau, 2012) with some stories given prevalence and others marginalised. The media holds power when it comes to public opinion which in turn can influence government agendas (McCombs, 2004). The reasons behind different media services focusing on certain stories are complex (McCombs, 2004) and can lead to sensationalist, biased or skewed reporting. This can be detrimental to the public view of mental health (Huang, 2003).

The research interviews for this project took place following the murder of Christina Edkins by a man who had been released from prison and had a diagnosis of paranoid schizophrenia. As discussed in section 1.7., high profile cases like this one are likely to put extra pressure on people who work in mental health particularly when considering risk. This story is shocking and tragic and is likely to instigate strong reactions in people which, in turn, can lead to further stigma around mental health difficulties (see section 1.6.1). The reporting around this case concentrated on certain aspects; namely, the mental health difficulties of the man who carried out the attack. Other aspects of his life, such as his release from prison into poverty and homelessness, were not reported in such detail. Perhaps the choices made in the reporting of this incident are indicators of an individualised Western society where the onus is on individual responsibility rather than collective or societal responsibility (Brannen and Nilson, 2005).

Noah commented in his interview that he had listened to a program on Radio 4 on the prison service that morning and said that it was a fact that there was a lack of proper risk assessments carried out in the prison service. He suggested that the prison service buy in CPs, stating

'it would mean fewer news worthy disasters when people are murdered by somebody who shouldn't be let out and similarly that people are let out when they should be let out in order to reintegrate because we keep them for too long'

Noah, p22

As well as prisons this statement also reflects the pressure around risk and protection of the public on acute mental health units. The legal responsibility usually sits with the psychiatrist as 'the responsible clinician' which is likely to influence the treatment decisions they make (see section 1.7). However, it also reflects the hierarchical structure of the inpatient unit, including who sees themselves as holding the power. Oscar commented,

'while I've been here...it's astounding the amount of...power, I think it's all about power'

Oscar, p7

Hoff (2009) stated that when a person is diagnosed with a mental illness they take on the identity of a patient and consequently fall into the expected roles of the institution. This can render them powerless and accepting of their 'treatment'. Noah describes how important it is that CPs are aware of the effects of medication. He comments on their long-term psychosocial effects,

'if someone's on antipsychotics that's gonna affect their motivation, general approach to life, the way their life is constructed..if somebody's taking an antipsychotic drug over a long period he's, it's true, less likely to be readmitted'

to hospital but they're also less likely to be married, in a relationship, to have a job and so on, cause they are very de-motivating and they're drugs that sedate you without sending you to sleep, fundamentally'

Noah, p8

The medical model, along with medication, comes with its own language (see section 1.2.1). According to Speed (2011), language can be analysed as a system of representation that reflects wider systems of meaning within society. He illustrates this by using mental health as an example. He argues that there are a range of possible discourses which exist for people to construct meaning into their talk about mental health. For instance people with mental health difficulties are often called 'patients'. This is a dilemma which Imogen briefly discussed when talking about language;

'I call them patients, I mean even that in itself is contentious sometimes, wouldn't do it in the community, but here, you know, it's a hospital I think it's fine to call them patients here, but even that issue, there's some Trusts where they want to call them customers now, they're all called customers and I think there's really something wrong with that and there is just something wrong with so much of it in so many different directions'

Imogen, p25

Speed (2011) sees these different ways of talking about, and positioning of, people with psychiatric diagnosis as indicative of wider social and political struggles. He sees the classification of 'patient' as accepting of the medical model where the biological aetiology is privileged over social and environmental factors. As we saw in section 1.5.1 this tension has existed for hundreds of years. Other types of description include 'survivor,' where medical categorisation is resisted bringing in different narratives such as those promoted by non-governmental organisations for example the Hearing Voices Network. Speed (2011) puts forward a third term of 'healthcare consumer'. This fits with the more recent government health policy around market forces and choice agendas (see section 1.4.). Speed (2011) suggests

that the introduction of choice has made health into an individual responsibility determined by lifestyle choices rather than a value based decision based on social equity and social justice.

The narratives presented above seem to be present in all of the interviews. The stories they tell, the way they tell them and the language they use represent different versions of a similar story which seems to point out the inadequacies of the mental health system but also the power and intimidation that it holds. There remains a sense that perhaps it is impossible to change. The next part of the analysis begins to elicit why this might be.

3.2.2 'Screaming inside'

'that's not to say that I don't think that the way that nurses talk about people at times is isn't horrific, it is, and it's shocking sometimes but I just think it's important to understand why and it doesn't necessarily, I don't know that it is (pause) I don't know what sometimes you can really do about it'

Participant X

'Screaming inside' relates to the narratives that were unspoken by the interviewees and act as counter stories to the accepting stance regarding the control of the system. When analysing the interviews the internal anguish of the participants was palpable. This showed in their choice of language, the stories they chose to communicate and their non-verbal communication. It seemed that whilst the participants were able to speak confidently and fluently around the role of a CP they appeared more tentative when discussing how working on an inpatient unit may have influenced their personal values. Social narratives that may contribute to keeping this story silent could include the expectations around the role of CPs. They are perhaps considered by others as emotionally strong and the holders of other people's distress because of the job they have chosen to do. Ella describes her experience of being in a specialist group with other CPs;

'on mass they're quite an intimidating, highly confident, we have lots to offer as psychology (pause) I tend to hide my light under a bushel a bit more, and I'm more comfortable with that but it felt as if that wasn't OK and I can totally

see why it isn't OK, we need to defend our role as a psychologist and what we bring that a CBT therapist doesn't and I'm on side with that'

Ella, p13

As Ella recounts, perhaps CPs are under particular pressure at the moment to hold on to their positions within the NHS and in order to do that they need to appear strong and capable.

It is also perhaps part of British culture that sees stoicism as a positive attribute. Society historically advocates the 'stiff upper lip' which is reflected in various literary works: for instance Rudyard Kipling's poem 'If' (Kipling, 1910, see Appendix 11). Ellie commented in her interview,

'I think in mental health we'd much rather talk about a hugely embarrassing physical illness that somebody has than about our own mental health'

Ellie, p8

This perhaps denotes an 'us and them' culture which is indicative of the medical model in that if you experience mental health difficulties you are ill and unable to function. The contrast evoked in the use of the term 'hugely embarrassing' suggests that such a personal admission of experiences is shameful for clinicians. Rapley et al (2011) stated that the dualist Western philosophy and culture helps in sustaining the idea of mental illness as the 'ghostly partner in crime' (p6) of physical illness. One can see how an admission to a personal experience of such difficulties may be avoided, even from CPs whose profession encourages the voicing and naming of distress of those in their care.

3.2.3. 'Connecting with humanity'

'actually it's fluid, it's not like you pick a tool and then 'psh' CBT 'dlllll'.... it's a moment by moment intricate, interpersonal kind of interaction and it was like opening my eyes, actually I could do the humanity bit'

Oscar p,17

The narrative 'connecting with humanity' is current in today's government policy which, as described in section 1.5.3, puts an emphasis on compassion. These policies follow recommendations in the Francis Report (2013).

People who use health and care services have the right to be treated with respect, dignity and compassion by staff who have the skills and time to care for them.

Department of Health, 2013

Connecting with humanity in society has been framed as relating to one another as human beings regardless of their differences. John Burnham's (1993) Social Graacccess is a well- known acronym to CPs and relates to remaining aware of difference. It stands for,

Gender

Race

Religion

Age

Ability

Class

Culture

Ethnicity

Education

Sexuality

Spirituality

These conceptualisations of difference are likely to have been introduced to the CPs on their training courses and in supervisory contexts in order for them to remain mindful of working with, and incorporating, difference into their practice. The introduction of concepts such as these, and the importance given to the therapeutic relationship (Egan, 2002) on CP training courses, is likely to have a significant influence on the narratives CPs choose to tell and the meaning they give to them.

The existence of inpatient units supports the notion that there is a division between people who are mentally healthy and people who are not, therefore, the existence of difference and power differentials is fervent. In the medical model mental health is considered from the point of view of the individual rather than a view that encompasses the human condition. However, people with mental health problems are often experiencing complex psycho-social difficulties, as discussed in sections 1.2.1 and 1.2.2 which are possibly the cause of their difficulties. Smail (1998, p1) stated,

'we suffer pain because we do damage to each other, and we shall continue to suffer pain as long as we continue to do the damage. The way to alleviate and mitigate distress is for us to take care of the world and the other people in it, not to treat them'

Heriot-Maitland et al (2014) carried out a study looking at the effects of a compassionate-focused therapy group approach to working with people on inpatient units which is perhaps more in line with Smail's suggestion. The approach was described as promoting concepts of common humanity and developing an understanding of compassion. The results showed a significant decrease in participants' levels of distress during group sessions. The group facilitators also noted the frequency of group members sharing their stories and, through this, participants reported feelings of normalization and validation. I will now go on to consider what happens when validation does not seem to be an option.

3.2.4 'Someone is screaming'

'an acute ward where people who have lost their husbands who never had contact with services before, people have lost their children, never had contact with services before, then find themselves within mental health services and on a ward, just neglecting themselves, kind of not managing'

Freya, p14

'Someone is screaming' represents the voices of the people admitted to inpatient wards that cry out through the narratives of the participants. I have labelled this section as 'unheard' as this is how the participants described responses to these voices. Participants told stories of people expressing their distress and, consequently, being labelled as 'attention seeking' or 'not mentally ill' and somehow not worth being attended to. Participant X discussed the relevance of language on a ward,

'because something is normal and common place to staff, they assume that the experience is the same for the patient, and I know some completely bamboozled, baffled, suicidal, anxious, person comes into the system and all these terms are sort of banded about, even anodyne words, even like you're gonna have a CPA review and dada and they're like 'what the fuck is a CPA review' (whispers) and they get highly anxious about it, I think we assume so much, even when it's not offensive, and that's really problematic (pause) and then there's the problematic stuff around being manipulative or attention seeking'.

Participant X

To have a mental health difficulty that is responded to in a negative way is likely to serve to add to a person's difficulties. Linehan (1993) stated that emotional invalidation, particularly of negative emotions, is an interaction style that is characteristic of Western societies that put a premium on individualism, including individual self-control and individual achievement. Michel Foucault (1980) discusses the relevance of knowledge and power in society describing it as having 'normalising

truths' which have the power to construct how people see the world and, as a consequence, their lives. The 'normalising truths' become dominant knowledge for those who have power and other 'truths' that do not fit in with this are suppressed, leaving some having to silently scream. In terms of mental health perhaps the dominant knowledge exists because it is easier to consider the fault within the madness of one individual (not ourselves) than within a society that we are all contributing to or trapped within.

Literature on the psychological process of suppression within individuals highlights the effects this process can have. Thought suppression or emotional suppression has been found to make the experience that is being suppressed more frequent and intense. Thus, if there is no place to speak out, it is likely to result in greater internal distress for the individual(s) that are unable to do so (Hayes et al 2004; Purden, 2004). Sadly the systems in Western society and culture do not seem to provide a safe place where people can speak out about abuse and the consequent suppression to manage this can lead to mental health difficulties (Dillon, 2011). This has been made stark with the recent publicity of 'Operation Yewtree' (which began in October 2012), a police investigation into allegations of child sexual abuse by Jimmy Saville and others, which has now reported that over 500 people (BBC News UK, 2014) have come forward to say they were abused by Mr Saville, with some incidents dating back to the 1960s. A report, by the Metropolitan Police and the NSPCC, called Giving Victims a Voice (Grey & Watt, 2013, p6) asked the question 'why did it happen and why was it not noticed and stopped by police, health, education or social services professionals, people at the BBC or other media, parents or carers, politicians or even society in general?'. Dr Chandra Ghosh, who was a senior psychiatrist at Broadmoor, where Mr Saville was alleged to have committed abuse, said she understood why more people had not made official complaints. 'These were people that nobody believed. So if they had in fact turned round and said he had abused them or raped them, nobody would have believed them' (News UK, 2014). It is truly shocking and a sad indictment on the society we live in that such a public figure seemed to find it so easy to abuse and remain almost unchallenged until after his death.

Hidden abuse is now recognised as a characteristic of the Victorian institutions discussed in section 1.5.1. (Fagin, 2007) and moving people out to more visible community settings seemed like a logical and politically correct move. However, this process has taken much longer than expected, and alongside these delays there has been a rush to move people, such that some have suffered under targets to get people moved quickly, resulting in unhelpful placements with some people still being rehomed. The effects of these policies were apparent in Ella's narrative. She described working with people who had lived in an institution all their lives. In her interview she considered what was being asked of staff and patients when they were told they had to move into the community;

'It all seemed very futile for staff and quite punishing for staff and patients to move them on from what had been their home for an adult life time'

Ella, p6

Policies around care in the community (Audit Commission, 1986) seemed to respond to incidents of abuse but perhaps the voices of the people affected by the new policies and procedures were not properly listened to, or responded to, and other factors, such as cost effectiveness, took precedence ultimately causing the people affected further distress.

There are likely to be multiple reasons why systems exist in the way they do and it is often complex and difficult to fully comprehend. People can be admitted to acute inpatient units by sectioning and, thus, by force because somebody else has decided that this is best for them or for public safety, or even, as has recently been reported, to secure them a bed (Royal College of Psychiatrists, 2014). Imogen and Noah both reflected on the system that exists today in terms of treatment of people who have acute mental health difficulties and considered legal and historical reasons that make it that way. They reflected that such ways were not because they are the best ways of helping the person in distress;

'Psychiatry still is the predominant discipline, for reasons of legislation, but also for reasons of history I think, not necessarily for good reasons now'

Imogen, p1

'It's not the ideal way of doing things and it wouldn't be where you'd be if you were starting from scratch now'

Noah, p7

The wider context which surrounds the participants in this research is likely to have had a huge influence on the individual narratives of the participants. The roles that they have on inpatient unit are determined by wider policies and national guidelines. These policies come about through historical, political, financial and cultural influences and are not always guided by best outcomes for individuals who are suffering and in need of care. Having considered some of the narrative resources available to the participants at the time of the interviews I will now go on to look at their individual narratives.

3.3 Considering the individual narratives

The way interviews are set up is likely to affect which stories are told, therefore, I will give some consideration to the interview process. Firstly, the participants were all CPs and were aware that other CPs were being interviewed. Secondly, they were being interviewed by a Trainee CP who was aware of many of the narratives available to the participants and who was able to understand the language that was used. Thirdly, two of the participants trained at the same place as the interviewer and would have been aware of who was likely to read the finished piece of work. These factors were all likely to influence how and which stories were told.

It is also important to keep in mind the various relationships that existed between the different participants and between the participants and the interviewer. The interviews were set up initially with the help of one of the participants which may have impacted on what others felt able to say, especially as they were aware (with the exception of Oscar) that the interviewer had been supervised by this person in the past. This introduces issues of power dynamics which were also present in other areas. For instance, two of the participants were managers to five of the other participants and additionally the interviewer was a Trainee, these aspects are both likely to have influenced how the interviews were co-constructed.

3.3.1 Stories of Restraint

3.3.1.1 The Spoken

'it's like a dance, and in that chaos you have to find a way of being your own clinician, maintaining your theoretical stance, understanding enough of what's happening with a patient, understanding enough of what's happening with the staff, and somehow not alienating absolutely everybody and also somehow not having a nervous breakdown yourself'

Imogen, p4

You can't beat the system

In the quote above Imogen seems to sum up how all the participants vocalised their experience to some extent. The role of a CP on an inpatient ward was described as multi-faceted and the environment in which they work was chaotic. Imogen compares the system to a dance where the CP has to tread carefully in order to fulfil their goals. The participants seem to describe being on the outside of a system which they attempt to infiltrate with different ideas and ways of working.

Learning to accept

Participants seemed to describe how, when they started their inpatient careers, they had expectations of making changes to the way things worked and the treatment of the patients. However, over time, they have had to lower those expectations and accept that they need to fit in with the system in order to survive.

'I found that my threshold for what I consider to be an achievement has diminished and diminished and diminished, and I don't think it's a bad thing.. it's just more realistic'

Imogen, p4

Participants discussed the importance of realism over idealism in order to protect themselves. Imogen's use of language is strong and emotive particularly her

repetition of the word 'diminished' which perhaps conveys her experience of a gradual disillusionment with her work. She seems to attempt to suppress this thought with the statement, 'I don't think it's a bad thing' which possibly also communicates – it is not a good thing either. The person whom I perceived to strongly advocate the concept of realism was Amelia who was one of the two most experienced clinicians and who had also provided supervision to some of the other participants.

'I probably am sounding overly negative, I call it being realistic (laughs) I think if you start off being realistic you stand a chance of not getting too overwhelmed and disappointed.'

Amelia, p12

The recurrence of these words by other participants suggests that, in all likelihood, Amelia has attempted to instil this outlook in her supervisees at an early stage in order to help them to manage their frustrations regarding the difficulties in achieving any change. Ava discusses her difficulty in accepting the lack of knowledge that other staff have around mental health problems and her tentative descriptions makes it appear that she is still struggling to accept it. She explains how she had been told about it but it took her over a year to begin to believe it.

'finally accepting that actually, .. which was always said to me but, it's something else actually believing it and seeing it when you probably need a lot of evidence to go to fully endorse that but, that actually a lot of the staff and the people they just don't actually know much about a lot of different mental health problems.'

Ava, p10

Amelia talks specifically about the contribution a CP makes to an inpatient unit. She seems to feel their role is valuable but ephemeral due to the rapid turnover of patients and the fact that CPs provide a different voice - one which people may not want to hear.

'it feels a bit like making sandcastles at the edge of the tide, that you can make what seem like quite elaborate good structures but you feel as soon as you walk away the tide will wash them away and they'll be gone and people won't really have a sense of you ever having been there'.

Amelia, p2

The stories seem to represent a narrative of a gradual realisation that, despite best efforts, the inpatient system is not going to change and a CP can work as hard as they like and make temporary advances but as soon as they walk off the ward any positive change will cease to exist. It is generally only in their presence that voices are used, words spoken and voices heard. Frank (2012) in his narrative work around illness discussed three different types of narratives, namely; restitution, chaos and restorative. Amelia and Ava's narratives fit with his 'chaos narrative' which describes multiple problems with any efforts to improve things being futile. This reminds me of a quote from Star Trek;

"We are the Borg. Lower your shields and surrender your ships. We will add your biological and technological distinctiveness to our own. Your culture will adapt to service us. Resistance is futile."

Star Trek - First Contact (1996)

The interviewees discuss the challenges they face trying to maintain their theoretical stance in a very medical environment.

'I think there's always this, you kind of feeling like your swimming in a different direction sometimes to the rest of the team'

Amelia, p1

They describe ways in which this makes working life difficult, here the system seems to hold the power over which discourse is said or heard; the system being the organisation and individual members of staff.

'everything's terribly medical but that doesn't really solve things and because it doesn't really solve things it means that all sorts of ways of being on the ward which are organised to keep things the way they are for the sake of keeping things the way they are I find'

Imogen, p3

Within this quote, one can sense the futility within the experience, there is that sense of order and efficiency prevailing over care and compassion that was discussed in section 1.5.1. Imogen also discusses how staff working on inpatient units see the medical model as being the only explanation for mental health difficulties and the only way to treat people.

'we can't treat it medically therefore it doesn't exist'

Imogen, p23

The very existence of an experience is questioned within this quote, one wonders what happens over time, when faced with this perspective as the value base within which one works. Further to this, one might question the utility of the compassion based policies, discussed in section 1.5.3., and perhaps develop some explanation as to why they do not seem to be being adopted.

Intimidation and power

There is a sense that the interviewees have a difficult balance between being part of the team and, at the same time, remaining outside of the team. They need to be part of the team to stand a chance of influencing it but they need to be outside of it so they do not become submerged in it and lose their perspective and 'distinctiveness'. However, they intimate that it is unlikely they will ever be fully accepted by the team due to the different philosophical and theoretical stance that they hold. Participants

gave examples of the intimidation they can face on inpatient units, and with this, incongruent behaviours:

'The team isn't always very valuing of what you're doing or they might say that they're valuing but they don't necessarily act in that way, taken off to be mainly kind of hostile and undermining whilst smiling at you'

Amelia, p18

Amelia suggests an uneasy undercurrent of feeling that can exist towards a CP on an inpatient ward. One can see how, when faced with this incongruence they may be screaming inside (see section 3.3.1.2). More overt methods of demeaning their philosophical and theoretical stance and the impact this can have were also discussed.

'if the people in power are not listening to you, you are banging your head against a brick wall a little bit...it's just felt a bit like, the staff could have been on board and were sort of almost there, they just needed a little...permission from their bosses and it hasn't happened and perhaps sometimes....it has been undermining to have people like the Consultant in these groups and...that can be quite damaging actually'

Oscar, p6

Throughout his interview Oscar told stories around power imbalances and the impact this can have on his ability to work in a positive way with staff and ultimately on the experience of those admitted to inpatient wards. He described how he aims to reduce issues around power with both the people admitted to the wards and the staff and how this can be threatening to some of his colleagues. He explains why he thinks a Consultant may value their position on the hierarchy;

'if your position and the power in your position is the highest level of meaning that your job has for you then the threat is gonna be difficult to tolerate'

Oscar, p7

Oscar discussed levels of meaning in terms of Coordinated Management of Meaning (CMM). This is a social constructionist theory of communication developed by

Cronen and Pearce (1985) which explores how meanings and actions emerge in context. It considers how wider social forces affect individual perceptions. This theoretical background is likely to have an influence on Oscar's chosen way of working and the narratives he chooses to privilege.

Noah also discusses the concepts of intimidation and power in terms of patients and staff and the importance of good management;

'If you were in a well-managed unit the staff are there to look after you and you get a feeling of protection from that, from the big burly guys, but in a badly managed unit or one that's kind of gone off the rails a bit it's the big burly guys make you feel more unsafe and in a badly managed unit they provoke problems because of the way they deal with stuff'

Noah, p3

Although Noah and Oscar's narratives fit with, 'you can't beat the system' storyline, they have different ways of telling this story. According to Frank's (2012) different types of narrative, their stories seem to illustrate a 'quest' narrative. Quest narratives follow a journey metaphor where people come across obstacles and overcome them. In their different ways, both Noah and Oscar seem to overcome the power dynamics and intimidation; there is a sense of fighting spirit in what they say.

Although I have discussed the individual narratives of the participants it is important to acknowledge how I, as the interviewer, co-constructed these narratives. I will now go on to discuss this further.

Co-constructions

All of the interviewees discussed a process of change from when they first qualified to where they are now. This narrative is likely to have emerged out of a co-construction with the interviewer. As the interviewer I recognise that my experience of CP is at a very early stage and I was interviewing people who I believed were perhaps wiser and more knowledgeable in this area. The participants seemed to

mirror my present experience when they described their own sense of naivety when they first qualified and started working on inpatient units.

'I think as a newly qualified psychologist it's very easy or on placement actually as a trainee I think that it's very easy to see what it is that's not happening in terms of thinking and feeling and wanting to come in and correct it. And the more that I work, the longer I work, the longer I realise that actually a lot of what we do is essentially by stealth'

Imogen, p3

In this excerpt Imogen describes why I had wanted to do this research and what I, initially, had hoped to achieve. When I worked as a trainee CP on a ward I did find the lack of 'thinking and feeling' shocking. I imagine that Imogen was able to surmise this and in this instant was perhaps talking directly about me. I have recognised through the analysis that I was approaching the interviews from a particular angle which was likely to be a significant factor in the construction of the interviews.

When the participants discussed how they had come to accept the unlikelihood of change I found myself becoming frustrated with these narratives, particularly the 'chaos' narratives which story how any attempts to improve the system are ineffective. I found it difficult to hear that things will not change and, during the analysis process, I became aware of my role in closing down some of the narratives that expressed this. I will describe this process below using one pertinent example. This clash was particularly clear in the interview with Amelia and, afterwards, I recall sensing irritation that the interview had not gone better, or rather not how I had envisioned it would go. At the time I found things she said negative and unhelpful, for example when discussing staff she said,

'it's a defence against doing what they find unbearable which is spending time with people whose problems are unsolvable and emotions are uncontainable'

Amelia, pg 12

During the analysis my understandings around this interview have transformed. As Andrews (2012, p12) stated when we revisit data 'we are different people, and the pasts of the data, and our own present reading situation, are as much 'another country' as are materials gathered in situations unfamiliar to us'. I have grown to appreciate what Amelia was saying and recognise that I closed down some of what she said by not always actively listening and responding. I believe that she may have picked up on this and as a consequence fought more strongly for the position she had taken. Our different stances created tension during the interview.

A: there's just so much when you lock basically lock people up who are kind of really erm at their most low and most desperate together (I: mm) the kind of infection of anxiety amongst them and the staff is is is everyone's always gonna be kind of functioning at a very basic level (I: mm) I think. Psychologically.

I: So is

A: Anyway I'm not sure that answers your question?

I: Er is that something that you think can change or just the way it is?

A: Erm I think is there's something a there's it it always makes me laugh because I think that there's there's always a sort of erm (pause) I think people always have a sense of if only about inpatient wards (I: yes) if only this happened and if only this happened it would all be OK and I think that is that is a nonsense it's always going to be difficult

(Amelia, p2)

This piece of dialogue comes early on in the interview and it, perhaps, demonstrates my lack of response to an interesting concept that she puts across. I believe this non-responsiveness encourages her to question the purpose of the research I am carrying out, perhaps putting it as another 'if only' representation. At the time my sense was she did not understand the purpose of the research but now I think she understood my intentions better than I. As a Trainee I perhaps could be seen as someone who is still at the idealistic stage and am yet to become realistic, perhaps this propensity had an impact on the construction of all eight interviews. I have come

to realise that this is an example of the way narratives can be subjugated or empowered, and why conversations in relation to these are important, yet difficult conversations can be like a dance that Imogen spoke of in section 3.3.1.1.

The narratives that I found more appealing at the time were the 'quest narratives'. I recognise that after Noah, Oscar and Freya's interviews which seemed to follow this storyline I felt enthusiastic and keen to continue with my research. This is perhaps not surprising as these narratives provided a more obvious sense of hope that there may be ways of not beating, but perhaps getting round the system in order to improve patients' experience. This was the opposite when the narrative was more chaotic and solutions were not available. Through the analysis, I have come to recognise that during the interviews I was enthusiastic and keen to hear about possible solutions to problems and was less keen to hear about problems or systems that could not be improved or changed. I now question what is most valuable to hear, and I wonder if this is how the clients, '*whose problems are unsolvable and emotions are uncontainable*' (Amelia, p12) might experience responses to expressions of their narratives.

I will now go on to consider the counter narratives I perceived as being unspoken by the participants.

3.3.1.2 The Unspoken

Critical Narrative Analysis (Emerson and Frosh, 2009) employ's a psychodynamic approach which originates with Freud's (1900) work on dreams and focuses on hidden meanings. Attention is given to what a participant may be trying to convey indirectly through the chosen stories that are recounted and the way they are recounted. Freud introduced the notion of 'levels of communication'. The translation from one level to another tends to be based in the service of motives, especially of defence. When a story is recounted this may represent significant people and conflicts other than those in the story. However, it must be remembered that the analysis is through the filter of the researcher's own mind and can never be a true representation of what the participant has communicated, only interpretations. There

are likely to be many historical and cultural factors which are contributing to the participants' choice of narratives which are not accessible. Meissner said;

'The meaning of words can never be fully grasped but only pursued'

Meissner (2000, p330)

Screaming inside

'the system intimidates you into not pointing out, I should have said, you know, 'well jesus, you know, he wasn't fucking mentally healthy was he?''

Participant X

As discussed in section 3.3.1.1 participants expressed an uneasy undercurrent of feeling between parts of the system and themselves. In this section I consider the stories that were not overtly spoken about and perhaps run counter to the spoken stories of acceptance and realism. Despite acknowledgment in the interviews about the necessity of accepting the system in order to survive, there seemed to be a narrative that was not said, which signified that it is not actually acceptable and has left people holding on to emotions of anger and frustration. This was demonstrated in the use of strong language by the participants which conveyed powerful emotions.

In the quote above Participant X is referring to what he/she wished he/she had said when a Consultant did not arrange a proper enquiry after a man had tragically hung himself on his child's swing; the psychiatrist allegedly said, 'he wasn't one of ours'. Participant X explained how he/she had questioned this statement to which the Consultant had replied 'he wasn't mentally ill'. Participant X said this incident happened a long time ago but, from his/her choice of language, his/her non-verbal communication and his/her choice to tell this story, it is apparent that he/she still harbours strong feelings of frustration and anger. He/she talks about people who work within the system,

'common sense gets, it needs to be trained out of people and they need to be acculturated in a way that enables them to happily say absurd things and do

absurd things...the interesting thing for me is that it's if you take a step back it's absurd, it's actually crazy'.

Participant X

Through Participant X's language and style it is clear that he/she does not support or respect the system he/she works in. The system mirrors the 'madness' that is assumed only resides within the residents of the unit. He/she demonstrates his/her frustration again when he/she discusses the British Psychological Society's (2012) inpatient guidelines for CPs which were discussed in section 1.8. He/she describes them as 'pusillanimous', saying,

'instead of beginning, you know, the absence of psychological thinking on inpatient units is a national scandal, it took this, that it would be really nice if you bought a little bit of psychology in, it would be terribly helpful.'

Participant X

His/her sarcasm reflects his strength of feeling. A dark sense of humour pervades his/her interview particularly when he tells tragic stories as the one above with laughter almost reflecting disbelief and covering emotions of frustration and anger which, in turn, perhaps covers experiences of sadness and trauma. Both Imogen and Participant X talk overtly about their strategic and deliberate use of humour to manage the distress of working in this system.

'I have no problem with dark humour I think it's absolutely a reasonable coping mechanism, I do it myself'

Imogen, p24

'I can be quite cut off and internally I use a lot of kind of a dry sense of humour'

Participant X

Participant X also points out his/her ability to be 'cut off' which helps him/her to manage. This is an ability that he/she may have developed as he/she grew up. He/She talks about his/her family in a light hearted way yet the narrative sounds sensitive and, possibly, painful.

'Cause the funny thing is in my family (laughs)no one values me whatsoever and they all think I'm shit (laughs) but actually at work for some bizarre reason people seem to think I'm good at my job, and I get a lot more (laughs) a lot more respect (laughs)'

Participant X

He/she describes how growing up in a large family with lots of fighting, that is 'a bit messy' and requires 'elbows out' has helped him/her to survive and keep things contained.

Participant X describes another way of managing in the system.

P:....'I think you do need to be a bit psychopathic, you need to be, I mean I'm prepared to make friends with people I don't really actually like, in order to influence things in the Trust. Many of them I do like, but I think there are some pretty malign people and they don't always know that I don't like them (sigh), some people seem to be a bit underhand

I: Do you find that difficult to do?

P: At first, increasingly not, I'm afraid. I've become a, I've probably become a bit ur, (pause) a bit tough minded'

Participant X

The words Participant X uses in this quotation, such as 'psychopathic', 'malign' and 'underhand', possibly evoke what it is like working in the worst part of this system. In this case Participant X represents the same person who faced the experience of the father committing suicide and this being managed dismissively and without emotion,

it is likely that he/she has developed his/her cynicism from experiences such as these. Following the question 'do you find that difficult to do?' Participant X seems to respond in a resigned way, almost as if he/she has been forced to go against his/her values, in order to uphold his/her values.

The same participant also acknowledges that you can't change the system but he/she says,

'I think we have limited expectations about ourselves because we're not gonna change the culture. Might have some fun pointing out from time to time, how silly it is.'

Participant X

The humour in this statement only serves to highlight how hard it must be to work in a system that goes against your values and the resilience that is required to survive it.

Most participants spoke directly about the isolation that they experienced as a CP working on a ward, however, they left the effects of that isolation unspoken.

'something I haven't mentioned is that it feels very isolated, your very isolated as a lone psychologist in this kind of setting'

Grace, p15

Grace spoke about her experience of isolation almost as an aside yet the words she chooses are sad and emotive considering humans are social beings (Fiske, 2013). She goes on to explain why supervision is so important. One might assume that she would speak about the effects of isolation at this point, however, she says it is important so that,

'basically you know you're doing a good job'

Grace, p15

There seems to be something that is not said within this statement considering her previous narrative, perhaps there is an emotional need beyond that of her ability to do her job well. The unspoken narrative from Imogen's interview becomes louder when she expresses her hopes,

'I hope I don't burn out, I really hope I don't burn out, (pause) I don't think you can know that until it happens'

Imogen, p27

The repetition in her words seems to express her inner anguish. She follows this hope with another, stating;

'and I really hope that my patients don't die, that's what I find myself hoping most of the time, I hope when I leave, that when I come back I'll have the same patients that I had the last time and that's really hard...because the reality is quite often they do die, not quite often but sometimes'

Imogen, p27

This narrative emphasises the extreme levels of distress and risk that people who work on inpatient environments have to hold on a day to day basis and perhaps helps develop an understanding of the necessity of accepting realism as a way to survive. Perhaps their isolation extends beyond that of the inpatient ward and into society in general which, as discussed in section 3.3.4. keeps these more difficult narratives suppressed.

Possibly parallels could be drawn between the isolation of CPs on inpatient units with people who experience acute mental health difficulties and their isolation in society. This was briefly touched on by Ava.

'that fuels a sense of what is the point of trying, to be honest, and start experiencing some of what the client feels sometimes as well, which is not nice'

Ava, p 8

The sense of futility and defeat seems to link to Imogen's fear of burn out. Participant X considered his/her experience of mental health difficulties to be a direct result of stresses from work. His/Her story seemed similar to other peoples as he/she had started with enthusiasm and ideas of change but the recognition of the unachievability of this became too difficult.

'It made me quite ill. I ended up going off with depression and anxiety..and had two and a half weeks off and then came back and it made me review what I can and can't do and I'll probably stay on anti-depressants for quite a while yet'

Participant X

His/her personal story again seems to run in parallel with people he/she works with. He/she discusses work he/she is doing currently with a patient.

'we've agreed that we'd work out ways of coping with the stress and the depression and the anxiety and the isolation'

Participant X

These unspoken narratives do not exist independently, I will now go on to discuss possible co-constructions.

Co-constructions

Most of the interviews seemed to contain a strong sense of frustration regarding the system that dominates inpatient units and the resulting treatment of people who were

admitted. The possible exception to this was Grace's interview which in Frank's (2012) terms might be described as a 'technical account'. These accounts depend 'on specialised knowledge authorized by experts' and can look like stories. A possible reason for Grace's story being co-constructed in this way was the different circumstances of her interview. The interview was observed by an Assistant Psychologist who had just begun work on an inpatient unit. Having an observer is likely to affect which narratives are chosen depending on who the audience is. Grace may well have given a technical account in order to inform the Assistant what she can expect, she may also have been reticent to communicate a counter narrative of struggle so as not to concern the Assistant.

Grace worked in a low secure inpatient unit which was different to the other participants who all worked in acute units. This too, is likely to account for some of the differences in narrative. Grace explained that the inpatients are there for an average of two years which is much longer than on acute wards, where there is 'early, proactive discharge planning' (JCPMH, 2013, p16).

'we can really get to know them very well. When you speak to the staff they really do know the patients very well and so that's quite different I think'

Grace, p7

Grace described how she works well with the staff team and the psychiatrist. During the interview I perceived a lack of emotion behind what Grace was saying and at the time I recall feeling frustrated that I had agreed to a third party watching. I think, as an interviewer, this made me try to uncover what might lie beneath and began to question things more, rather than trying to sit with Grace and listen to what she had to say. On reflection, I think many of the differences in Grace's account were possibly due to the different unit she was working on. Perhaps, the longer lengths of stay had an impact on how she experienced this work, and the experience of the people admitted to the ward.

It is possible that I found some satisfaction in the counter narrative 'I am screaming'. When participants showed their distress through their language and non-verbal communication I experienced a sense relief; as it mirrored my experiences on an inpatient ward. Conversely, when they did not, my experience was disappointment,

almost echoing the storylines within my analysis; it was as if my experience remained unheard. Interestingly, on reviewing the transcripts, when people outwardly expressed their distress I found this harder to respond to. This tension is perhaps what prevents people being more open about their emotions. At one point Grace did describe moments in her job when she felt distress, and, despite my desire for this, I shut it down and I tried to reframe things in a more positive way. When she discussed patients 'rejecting' her I explicitly said 'it could be a positive thing'. This led to a different construction than if I had responded by listening more attentively. The following extract illustrates this tension:

G: 'and it's something very controlling about them sort of rejecting me (I: yeah) and saying, no I do not want meet with you, I do not want to come to your group (I: yeah)

I: I guess it could be a positive thing in a way

G: Erm, well, yeah

I: Giving them some something to have control over

G: Yes, I mean I think I think that they do some of them probably do see it that way, that actually something quite good about saying no (I: yeah) to me and no to coming to the group (I: yeah) but that has been a real challenge, because this week we didn't have anybody come to the group.

Grace, p9

Again when she repeats things in the way I have construed them I encourage her by saying 'yeah' after each point, therefore, giving power to these statements. Through the analysis I found other examples where I closed dialogue down around distress; perhaps, it was not spoken because I closed it down. I wonder if the same processes are involved more widely and my micro experience portrays a more macro one on a societal level, and in particular, within systems that manage and deal with acute distress.

The above quote gives a clear example of how my responses to some of the participant's narratives were potentially leading and this is not recommended for qualitative interviewing. The purpose of the narrative interview is to provide an opportunity for the participant to give a detailed narrative account of their experience with the interviewer maintaining a neutral stance (Murray, 2008). Although I started

each interview with this intention, through analysis it can be seen that at times I found this a challenge. I was keen for participants to recognise that I was interested in their accounts and attempted to show this by making encouraging nods and remarks however sometimes I went beyond this and used more overt commentary which possibly disturbed the narratives of the participants. The interview schedule (see Appendix 5) contained two orientating questions and other possible prompts that might be used. These should have only been used at the end of the participant's narrative which as they were designed only to obtain clarification. Mishler (1986) stated:

'The interview's presence and form of involvement – how she or he listens, attends, encourages, interrupts, digresses, initiates topics, and terminates responses – is integral to a respondent's account. It is in this specific sense that a 'story is a joint production.'

(Misher, 1986, p82)

I have attempted to reflect on my responses to the participants in detail in order to consider the possible influence these may have had on the individual narratives. This has formed an important part of the research however it is clear that my interviewing style was naïve at times and goes beyond the recommended conventions for interviewing and has potentially provided leading results.

The next section considers stories of release where people have been able to express their emotions. This can have different consequences depending on whether they are heard or unheard.

3.3.2 Stories of Release

3.3.2.1 The Heard

'the smiles I've seen from staff, who tentatively say something and are really anxious about whether they're saying the right thing, and you give them positive feedback'

Oscar, p.19

Connecting with humanity

The dominant narrative entitled 'connecting with humanity' seems to represent positive experiences that participants had when working on inpatient units. These include making connections with people with severe mental health difficulties,

'you see a sort of acuity and an intensity of experience with your patients that you don't really get in other contexts .. just because the level of distress tends to be so much higher, you can meet people at a point where often their ability to make a connection with you is much stronger, actually, than it might be in another context.'

Imogen, p1

Understanding mental illness

Through the interviews participants seem to describe a deep concern and compassion for people with acute mental health issues and a passion for fellow human beings. They describe being drawn to working with people with more acute problems because the connections made can be stronger. It is almost reflective of the intensity of distress that may also emphasise a sense of vulnerability which becomes evident during acute crises. Freya mirrors this, saying:

'When people feel at their most desperate, their most vulnerable, they share things with you that they've never shared with anybody else and that's one of the other things that I really like.'

Freya, pg22

There is a sense that Freya feels something rare and intimate happening between herself and people she supports and this connection is something she values in her job. Freya describes attempts to genuinely connect with all people no matter what their role. Other participants describe genuine connections at work with the patients only, rather than the staff. In these narratives the staff featured more as a client group that require strategic connections to be made in order to work in the best interest of the patients. Noah, when discussing his values, states:

'Solidarity with the rest of humanity, particularly suffering humanity, is important to me, coherence, sanity, clarity and truth, those are important to me'.

Noah, pg19

Noah does not see himself as separate from people with mental health problems, it seems important that he aligns himself 'particularly' with them. Hacking (2006, pxi) discussed the 'purity of the possessed' describing people with acute mental health problems as 'those who not only speak the truth in paradox, like the fools in Shakespeare, but who are also themselves the truth'. He comments on Foucault's (Foucault, 1961, pxxxiii) phrase 'inaccessible primitive purity' and I wonder if it is partly from this perspective that Noah finds cohesion to his values. Afuape (2011) sees mental health connecting in a deeper sense with something meaningful. There is an emotional honesty that may be present at times of acute distress and with this a connection with human vulnerability.

Needing validation

Freya, in contrast to Noah, stories her connections with patients as well as staff. She describes how it has taken her over a year to make positive connections with staff and now, finally, she feels she is a trusted part of the team. She describes a strong need to feel valued and to be useful which perhaps helps her to empathise with the staff and the patients. Freya describes working with a selectively mute lady who was a patient on the ward where she worked,

I sat with her for fifteen minutes twice a week and actually at the end when she started speaking she [said] just how much she appreciated that time, that space, .. after she was discharged she sent me a copy of her poems that she'd written ... and she said it's a bit like the Pink Floyd song 'knock knock is there anyone there' .. I wondered if that was what she was waiting for people to see if there was anybody there.. and actually although she didn't say an awful lot, it meant an awful lot to her.

Freya, pg21

Freya comments that as this lady was not speaking she would have been unlikely to have accessed Psychology in a community setting. However, this extract demonstrates how important it was for her to have someone there to give validation to her and to her experience. Freya explained how she spent only a short amount of time with this person but her ability to demonstrate that she was with her 'meant an awful lot to her'. In overstretched settings, facing cuts and targets, what gets lost is time and space as discussed in section 3.2.1.

Freya does not see people who are admitted to the ward as different from anyone else and can empathise with peoples experiences, recognising that anyone could be admitted, including herself, if they suffered the same traumas. She values being with people at this time in their lives stating,

'The idea that there's a continuum and we're all somewhere on that continuum we just slide up and down it, depending on what's going on, none of us are immune to this, at any point , given any type of trauma that happens in our life we could, any of us could be on the ward'

Freya, pg14

'if something happened to my family, to my husband, to my child I could easily end up on a ward'

Freya, pg14

Perhaps, for most staff on an inpatient ward, this might be too terrifying to admit which is why things on a ward are '*organised to keep things the way they are*' (Imogen, p3), with a clear 'us and them' culture. In this way people do not have to acknowledge this potential and, therefore, do not have to connect with their own vulnerability.

Oscars describes how he views other people on an equal level and how he views his role as a CP;

'I don't think you need a degree, I don't think you need clinical training to be able to have a good idea about what might help someone. I think our role is to give people frameworks to have ideas'

Oscar, pg7

Oscar's view emulates that of Safran & Muran (2000) who recognise "the quality of the therapeutic alliance is the most robust predictor of outcome" (Safran & Muran, 2000, p.1). Oscar also describes his interest in learning about different ways of working by learning from the staff and not holding a position that one way of working is superior to another. He seems to be valued by the staff perhaps by providing validation for their thoughts and ideas.

'you might get a member of staff coming forward and saying, ...someone was talking about witchcraft or something and then someone will come forward and tentatively say, back where I'm from, the village I'm from this is the sort of thing that we would talk about or someone will come in whose Muslim and saying well the jin that we believe in, possession and .. , and you say excellent, so what would you do in your village, what would that.. help there, could we be bringing some of that into here'

Oscar, p29

This approach is at odds with the medical model and Oscar states that he has to have these conversations on a one-to-one basis with staff as publically it is too much of a 'threatening space' (Oscar, p20). This demonstrates the power and rigidity of the culture on inpatient units which is likely to make it difficult for people to be flexible in their thinking around individual formulations.

The conflicting working practices of other staff on inpatient units perhaps contributes to the value that participants put on peer support.

'you need a kind of collegial feeling in the department otherwise you are sunk, but you also need to be sussed, you need to be canny'

Noah, pg20

Without it, as Noah puts it, 'you are sunk'. This language demonstrates the continuing battle to survive against a hostile culture. The participants also discussed the importance of supervision to have your experiences validated. For example, Ava describes how

'Supervision is incredibly important and I've been very lucky to have a very experienced supervisor whose worked in inpatient services for a long time and, in many ways, I guess it's almost like when you work with a client I think just having, urm, your experiences validated'

Ava, p6

Ava again, as in section 3.3.1.2., likens her experience to 'a client', accentuating the need for all human beings to have their experiences validated. Validation of staff experiences is likely to increase their ability to validate experiences of patients. Brett et al (2014) carried out a study looking at predictors of distress associated with psychotic-like anomalous experiences and found that while psychotic-like experiences in themselves are not necessarily distressing (as discussed in section 1.2.2.), appraisals and responses to anomalies as well as social context do predict distress. They conclude that the implication for treatment is to provide normalizing and validating contexts in which the experiences can be accepted, understood and shared. Cuts and targets are likely to devalue spaces like supervision and reflective groups which may make working in inpatient units in a compassionate way, difficult.

Co-construction

The dominant narrative 'connecting with humanity' helped me to connect with the purpose of my research. This narrative seemed to point, not only to an alternative way of working on inpatient units, but a way to develop personal resilience. As mentioned in the 'method' section after I had my first child my perspective on life changed and when I heard stories that fitted with my experience I gave them power by agreeing and responding positively to them. This can be seen in the examples below when Ava and Imogen discuss how it has helped them cope with inpatient work.

'having a child can do to you know (I: yeah) this sort of just putting things into perspective a bit more I think that really helped'

Ava, p9

'I'll draw a line under things much more (l: mhm) which is a hundred percent to do with the birth of my child (l:mm)'

Imogen, p17

CPs go through many years of training developing their ability to connect with humanity and to use this in their work with people in distress. Unfortunately this seems to be rare on inpatient wards and in society in general (see section 3.2.4.).

3.3.2.2 The Unheard

'No need to hear your voice when I can talk about you better than you can speak about yourself....I want to know your story. And then I will tell it back to you....in such a way that....I am still author, authority. I am still the colonizer, the speak subject, and you are now at the centre of my talk'.

hooks, 1990, pp151-2

Someone is screaming

This section relates to people expressing their distress but not being heard. This seems to be one of the consequences of using the medical model to manage severe mental health difficulties. People in distress are 'treated' for their mental illness by 'experts' in preference to being encouraged to express their distress and time being given to process it and understand what lies behind it.

Treatment of patients

This narrative incorporates participant's experiences of how people can be treated when they suffer an acute episode of mental distress. The stories seemed to follow a familiar pattern. A person is admitted to an inpatient unit because they have

expressed their distress in some way. Rather than finding a safe space they have sometimes experienced callous and invalidating treatment which has little resemblance to the policies calling for compassionate care (see section 1.5.3.). Participant X describes the following scenario;

'a psychiatrist said recently about a patient, 'oh poor X I feel so sorry for her', I was quite impressed, thinking cor empathy, that's good, he said 'yeah she certainly hasn't been endowed with the gift of beauty has she'. I was like ooom, she's got X amount of problems and you feel sorry for her cause she's not very pretty ..wow'

Participant X

Many of the stories express the absurdity, the sheer contrast between what raises concern and what does not, Participant X's quote above highlights an example of experiences within the system which demonstrate the way some staff think (or do not think) about other people's distress. This seems particularly pertinent in the case of Personality Disorders - an issue where there may be high levels of emotional inconsistency and unpredictability. The culture of an inpatient unit seems to dismiss people with this diagnosis as people who are not mentally ill.

Participant X describes this tendency and goes on to illustrate it with an encounter a patient has with a psychiatrist;

'How do you confront that? If a Psychiatrist says I think this person, who's just swallowed some batteries and has cut their little toe off is healthy. Hasn't got..they're not ill (pause) and sometimes that comes back to bite them. I didn't see this personally, but I know that a Psychiatrist said to a person 'you're playing a game with us aren't you?,' in a ward round, and she bit a chunk of flesh out of her arm and spat it into his lap so, but I don't think he said that to anybody again (I: no)

Participant X

The participant's descriptions of interventions made by Psychiatrists can tempt the listener or the reader to vilify the individual Psychiatrist being discussed. However, as mentioned in section 1.7, it could be argued that the system that the Psychiatrist is working within creates the individuals seemingly reprehensible actions. In line with social constructionist theory, it could be argued that the Psychiatrist role has been constructed by Western culture where the medical model is dominant and roles are carried out from within this frame. In his book *Asylums* (1961), see section 1.5.1, Goffman asserts that one way in which individuals deal with each other in Western society is as server and served. He explores the assumptions between these relationships and attempts to explain some of the problems associated with acute mental health units from this framework. Both the staff and the patients fulfil certain roles on the unit and through these terms of reference they interpret what is happening around them as well as how they see themselves. Individuals rely on these stereotypes to understand and respond to events.

Within Goffman's 'total institutions' there exists a basic split between a large managed group (the inmates) and a small supervisory staff. The two groups perceive each other according to certain 'narrow hostile stereotypes' (pg. 18) and any social mobility between the two groups is restricted with social distance 'typically great and formally prescribed' (pg.19). Through these organizational dynamics professional roles and choices are shaped. If individuals within the two groups begin to cross boundaries then this can cause an imbalance within the system which can lead to instability and perceived greater risk. With Psychiatrist's as the holders of clinical responsibility this perhaps goes some way to explaining why they may keep a tight hold of the beliefs constructed within the medical model.

This study did not directly access the words of the people admitted to inpatient wards but they can be heard through the CPs caring for them. In turning to the experience of a former user of services, Jaqui Dillon (2011) describes her experience on an inpatient unit. She explains that on admission she knew that the cause of her distress was the result of the horrific abuse she had experienced as a child. When she tried to talk about it she was either not believed or was told it was best not to speak out. The effects of not being heard and being in such an 'unsafe environment' were, she said, 'potentially lethal', adding;

'Ironically, the place that was meant to provide sanctuary for me became the place that nearly drove me over the edge.'

Jaqui Dillon (2011)

The contrast between what was meant to be provided and what really happened is extreme. Perhaps this could be likened to the contrast in the values of efficiency, cuts, organisation and procedures with the values of compassion, humanity and reflection. The experiences of Jaqui Dillon resonate with some of the narratives in these interviews. Ava describes a patient who was responding well to therapy, however, it was not recognised as a useful part of treatment.

'so somehow showing up at 9 O'Clock for a pill is seen more as a treatment than sitting down with someone for an hour, even if it's just once a week, and working on helping them leave hospital'

Ava, pg4

Here the sense is that adherence to medical model treatments is more valued. The difference in time required for each intervention also seems to evoke a sense of value. Adherence to medication requires minimal time (it is cheaper) whereas adherence to an hour's therapy session is more time consuming and expensive. Interviewees discussed therapeutic groups that they run and describe them as a useful space for patients to talk. However, it was also recognised that these groups are not generally recognised as a part of a patient's treatment. Noah illustrates this in the following;

I've been in a group on a ward, where there's a dark window in it and a nurse taps on the window and points at a patient...we need so-and-so to see the doctor and I said well you know you're not having him, and they said but it's, it's part of his treatment, (pause), so anything else is not treatment'

Noah, p9

This interaction also seems to illustrate the 'them and us' culture (see section 3.3.2.1.) that is adopted on an inpatient ward, where the person being talked about does not seem to have a say. Afuape (2011, p43) states that the distinction or split between sane and mad people is 'unhelpful, simplistic and dehumanising'. Yet in adult acute inpatient units this division is difficult to ignore. It appears that on inpatient units there is minimal space to consider the causes of people's distress. Further, the way patients express themselves tends to be seen as illness related and, thus, is not listened to. However, there are many different ways of expressing our experiences. Amelia describes why she likes working with people who experience psychosis:

people with psychosis are thinkers, they're trying to make sense of things and they might be in, they don't realise it, but they might be making sense of it in very creative, imaginative ways...they might interpret those creative and imaginative ways very literally but I like the way they think how they try and make sense of things'

Amelia, p5

Here Amelia is able to step back from preconceived ideas about what might be happening and *listen* to how the individual might be making sense of the experience. Experiences of 'psychoses', and the subsequent responses of others to such experiences, can undoubtedly be traumatic; thus, trauma is an experience that may permeate patients lives, from earlier traumatic experiences (Read et al, 2012), to psychotic experiences, to the experiences of other's responses to expressions of distress. However, mirroring Amelia, Afuape (2011), sees these experiences as leading to a search for meaning that is potentially transformative. This search for meaning can be viewed as a form of resistance against experiences of abuse, oppression and prejudice, as well as against living in a society that stigmatises mental illness (see section 1.6.1.). The aim is to bring about better circumstances via 'creative' and 'imaginative' ways transcending traditional boundaries - perhaps this might be difficult to accept in the culture of an inpatient ward.

Thinking and feeling

'the staff team is organised in a particular fashion against thinking and feeling'

Imogen, p3

Imogen describes how staff can appear to behave punitively because they (the staff) have stopped thinking and feeling. This is perhaps the opposite to the experience of people who are admitted to the ward where thinking and feeling are extreme in frequency and intensity. This is dealt with on the ward using medication to numb thoughts and feelings as described in section 1.7. The participants are not blaming of the staff for this and can empathise with their behaviour, recognising that if they were working full time on the ward, without proper supervision, they would be likely to work in the same way.

'I don't know if I was a nurse going in and working on an inpatient ward that I wouldn't use the same defences'

Amelia, p8

Amelia's use of the word 'defences' suggests, although the behaviour is understandable, it is perhaps not acceptable. Defences are required in order to ultimately protect themselves from harm. Ava also shows empathy for staff explaining that if they were continuously psychologically minded, showing empathy and compassion, it would

'destroy them, ultimately it would just eat away and drain them'.

Ava, p2

This seems to highlight the damaging nature of the whole experience. When thoughts and feelings about distressing experiences are vehemently suppressed they become more frequent and intense (see section 3.2.4). Ultimately people have to scream, but it is still not heard. Ava describes the staff as shutting themselves down too far when they no longer see or listen to the people they are supposed to be supporting leading to the perception that people's behaviour is annoying. Dealing with moment to moment issues on a nursing shift can lead to fire-fighting. There is

no time, space or scope to consider and keep in mind context. Participant X discusses the lack of supervision that nurses experience.

'the reason the staff are behaving like that is because they get clinical supervision once every six months with somebody who doesn't, you know, I've got more psychological capacity in my thumb than some of the people who supervise these nurses'

Participant X

The strength of language Participant X uses in this extract indicates strong feelings of frustration which are likely to be derived from experiences with the people he/she is criticising.

The participants describe how they work with nurses to try to increase their thinking and feeling. Amelia describes the CP role as acting as the nurses' superego. She describes how the other members of staff on an inpatient unit have ideas about what a CP might be thinking and, therefore, just the presence of a CP in a care review can change the way people behave.

'you don't even have to say anything in a way you could just put, it's a bit like kind of putting a inflatable policeman in a police car and sitting it at a junction, ...it will change people's behaviour even if there's no one there'

Amelia, p3

Participant X describes the way he/she might encourage staff to begin to think and feel in a different way about a patient.

'oh she's just oh she's playing games, da da da da, I'll just say something like, yeah my god it must be awful to be her, imagine that the only way you can get someone to talk to you was by lacerating your own thigh, holy shit, that must be fucking terrible'

Participant X

The strong language and the sarcasm in this statement, again, possibly display underlying frustration and anger at the lack of recognition towards underlying issues and the context which has led to an inpatient admission. A homeostatic metaphor used in traditional family therapy proposes that families (or wards perhaps) are systems that view change as a threat and respond with attempts to maintain stability even if this sustains the problem. Nichols (1994, p466) points out that ‘tactics to outwit resistance are the very essence of strategic (family) therapy’ and so sophisticated strategies are developed to out-manoeuvre people’s opposition. As Imogen suggests;

‘If anything will ever change in these environments it’s got to be because you’re punching at lots of different levels culturally, strategically, group wise and individually’

Imogen, p7

As discussed in 1.2.2 research has shown that people who receive psychiatric interventions for ‘psychosis’ are more likely to have a history of trauma than those who do not seek professional help. Many have reported high rates of childhood sexual abuse and other negative life events such as poverty, racism, sexism and homophobia (Kingdon and Turkington, 1999, Romme and Escher, 1989, Romme et al 1992). People who are on inpatient units are, therefore, people who have experienced trauma and are reacting to it in a way that any human being might react, as suggested by Freya in section 3.3.2.1. Their reactions are normal (Bentall,2009), what links all human experience is a search for meaning, and yet people viewed as ‘ill’ or ‘irrational’ are often not listened to, have choice and decisions taken from them and are not viewed as having anything to offer to the dominant view of humanity or reality. ‘Listening to clients who have experienced ‘psychosis’ we come to better understand that these experiences, although often distressing, are meaningful, decipherable and linked inextricably to a person’s lived experience’ (Afuape, 2011 p47).

Co-construction

The reason I first considered this project was because I believed inpatient users were not always being listened to or responded to in a helpful way. I believed their

distress was minimised and viewed as problems from within the person rather than considering what may have caused the distress. It alarmed me, therefore, when carrying out the analysis how frequently in the interviews I closed down people's expressions of distress, as discussed in section 3.3.1.2, and how I did not always listen to the distress of the people admitted to an inpatient unit which 'screamed' through the narratives of the participants. When interviewing Freya I enjoyed her story of how she persevered to gain the trust of staff and how she managed to become a valued member of the team. However, when another more difficult story was mentioned it seems I tried to move Freya back to my own *preferred story*.

F: 'it's really hard when people are put on section and you know, their freedom is taken away from them and you see very unwell people that are, you know, it can be very upsetting when they're pleading to have leave or they end up going to more secure settings, to a PICU or something'

I: 'Have you found that you've got more used to that or hardened to that or (pause) does it remain quite a difficult?'

Freya, p12

There are innumerable responses to Freya's narrative and I believe the choice in my response was about moving her away from the distress of what she was discussing; perhaps a more 'thinking and feeling' response would have been to acknowledge or validate what she had said. In the response there is a pause before 'does it remain quite difficult?' which suggests that this part of the question was harder to ask possibly due to my own fear of the answer being 'yes' as this would be more difficult to hear or respond to. I have separated two dominant narratives into the heard and the unheard which can be viewed on a macro level. Here, in this interview, I can see how this also happens at a micro level. Despite my training in learning how to tolerate people's distress I found examples throughout the interviews where I avoided it. Tolerating other people's distress is difficult for most people to do – it is an automatic and habitual unspoken response; therefore, it is perhaps not surprising that staff in an inpatient environment who are constantly faced with extreme overt distress find it difficult to listen to.

I will now go on to summarise the result of this research

4. Conclusion

This project was guided by the research question ‘how do Clinical Psychologists narrate their experience of working within adult inpatient mental health settings over time?’ To answer this question it was necessary to look at the wider society, including its history and culture, and consider what might be influencing individual narratives. The Clinical Psychologists who took part in this research all work for the National Health Service, therefore, this was given particular consideration. The NHS was born out of World War II and signified the beginning of the Welfare State with free healthcare for all at the point of delivery. This was a time of austerity for most but there was also a strong feeling of hope and solidarity (Spirit of '45, Ken Loach, 2013). In Appendix 12, I have included an extract from Harry Lesley Smith’s book *‘Harry's Last Stand: How the World My Generation Built is Falling Down, and What We Can Do to Save It’* (Smith, 2014) which stories what life was like before the NHS introduced free healthcare. This story is shocking particularly to those of us who have not known life without the NHS and it is a frightening thought to think of the country without it and healthcare returning to only those who can afford it.

‘Do you ever stop and ask, ‘Is it all going to happen again?’

Sassoon, 1919, ‘Aftermath’ see Appendix 13

History affects what happens in the present and it is important to pay attention to it. Our society is fast paced and full of distractions with beguiling media and entertainment which can make it easier to stop noticing what is happening around us.

Summary of the findings

From the analysis of the eight interviews of CPs working in inpatient environments four dominant narratives were found. These were; ‘you can’t beat

the system', 'I am screaming', 'connecting with humanity' and 'someone is screaming'. To place these in context, it is important to recognise the current dominant societal narrative around inpatient units. Cuts to NHS services have created a massive strain on the system which is becoming increasingly apparent on mental health inpatient units, where demand is increasing but services diminishing. This is likely to affect all staff who work on inpatient units. Simultaneously, to this situation the government has been calling for more compassionate care following tragic stories of neglect and abuse in the system. However, from the history of inpatient care it can be seen that in times of lessening resources compassionate care decreases. I will now go on to discuss the dominant narratives from the research findings in turn.

Firstly, the dominant narrative 'you can't beat the system' involved Clinical Psychologists entering a system with an opposing value base to their own. In this medically dominated system people with acute mental health difficulties are perceived as having an illness that needs to be cured and 'treated' with medication as opposed to an alternative view put forward by the participants which involves validating and listening to individual's experience of distress. The participants told how they entered the system with hopes of making changes yet gradually, through negative experiences, developed a sense of acceptance that the system cannot be changed. To survive within it necessitates a realistic outlook and an understanding that hopes of change will lead to disappointment. The participants developed an ability to appreciate any small changes within the system that they were able to make.

The second narrative was given the title 'I am screaming.' This was not directly spoken of yet appeared silently through the way the participants told their stories, through their use of language and through their non-verbal communication. This narrative was one of frustration, anger and loneliness which had built up over time. The stories showed that the participants were under growing pressures around keeping their jobs and, as they were usually the only CPs on a ward they were isolated. This research showed how the participants tolerated distress on many levels, much of this being instigated by

the system they worked in which impacted negatively on the care of the people who used the service. From the analysis I could recognise my own difficulty in sitting with distress during the individual interviews, perhaps contributing to participants not verbalising their emotions. Participants talked of becoming 'tough minded'. However, the anger they experienced came through via their expression and perhaps betrayed the vulnerability that lay beneath. Such intense experiences can lead to burn out. Perhaps parallels can be drawn between the isolation and vulnerability of the participants and the isolation of people with severe mental health problems in society.

Thirdly, the narrative 'connecting with humanity', offered stories of hope and achievement where participants had experienced connections with others, most pertinently with people in severe distress. They described the 'emotional honesty' of people in distress alongside the search for meaning through creativity. These perceptions were in stark contrast to those put forward within the medical model. Participants narratives showed how connections with people admitted to the ward became a main source of enjoyment in their roles. They also storied the value and vital importance of peer support and supervision. This provided them with time and space for their experiences to be validated enabling them to go on to work with people who were experiencing severe distress and to work in a system that they did not have faith in. Participants showed that through connecting with humanity the 'them and us' culture can be dissipated, however, it seemed the systems strived to prevent this from happening.

Finally, the fourth narrative 'someone is screaming' related to the people admitted on to the ward with their screams being heard through the participants' narratives. Conversely, however, the screams were left unheard on the inpatient units. Participants described how staff, in order to survive, had stopped listening, thinking and feeling. Time and space to reflect was not available to staff, therefore, their experiences were left invalidated making it impossible for them to extend compassion to others. The participants described how CPs could make a difference when physically present on the ward, however, once they left the structures they built fell down. The suppression of experiences was

aided by medication and mirrored by the behaviour of staff and, although it was understandable, it was not helpful. Rather it resulted in screams of people in distress not being heard and this invalidation and suppression led to further intense thoughts and feelings of distress. Participants recognised the need for the core value of compassion on wards. However, although the need was abundantly clear, and this includes the government policies stating this, compassion was not an easy option (see Appendix 14). It would appear the system's status quo was strong and the call for compassion seems unlikely to be achieved unless it can be facilitated in terms of support and resources. I will now go on to consider the clinical relevance of these findings and their implications.

Clinical Relevance and Implications

This research provides an understanding of how CPs experience inpatient units. Their narratives reveal inpatient wards as invalidating environments where the emphasis is on cutting costs rather than compassion. This has concerning implications on many levels. I shall list these below.

- The CPs themselves are attempting to understand and support individuals who are admitted to inpatient wards. However, they appear to be doing this in isolation. The suppression of their thoughts and ideas is frustrating and invalidating, leaving them in danger of burn out.
- The staff on the ward are organised against thinking and feeling. People are working in volatile environments and it is vital that they get space to express, listen and reflect. This does not seem available to the staff on inpatient units. As well as their own health being put at risk through suppression of their emotions it makes it very difficult for CPs to engage with them and guide them towards helpful ways of working with people in distress.
- The people who are admitted to wards are likely to have had abusive and invalidating earlier experiences. Wards need to be safe places where they can have time to express themselves, process this and experience

validation. The opposite seems to be happening which potentially leaves them feeling invalidated, thus perpetuating their experience of abuse and neglect.

These implications based on the experiences of CPs in this study are not positive. The aim of this study was to provide insight into how the core values for improving inpatient care could be maintained. Staff on inpatient wards will not be able to follow the governments ideals of a 'culture of compassionate care' if they are not provided with the support to do so. If order and efficiency remain the priorities it is unlikely the situation will improve. It would appear there is a clear contradiction in today's government between their favoured narrative around compassion and their actions involving the cutting of services to save money. These cuts put services under immense strain and this pressure and subsequent fire-fighting seemed to render it impossible for important underlying issues to be considered. When work becomes more about survival, time and space can get lost. However, I would suggest this is what is needed for people to be able to support others, make connections and show compassion. Inpatient units currently do not have the underlying ethos to facilitate this and, therefore, it is appropriate to deal with this at this fundamental level.

Critical Review

Through the use of narrative analysis this research has developed a deeper understanding of the experiences of CPs on inpatient wards. To my knowledge, this has not been previously undertaken and, therefore, fills a gap in the literature. The research has developed insight into how cultural and historical narratives around inpatient units and mental health can affect the personal narratives people choose to tell. These narratives provide insight when considering healthcare for people who are vulnerable and in need of care. It is hoped that this study will help to inform commissioners and deliverers of services, that change is necessary and what, and, how this change occurs.

The results that came from this study were derived from eight co-constructed interviews and rely on personal interpretation. The narratives, therefore, cannot be generalised. However, they can be used to inform and develop ideas about what is likely to improve services. Throughout the research, I have attempted to be transparent about the methods I have used. It is likely that the quality of the study would have been improved if I had written a diary in order to monitor my own changing reflections over time. However, reflexivity was considered throughout the study and regular discussions and contact with my supervisors helped to maintain this.

Implications for further research

Further research could be carried out using a similar methodology but on inpatient units where the medical model is not dominant. This could be on specialised units for Personality Disorder or in therapeutic communities. The results could then be compared. The experience of other staff who work on inpatient units could also be explored, for instance nurses, psychiatrists and managers. This will provide further insight into the system that is currently in place and help to develop ways to improve it. It would also give voice to the professions that did not have a voice in this research.

Before embarking on this research I considered interviewing CPs in a different country which use different approaches to supporting people with severe mental health problems. In the interview with Oscar (see Appendix 7) he discussed an open dialogue approach (Seikkula, 2002). This approach emerged in Finland and, there, has improved the care of people in experiencing distressing psychotic symptoms. It involves working with the social network of the person in distress and generating a dialogue to construct words for 'experiences embodied' in the persons psychotic symptoms. This approach seems to fit with the participants' notion of people experiencing psychotic symptoms as finding a creative way to discover new meanings. As a follow up to this study, it would be interesting to explore CPs who work in this way and to consider the implications of this.

Final comment

It seems fitting that I began writing this conclusion on the 70th anniversary of D-Day when people are remembering the people who died on that day. This demonstrates that society does recognise the need to create space to remember, to express and to listen. I listened to a radio programme on the 4th June (Radio 4, 2014) which featured an interview with Jim Radford, the youngest known man to serve on D-Day. He described his experience and through this, disputed the 'glory' that is sometimes represented in narratives about this day in our history. He said he has stopped going to the Cenotaph on Remembrance Sunday because the *'ceremony has been hi-jacked by politicians, by the Royal Family, by the church'*. I am repeating his words because I see this narrative as fitting in with the overall narrative that seems to have weaved its way through this research. It is important for peoples' experiences to be expressed and for there to be space for them to be listened to, otherwise they can become 'hi-jacked' by the dominant and more powerful narratives in society and can leave them feeling unheard and invalidated. This only leads to an ongoing cycle of distress. Winston Churchill said;

'Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen.'

Winston Churchill (1864-1965): the Churchill centre

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Appendix 1

Cultural references to mental health inpatient provision

Painting

William Hogarth (1732-1733) A Rake's Progress

Francisco Goya (1793-1794) Yard with Lunatics (Corral de locos)

Francisco Goya (1824 -1828) Lunatic behind Bars (Loco tras las rejas)

George Wesley Bellows (1907) Dance at the Insane Asylum

Vincent Van Gogh (1888) Garden of the Hospital in Arles

Poetry

John Clare (1841-1856) – I Am

Wilfred Owen (1917) – Mental Cases

Alan Ginsberg (1955) – Howl

Film

Bedlam – 1946

Spellbound – 1946

The Snake Pit - 1948

Lilith – 1964

One Flew Over the Cuckoo's nest – 1975

The Bell Jar – 1979

12 Monkeys – 1995

Regeneration – 1997

Girl Interrupted – 1999

K-Pax – 2001

Literature

Virginia Woolf – Mrs Dalloway – 1925

Samuel Beckett – Murphy – 1938

Mary Jane Ward – The Snake Pit - 1946

Ken Kesey - One Flew Over the Cuckoo's nest – 1962

Sylvia Plath – The Bell Jar – 1963

Hubert Selby Jr. – Requiem for a dream – 1978

Pat Barker – Regeneration – 1991

Paul Coelho – Veronica decides to die – 1998

Gene Brewer – K-Pax – 1995

Will Self – Umbrella – 2012

Appendix 2

Changes in the NHS from 1946 to 2012

- The 1946 Act created a tripartite system for the administration and delivery of health care, including:
 1. Local Authorities: provided public health, community and school medical services.
 2. Local Practitioner Committees (LPCs): funded family doctors, dentists, and pharmacists.
 3. Hospital Management Committees (HMCs) managed hospitals and Regional Health Boards were established, with responsibility for all the HMCs in their area.

- 1974: NHS health authorities (providing health services) and Local Authorities (providing social care, housing, and education services) were organised so they covered identical geographical areas in order to improve joint administrative decision making and implementation. Additionally, LPCs and the HMCs were brought together under one management system with the aim of improving coordination of both health and social care functions thus creating Health Districts.

- Early 1990's: Creation of NHS Trusts: not directly managed by the Department of Health, they had their own Board of Directors, half of whom include the senior professional managers and administrators of the services provided by the NHS Trust, including a Chief Executive, and medical, nursing and finance directors. The other half consisted of nonexecutive directors, including the Chair of the Trust, appointed directly by the Secretary of State for Health. The Chair of the Trust is ultimately the leader of the Board of Directors, to whom the Chief Executive is accountable. Since the Trusts were established, there have been many mergers so that now the typical pattern of NHS Trusts within an area is that there will be one NHS Trust providing all general medical and surgical services and one separate NHS Trust providing all mental health services.

- 1997: incoming Labour government initiated two major changes:
 1. Increasing the autonomy of providers

2. Set increasingly prescriptive performance targets for providers.

There was a fundamental shift of control by specialist health care, represented by hospitals, towards greater control by primary health care, represented by family doctors and staff working closely with them and directly in the community.

- 2002: the creation of Primary Care NHS Trusts (PCTs) which have a major role in commissioning all local non-specialist health services and function as the employer of health care staff working in the community and in primary health care services. With this also came the introduction of 28 Strategic Health Authorities, which replaced the District Health Authorities.

Three consequent three tier system

- 1) The central Department of Health (DoH) determined national priorities and strategies and established overall levels of funding negotiated with the Chancellor of the Exchequer. The DoH set performance targets as a means of monitoring access, quality and expenditure for the delivery of health care services, headed by the Secretary of State for Health.
 - 2) The DoH exercised its administrative authority through 28 Strategic Health Authorities (SHAs) which were essentially outposts of central government. Their function was to monitor Primary Care Trusts and other Trusts to ensure they commission and deliver services in accordance with national priorities established by the DoH of the central government.
 - 3) The providers, PCTs and other Trusts such as Mental Health Trusts managed and provided the whole range of health care services
- 2003: hospitals were transformed into 'foundation trusts' where they were put beyond ministerial control to give market forces more influence over hospital policy and they were able to generate income from private patients and run businesses jointly with commercial companies. Contracting-out clinical care has gradually increased in other parts of the health system.
 - 2008: the Department of Health began to experiment with a policy of full competition on the provider side.

- 20th May 2010: the Conservative – Liberal Democrat coalition agreement declared an intention to "stop the top-down reorganisations of the NHS that have got in the way of patient care"
- Two months later a white paper outlined what the *Daily Telegraph* called the "biggest revolution in the NHS since its foundation", *Equity and Excellence: Liberating the NHS* (Department of Health, 2010)
- 19th January 2011: the bill was introduced into the House of Commons and received its second reading. NHS Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) will be abolished, with projected redundancy costs of £1 billion for around 21,000 staff. £60 to £80 billion worth of commissioning will be transferred from PCTs to several hundred clinical commissioning groups, partly run by GPs. Around 3,600 facilities owned by PCTs and SHAs will transfer to NHS Property Services, a limited company owned by the Department of Health.
- 4 April 2011: the Government announced a "pause" in the progress of the Bill to allow the government to 'listen, reflect and improve' the proposals after an increase in opposition pressure, including members of the Liberal Democrat party and the British Medical Association.
- 20 March 2012. The Bill received Royal Assent and became the Health and Social Care Act 2012 on 27 March 2012. There will be five key national bodies: the Department of Health, the National Institute for Health and Clinical Excellence, the Care Quality Commission, the NHS Commissioning Board, and the economic regulator Monitor.

Appendix 3

What is the history of acute inpatient care?

By the early eighteenth century the country's population was rising and people deemed to be mentally unwell and considered particularly disturbed or violent were placed in 'houses of correction' or workhouses. In the affluent classes, however, people with mental health difficulties could be sent to private 'madhouses', which were small institutions run for profit. Although the causes of mental distress such as abuse and oppression may have been the same as they are today, there was no consideration of this in these contexts. However, similarities could still be drawn to treatment where it was the symptoms that were addressed rather than the causes, just as it is today.

Towards the end of the century, care for the insane became widely recognised as a part of medicine. This is reflected in The Madhouses Act 1774 (see Porter, 1990) which created a Commission of the Royal College of Physicians with powers to grant licences to premises housing "lunatics" in London; Justices of the Peace were given these powers elsewhere in England and Wales. Admission to a "madhouse" required certification signed by a doctor, and lists of detained residents became available for public inspection. At the House of Commons Select Committee in 1815, Thomas Monro, a physician at the Bethlem described the regime imposed on the 'lunatics' in the asylum:

"we apply bleeding, purging and vomit, those are the general medicines we apply... All the patients who require bleeding are generally bled on a particular day, and they are purged on a particular day... Thereafter, of course, patients were kept chained to their beds four days out of every seven."

House of Commons Select Committee, 1815, p93

Attitudes towards mental illness began to change during the Enlightenment (beginning in the late seventeenth century) when they were viewed as a disorder requiring rehabilitation for treatment and cure. The catalyst for this shift in thinking

was possibly a consequence of the remission of King George III's mental disorder. The introduction of moral treatment was initiated by the English Quaker, William Tuke (see Tuke, 1813), who opened the Retreat in York in 1792. Tuke's motivation for this followed the death of a fellow Quaker in a local asylum in 1790. Again, it would not be surprising if this compassion stemmed from such a close experience of the issues associated with extreme distress at that time. Patients at the Retreat were looked after with respect, they were provided with good food, work and companionship and the drastic measures of other asylums which were not effective were abandoned. Residents had daily routines of both work and leisure time and a family-style ethos was created. Tuke's work mirrored that of the French doctor Philippe Pinel (see Hergenhahn and Henley, 2013) who in 1792 became the chief physician at the Bicetre hospital on the outskirts of Paris. Before his arrival, inmates were chained in cramped cell-like rooms where there was poor ventilation. Pinel met, and was influenced by, Jean-Baptiste Pussin who advocated for patients to be freed from their chains and for physical punishment to be banned. Pinel argued that mental illness was the result of excessive exposure to social and psychological stresses, just as research shows us today (WHO, 2001). Pussin and Pinel's approach was seen as remarkably successful and they later brought similar reforms to a mental hospital in Paris for female patients, La Salpêtrière. The pioneering work of Tuke, Pussin and Pinel over two hundred years ago is seen as the founding of moral treatment.

With the arrival of industrialisation (see More, 2000) came the migration of people to cities where they worked long hours in jobs, were far away from home and lived in harsh conditions. It was difficult for families to look after someone with acute mental health problems and it became an expectation that care should be provided publicly. By the mid-nineteenth century people with mental health problems were placed in large institutions paid for by the state and charitable organisations. Asylums were built following the County Asylums Act of 1808 and 1828, The Lunatics Act of 1845 and the Lunacy Act of 1890 gave mental hospitals or "asylums" the authority to detain "lunatics, idiots and persons of unsound mind". Each county provided an asylum for "pauper lunatics", who were removed from workhouses into asylums. The "Lunatic Commission" was established to monitor asylums, their admissions,

treatments and discharges. Asylums had to be built within easy reach of towns where doctors were likely to be living and in healthy and quiet surroundings. Gradually, the contrast between the pleasant surroundings and the environment inside these buildings became wider.

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Appendix 4

PARTICIPANT INFORMATION SHEET

Title of Research

Clinical Psychologists experience of working in an acute mental health inpatient setting.

Introduction

You are being invited to take part in a research study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of this study?

The purpose of this study is to explore in detail Clinical Psychologists' experience of working on an inpatient unit. It is hoped that, through narrative orientated inquiry, in depth insight will be gained that will help to inform future research and service development within inpatient units which will ultimately add to patient and staff experience. The specific aims are as follows:

- To explore how Clinical Psychologists experience working in acute adult inpatient units including their experience of relationships and communication.
- To consider how Clinical Psychologists working in inpatient settings cope with both challenges and opportunities within the system.
- To provide insight into possibilities of how patient experience of inpatient units could be maintained or improved.
- To further consider the mental health system and the position held by Clinical Psychologists.

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason.

What will happen to me if I take part?

If you decide to take part in this study, you will take part in a one hour interview conducted by the researcher. The interview will be audio recorded and stored on a password protected and encrypted USB drive and backed up on a password protected and secure computer. If a transcription service is used to transcribe the interviews, this will involve typing up the interview verbatim. A signed non-disclosure / confidentiality agreement will be obtained from the service prior to giving them the recordings. Any personal information will be changed in order to preserve anonymity.

What are the possible disadvantages, risks or side effects of taking part?

It is unlikely that you will experience any disadvantages from taking part, however, it is possible that personal emotional distress could occur during the interview. The interviewer will check with you whether you are happy to continue the interview at certain points and you can request to terminate the interview at any time. You are free to withdraw any information you give at any stage during the process.

What are the possible benefits of taking part?

You will be able to express your views and share your story of working in an adult mental health inpatient unit as a Clinical Psychologist. The contribution you give will be heard and valued and will hopefully lead to recommendations, service planning and further research on the effective running of inpatient services.

How will my taking part in this study be kept confidential?

An audio recording of the interview will be made. The interview will be audio recorded and stored on a password protected and encrypted USB drive and backed up on a password protected and secure computer. If a transcription service is used to transcribe the interviews, this will involve typing up the interview verbatim. A signed non-disclosure / confidentiality agreement will be obtained from the service prior to giving them the recordings. Only the researcher and her supervisor will have access to the information. Any personal information within the transcription will be changed in order to preserve anonymity and the supervisor will be blind to the identity of participants.

What will happen to the results of the research study?

The results of the research study will be included in a Doctoral thesis which will be examined as part of the researcher's Doctorate in Clinical Psychology. There is a possibility that the research could be published in an academic journal.

Who has reviewed this study?

This research has been reviewed by the ethics committee within the University of Hertfordshire.

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email: marycharitycook@hotmail.com

This research is supervised by Dr. Saskia Keville, Acting Academic Tutor, University of Hertfordshire: s.keville@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix 5

Sample Interview Questions

Major Orientating Questions

1. Since you started your job what has it been like working on an inpatient unit?
2. Compared to others around you, has your story been similar or different?

Question prompts

1. What drew you to inpatient work?
2. What has been challenging for you along the way?
3. Where do you draw your strength from?
4. How do your values influence your work/ have they changed?
5. How has working on an inpatient unit changed the way you think or feel about yourself?
6. Has your role changed since you started your job?
7. How is language used on the ward and what kind of impact does this have on the unit?
8. What is your sense of the impact that psychology is having on the inpatient unit?
9. What are your hopes for the future?
10. Anything you would like to add that we have not covered?

Appendix 6

CONSENT FORM

Project Title: Clinical Psychologists experience of working in an acute mental health inpatient setting.

Researcher: Mary Bentley

Statement by Participant (please initial all boxes)

Participation in the study;

- I confirm that I have read and understand the information sheet for this study.
- I understand what my involvement will entail and any questions have been answered to my satisfaction.
- I understand that the research interview will be audio recorded.
- I understand that transcriptions will be made of the audio recordings either by the researcher or a transcription service who will be required to sign a confidentiality agreement.
- I understand that any personal details will be changed on the transcripts to prevent identification.
- I understand that my participation is entirely voluntary and that I can withdraw at any time without having to give a reason.
- I understand that if I were to disclose any information that would suggest there was risk of harm to myself or other people, the researcher would pass this information to her supervisor and other services as appropriate.
- Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.
- I agree to take part in the study

Participant's Name: _____

Participant's Signature: _____ **Date:** _____

Storage and publication of the study;

- I understand that all information obtained may be shared with the researcher's clinical and research supervisors.
- I understand that it will be part of the research to include certain excerpts from the interviews in the final write-up .
- I agree that research data gathered for the study may be published.

Participant's Name: _____

Participant's Signature: _____ **Date:** _____

Statement by Investigator

- I agree that the project and the implications of participation, have been appropriately explained to this participant.
- I believe that the consent to participate is informed and that the participant understands the implications of participation.

Investigator's Name: _____

Investigator's Signature: _____ **Date:** _____

Appendix 7

Transcription Agreement
Doctorate in Clinical Psychology
University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Mary Bentley

and

John Bentley (Speech and Language Therapist)

The recipient agrees not to disclose any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

Signed:



Name:

J. BENTLEY

Date

21.11.2013

Appendix 8

Transcript of interview with Oscar

I: OK, so I've started the recording (P: mhm) erm so the first question's quite broad erm and I just wanted to know erm since you started your job what's it been like working on an inpatient unit?

P: Er well I started working I've worked on inpatient units for a long time, I did a lot of my training on inpatient units so I'm sort of, I feel like I've been working there for quite a lot of years, but I've only been working in this job, erm, I work partly in a rehab ward, three days a week (I: mhm) and then two days a week on an acute ward (I: mhm) so a sort of split post erm, and I've been doing the rehab part for about erm two years and then the acute one for about three three and a half years

I: and the difference between the rehab and the acute?

P: Big difference. So, er I mean the in the practicalities the acute ward is much quicker much faster sort of erm, my work is very much assessment based (I: mhm) I do sort of very brief interventions of people but it's mainly assessment and signposting onto community services (I: mhm) chari erm, either, non-statutory or or the community psychology teams and things like that, erm, the rehab ward er is much more long term work and, both involve team working in the teams but I think the rehab ward, because the importance of, I think the the role of the team is perhaps more linked to therapy in the longer term ward (I: OK) than it is on a short term ward where it's it's kind of referring people on getting the sys support in place and so it's less about active therapy in the ward itself whereas on the rehab ward therapy is sort of it's it's a therapeutic space the whole ward erm so in that sense there's a difference in terms of the team (I: mm) and erm my role I find is far more with the team on the rehab ward than it is perhaps on the acute ward. Different anyway (I: mhm) so,

I: So your experience must be quite different then (P: mm) on the on the two wards

P: Ya, erm

I: I wonder, it might be helpful to kind of split them (P: mm) and say what it's like on the acute ward first, maybe (P: ya) how your experience has been

I: So, so my experience on the acute ward has been erm (p) it took me a fair time on, in both actually, to get used to the, you do training and you do longer term pieces of work with people and you do formulations (I: mm) da da da da, and you learn how to do all that, erm I'd I'd been I'd worked on a PQ the year before on my last year of training I was on a PQ, here, so (I: mhm) I was already knew some of the staff, I already had a way of working I was comfortable with on an inpatient unit, but it took me some time to get used to applying that in the the PQ was more like a longer term ward (I: mm) in many ways and so er that was quite quite eye opening, you know you just didn't have the time that you had elsewhere (I: mm) sort of much quicker erm (p) I found I mean I suppose so other i e starting any new job is gonna be difficult (I: mm) to get used to but erm it's really I think I find it really rewarding across both the wards, both of them in different ways. I think the acute ward I find it you know you're you're sort of team people, you do see people recover quite quickly (I: mm) erm, in most cases, and it, you know, you can play a part in then engaging in even if it's just talking (I: mm) erm, we, I run a regular talking group on the ward and sometimes people won't engage in anything,

I: On the acute ward?

P: ya (I: ya) but they'll come to the talking group (I: yeah) which is which has no it has no erm (p) the idea of the talking group is quite brief, it's quite a basic aim which is to get people talking and that's it (I: mm) there's no preconceived ideas about what we're gonna discuss (I: mm) it's all down to people in the group (I: mm) so it's sort of a bit of a sort of s a bit erm, Yalom sort of inspired (I: yeah) but erm it it's very interesting once you people come to the group you know they might start engaging there (I: mm) which they haven't done before and you can play a bit of a part in that (I: mm) so I find that very rewarding on in the acute ward erm on the rehab ward it's just everything's a lot slower (I: mm) than your it's it's erm ya, a lot slower and it er I think it requires more patience

and sort of erm one of the big differences of starting on that ward was just the sort of need to hold up a bit and and hold in mind that this is going to take time and it has to be OK that it takes time and this most most of the staff you have to ride a balance between between erm saying that change can occur (I: yeah) and believing that change can occur (I: yeah) but then also holding the anxiety where that change doesn't happen (I: yeah) just like that (I: yeah) because that's how people expect it to happen (I: yeah) and it's you know you have to it it it sometimes feels that you just have to remind yourself and the staff and the service users that when somebody has been through as much trauma or loss or whatever it is you know (I: mm) which which you know every person admitted to that ward has been through enough you know that it's gonna take a long time (I: mm) to see really significant change (I: mm) so erm they bring different challenges and different erm rewards really (I: mhm) but erm (p) yeah

I: Do you see part of your role, then, talking about the rehab ward as erm keeping the staff motivated and

P: erm I think (pp) I think if I said motivated that would kind of suggest that they weren't motivated and I have to hold the motivation and I don't think I have to hold the motivation it's more about holding the interest (I: mm) and the curiosity (I: mm) that actually that that's er people are motivated and very lucky people are motivated some teams they're not (I: mm) but it the team is motivated but sometimes the motivation can be directed in sort of ways which you know the motivation is we need the ward to be quite for example. So if someone's shouting 'you need to be quite' (I: mm) rather than 'what are you shouting about' you know (I: mm) 'can we deal with it in another way that maybe has more work involved but may lead to more (I: yeah) success therapeutic outcomes (I: yeah) so it's not about motivation but it's more about being curious about, well why is that person shouting and (I: yeah) sort of feeding into that erm I mean one of the things that I've (p) I think it's very easy for Psychologists to come onto a, well I don't know if it is, but I could see it being easy, to come onto a ward and maybe assume that you are bringing something that was sort of

special (I: mm) unique, you know, nobody else has thought about this before. Actually I've found that a lot of the nursing staff in particular have very complex formulations about the way that people are acting and behaving. They just don't have a space to think and explore them (I: mm) and to actually you know put them put one and one together (I: yeah) you know and that is a big part of my role. Just saying 'wait (laughs) we don't need to go any further let's just think about what you've just said' (I: mm) 'what does that say about that person' (I: mm) 'what what might you expect from someone who'd experienced that' or 'who was saying that' 'what might' you know sometimes it's sort of going back to sort of the Padesky stuff (I: mm) and just doing a very very little formulation of (I: mm) what someone's feeling, expressing, and what they're doing and how they're thinking (I: mhm) and it can be as simple as that but it gives the it gives the staff licence and kind of permission to think and (I: mm) that's I think that's the ff one of the most dangerous things about the ward that if people stop thinking then then they could be as motivated as they like but the work isn't really, the therapy isn't really happening (I: mm) so yeah, so I think in terms of roles that was a key one (I: mm) for inpatient work (I: mm)

I: Erm, can you talk a little bit more about the challenges that you face

P: Challenges, (p) one so (p) more challenges I think have come from me and my expectation of what I should be doing, if you like (I: mhm) it's taken me a long time to come to the conclusion that that's what I should be doing (I: mhm) erm and I still find myself a little bit sometimes (p) that actually takes a lot of work and in er one of the challenges is that outside of inpatient units psychology is seen as a contact based errrm service if you like (I: yeah) it's measured by its contacts (I: yeah) now a direct clinical contact (I: yeah) in inpatient units you could spend an afternoon with a nursing team formulating someone, that could have far more benefits (I: mm) for the ward environment, for the individual and for the staff (I: mhm) than spending an hour with that individual (I: yeah) but you wouldn't (I: yeah) count in the sense of (I: yeah) perhaps how contacts were measured outside so

that's that filters through and I think you get or I certainly have had a bit of an internal pressure, you should be seeing people to keep those (I: oh really?) contacts up (I: right) and and

I: So that's still something that is expected

P: Here, it's not so bad actually, here, it's never been, we've never been pushed to see people but almost the, well we're currently in the process of having more erm (p) more tighter kind of mm targets and data sort of, what do you call it, activity kind of erm (I: mm) monitoring (I: mm) which might make it more more contact based in the future so I spose I I haven't it's more, I'm more aware of that now but I think when I first started working on inpatient wards that was what I was used to (I: yeah) t t contact based, so I was sort of feeling like, ah I had to I had to see at least this many people for one to one (I: yeah) that will last an hour and actually in inpatient units you know it doesn't work like that (I: yeah) I don't think it works like that. If I only saw the people that would sit with me for an hour and those people that came in you know, and then wanted to go out, and then wanted to come in again, that, you know you have to be so much more flexible (I: yeah) with what you call a contact for, firstly and then what you think of as therapeutic work (I: yeah) cause therapeutic work doesn't necessarily need to involve the individual, it doesn't need to be an hours session, it might not even be you know I've done therapeutic cake baking and stuff like that, (I: mm) you know you have to think erm, I think you have to be a bit creative (I: mm) a bit creative to be able to do that kind of work

I: and are you given the time to, you said spending an afternoon with staff formulating around a patient, (P: mm) do you get that time to do that kind of work?

P: errr, not nn not as much as I would like (I: mm) (p) erm we have kind of specific there are specific kind of issues erm certainly in the rehab ward, erm, we have a Consultant who likes to lead, erm, and struggles a little bit to share that power of leading

I: Is there just one Consultant on the ward?

P: So we've got two on both (I: right) no, three on one and two on, so there's two on the rehab ward and three upstairs on the acute ward erm,

I: Sorry I interrupted

P: No, no, no not at all, erm so one of the, the main Consultant on the rehab ward tends to not want to share that power as much so doing staff (p) you need to have, I've I've found that you need to kind of have the people in authority on board with your (I: yeah) staff work in order for it to go (I: mhm) kind of smoothly and for people to listen to you if if the people in power are not listening to you, you are banging your head against a brick wall (I: yeah) a little bit and that's happened a few times in the work I've been doing on the rehab ward, it's just felt a bit like, the staff could have been on board and were sort of almost there (I: yeah) they just needed a little you know permission (I: yeah) from their bosses (I: yeah) and it hasn't happened and perhaps sometimes it's felt, well hasn't felt, it has been undermining to have people like the Consultant in these groups (I: yeah) and then then that can be quite damaging actually but (p) I mean this is I think this is one of the things I've really learnt is that actually nursing staff as a whole are very keen to to learn (I: yeah) so I mean, one way around that is just, you just find the times when you know you can just get a certain group you know, the nursing staff together (I: yeah) and you know treat it as a sort of nursing support (I: yeah) type approach rather than something that would necessarily need to involve other (I: yeah) erm senior members of the team if you think that's going to be a problem, erm, I mean there's always politics in these sorts of places (I: yeah) and I mean there's always politics everywhere, but I do wonder if that's another difference, it was certainly something that I was aware of when coming into inpatient units but while I've been here I've just it's astounding the the amount of, now I think it's power, I think it's it's all about power (I: mm) and how how you, so who says what's wrong with person 'A', who says what we do about that (I: mm) and personally I believe that you don't, erm probably a bit controversial, I don't know, but I don't think you need a degree, I don't think you need clinical training to be able to have a good idea about what (I: mm) might help someone (I: mm) I

think our role is to give people frameworks to have ideas (I: yeah) but then their ideas are much better than ours (I: yeah) and that's really difficult if you rely, if you hold your power as as the reason why you do your job and a kind of (I: yeah) er er erm, I kind I always think of the CMM, you know the that you look at levels of meaning, and I think if your position and the power in your position is the highest level of meaning that your job has for you (I: yes, yeah) then the threat to that (I: yeah) is gonna be difficult to tolerate

I: Do you think there are people who see you as threat to that?

P: Well I think if they hold their job as important because of the power it gives them and someone comes in who should also do that, but doesn't (I: yeah) and and is happy to give that power (I: yeah) to others, that's threatening (I: yeah) because then what does that say about their way of (I: yeah) holding power (I: yeah) erm, and I'm not saying that I, you know, there are times when you don't share power and you do need to ss you know do need to make things quite clear and (I: yeah) you bring people up on things if that needs to happen but I'm definitely not someone, I don't, I don't walk around with my my Clinical Doctorate badge on or anything like that (P and I: laugh) so

I: Are you involved in erm Ward Reviews (P: yeah) and Ward Rounds and

P: Yeah

I: and is that with the Psychiatrist and the nursing team

P: mm, yeah

I: and do you erm have quite a lot of input in them (P: erm) and does it depend whose

P: It depends a little bit there bec (laughs) because I'm working across two wards the doctors actually, most the doctors really want you to be in there, they they really value Psychology input erm, depending on what doctor it is, depending on what input they want, for some it's just 'are you gonna refer them to this because we want to tick a box' (I: mm) for others they're really interested

in 'how could we how could we formulate this' and you know they're interested in more of your psychological opinion rather than your ability to refer someone. Erm, (I: mm) so I usually provide written kind of feedback from any session I've had during the week where there (I: OK) but but I because, so I work, cause of the two wards both have two Consultants, well one has three, I don't have every morning, I could be either one or two ward rounds (I: mm) for the whole morning (I: mm) so actually (I: mm) I wouldn't get any clinical work done (I: mm) if that was the case (I: mm) so I tend to just, as much as possible which is sometimes it's not, cause they don't all, they tend to keep to the erm, timetable (I: mm) but as much as possible I try and pop in and pop out (I: mm) of the ones that are relevant for me (I: mhm) of people I've seen that seems to be the best best way of doing it but er that's a dif that's one of the difficult things I find time wise to do what I want to do (I: mm) with a client you know, you you balance things up, you, one thing (I: mm) you have clinical contact here and you lose the (I: mm) the sort of feedback (I: mm) bit somewhere else so

I: Are you the only Psychologist on the wards?

P: Well, I the only Psychologist, well, so the acute wards here (I: yeah) all have one part time, so two days a week Psychologist, the rehab ward has recently gone through quite a big change, and they've gone from being a strictly speaking kind of psychosis rehab ward for severe and enduring (I: mhm) erm primarily psychosis people to erm we're still in the process of thinking about what we actually do but basically complex cases (I: mm) so it could be personality disorder, it could be autism, it could be (I: oo) all sorts and mild learning disabilities. So erm and as that's that only changed about three or four months ago and so we're still figuring out what we're gonna do, and as part of that change the, there was funding given to employ another psychologist to make up the two days I'm not there (I: right) so we've just had a new Psychologist start, last week, (I: right) who is sort of being inducted at the moment, but that will only be for about six months, as er, short contract really (I: right) so, yeah, generally speaking it's one per ward. I mean, yeah, in addition to that we've got other

therapists, and stuff, so there are, there is other therapy available, but the only psychologists are, just you know one on each ward (I: mhm)

I: Erm and where do you get, the challenges that you face and the work that you're doing, where do you get your support from?

P: We have a very tight psychology team here, so each ward has one psychologist and then we've got day hospital and home treatment team which also has two psychologists who split that post with the ward work so we actually have four erm, full time, well three and a half full time psychologists on the unit at any one time (I: mhm) during the working day. We then have our supervisor whose Consultant who who kind of comes in and out she's here, I think, one day a week officially working here er, but we sort of see her in and out erm, then we have trainees, so usually we'd get a couple of trainees each year (I: mm) that be with us for a year, and we've just lost our assistant, to the counselling psychology course (I: mm) but we will be getting another assistant as well so, we've got, and and it's a it's a it's it's very much peer support based (I: mhm) kind of structure (I: mm) we all get supervision and everything but I personally find it's much more helpful going to one of the other Psychologists on the ward and saying 'look this has been a difficult one (I: mm) I don't know what to do', or 'this is going on, what do you reckon', erm and we do that between us (I: mm) and it's it's, although we have different levels of experience and stuff (I: yeah), erm, actually, you know, I think we find that there are different one's of us who are better at dealing with certain things (I: yeah) so that works really well, and I've er I've I've done a li I I say the the the most important thing I would not still be here if it wasn't for that type of support (I: yeah) I know I wouldn't I, it just

I: Because?

P: There's so much, there is, you get so mm, thinking of the way I work I put a lot of myself into the job (I: yeah) and I don't think I could do that erm, without the support I've got, it's, it's, it's g sort of, quite draining work with the things that get discussed (I: yeah) and you know, there, erm (p) I, the

politics actually, I mean the service users is one thing but I think, well I think I feel like I'm trained to talk with people about difficult issues and trauma (I: yeah) but the political side of working in an inpatient unit

I: So in terms of the power and whose

P: In terms of the power

I: got the power

P: Yar and having these these, you know, there can be fights about power (I: yeah) and the, you know, (p) and it can be really draining to get involved in it, and you have to get involved in it otherwise you you have to sort of stand your ground a bit (I: mm) so that can be quite that's probably more draining than the actual clinical work itself (I: mm) erm, and managing expectation, that's another challenge I think. Whilst you've got your own expectations of what you should do (I: yeah) of course the doctors and the nursing staff will think they also know what you should be doing (I: mm) so there's a constant re reminding (I: mm) of what your role is (I: mm) erm, which I think, I'd guess that would happen less in a sort of all psychology team (I: mm) erm, but it's it's good it means they means it's a bit flexible as well if you decide you want to change what (laughing) your role is you just give different feedback when people ask an (I: yeah) so I I I really enjoyed that aspect of the work it's another part of the work that's good. It's so different, the work is so different, the people, it's, things changing all the time (I: mhm) so it's quite exciting.

I: I was gonna ask about the language that's used on the ward, I never quite know how to phrase this question (laughs) but how it influences what happens on the ward or the atmosphere in the ward

P: Interesting. Erm, (pp) when you say language (I: mm) erm (pp) it's quite, I would say mm, but it's quite an individual thing I'd say first, because certain members of staff will have a certain way of communicating (I: mm) which they have found works best for them and it sometimes doesn't seem to be the best way of communicating so its ll using your voice shouting and you know if you're a big

man you know, your language could be body language (I: mm) erm you know puffing up chests and things happens quite a lot (I: mm) erm,

I: This is the patients or the staff or both

P: Staff

I: the staff

P: (That's one?) (I: yeah) but I mean I'm thinking about language in terms of communicating (I: yeah) between people (I: yeah) and I'm thinking you know I if I could wave a magic wand I don't think it would be working as it as I think it should then you would have people you know kind of following the main you know Rogerian ways of being (I: yeah) with someone (I: yeah) and being empathic and you know giving people erm space to experience themselves and however distressing that is (I: mm) erm (p) but there but there are ways of communicating that happen here that are there to shut down communication (I: mm) and to keep you quite (I: mm) and you know I think working in, it's here probably more so in forensic units and even more in prisons you know, there's an almost like a graded (I: mm) kind of thing erm there's a there is a sense for some people I think that attracts them to the job that it's there is a sort of not jailer mentality but erm (p) protecting perhaps protecting the community or (I: mm) if you like (I: mm) which is a part of the job (I: mm) but I think maybe it attracts people, what people learn that that's how you, that's how you manage when you're feeling anxious (I: yeah) erm and

I: Your kind of controlling aspect there

P: Yeah, yeah. You know what what most times the puffing out of chests doesn't happen without some sort of provocation and so I understand that it's probably as much a you know reaction as it is a (I: yeah) a just a way of being (I: yeah) but erm yeah. So I think that language in terms of communication can sometimes be quite damaging to the therapeutic environment on the wards.

I: Is that something that you might erm comment on or (P: yeah, yeah) or talk to people about?

P: Depends, does, I mean it obviously depends person to person, erm I've got an interesting story actually about, this comes back power again, erm this Consultant when I just, probably about two or three months after I started I was talking to a service user in the ward round and the doctor felt like they we should meet and that seemed like a good idea. So I said I'll come and find you later on today and we'll think about when we can sit down and have a chat, and after the service user left the room the doctor said to me I don't think you should use the word 'chat' (I: oo) I think that's undermining your your skills and your qualifications and you you would do therapy, which you know, I think it's a good example (I: yeah) of how language and power are are completely together (I: yeah) you cannot (I: yeah) get one without the other erm and oh I don't know why that story just came to me but it just felt quite appropriate (I: yeah) but it's that kind of thing that, so if I saw for example someone puffing out their chest or you know, depending on how escalated the situation was you can come over and there are ways of trying to deescalate without ? (I: mm) and I have had to deescalate certain members of staff (I: mm) at times, either they've come out of a really difficult situation and been you know (I: mm) that kind of fight or flight (I: yeah) sort of reaction or they're in it and they shouldn't really be in it, when they're getting so worried and worked up, so erm (p) yeah (p) but yeah the ways of talking I think can make such a difference (I: mm) erm and you if you if you it doesn't take very long before people start, you know service users, will start using the language (I: yeah) that you use (I: yeah) and that's really, when that happens you think well this is why, do you want a service user to puff out their chest, do you want a service user (I: yeah) to think that the only people that they can talk to are psychologists because they're the people with the expertise (I: yeah) the chats aren't worth it I think (I: yeah) and that's not what you want really (I: mm) you want people to feel comfortable with other people (I: yeah) so I think the language, it has a use and that mm for me that main use is how you com communicate with professionals about what you do to maintain your your authenticity (I: yeah) as a professional and that's that's the main way I'd use that

language (I: mm) other than that I don't see it being helpful for service users (I: mm) really (I: mm) erm or staff when it alienates (I: mm) and so

I: When you run the talking group are there nurses and staff

P: We have

I: Staff in there with you

P: Erm, So we have, I haven't got a trainee at the moment but if there was trainees there they would tend to come in, on on the rehab ward erm (p) well on both rehab and the acute ward we have some members, they go by different names, but they're basically band 3 support workers or social therapists or assistant practitioners or whatever you call them, and and I've got a very good group which we've kind of grown up together with the groups that if one of them is on shift they will come in to the group (I: OK) and then we will have a bit of a chat beforehand about whose on the ward and who might come and then a debrief afterwards about what was discussed and what it means about individuals (I: mhm) so we've had nursing staff in the groups, we've had trainee ward doctors in the groups, erm, I try and keep more consistency with the rehab group because it's it's a bit more of a oh it's a much more consistent (I: yeah) attendance (I: yeah) it gets more like a closed group in some ways, erm, but because of the level of distress and you know how people are on both wards you you find I find it unhelpful to say the door is closed er but in terms of facilitation I try and get as much contin continuity (I: mm) as possible so yeah so try and get them involved and the feedback is that they usually find it really helpful

I: The staff?

P: Yeah, they come out going wow, I didn't even know you know I didn't know they could have that conversation or I didn't know that that's (I: yeah) how they were feeling or erm (p) sometimes it's an issue for the service users and you'll find that things are directed at one person

I: an issue for who's in the room

P: Yeah

I: which staff members are coming in or

P: So if a nursing member of staff is in the room and the issue of discussion is medication you might find everybody's looking at that poor person (I: yeah) (laugh) and just sort of directing it (I: yeah) and then it's you can remind people about you know other things and the fact that there is this distinction between the staff and the service users (I: yeah) and sort of exploring that (I: yeah) erm, so there are ways of managing those sorts of things I think (I: mm) but erm, yeah

I: Erm, this is another question I struggled to, erm, put into words, I wanted to ask about your values

P: mhm

I: firstly what they are whether they've changed since you began working in an inpatient unit and how working on an inpatient unit fits with you're or whether it does sit fit with your values?

P: What do you mean with my values?

I: Well I don't know what your values are (laughs) so

P: So for values could be my personal values of life or it could be my values in terms of my job, could be

I: More, the kind of wider erm

P: Wider, sort of life

I: Wider, Yeah

P: Values

I: Yeah, it's quite a big question (laughs) to put on someone

P: It is a big question, it's a good question, it's a good question (I: laughs) erm I've a period of time when you won't have to transcribe (I: laughs) let me think (pp) interestingly I think when I started here on the PICU during my training I was in a bit of a, in terms of the job my head was in a bit of a spin as to whether I wanted to be a Psychologist and whether this was (I: mm) what I really felt was what I wanted to do, and I think at that

I: This was in your last year of training

P: That was the last year of training (I: yeah) and I think I was questioning a lot (p) about my my whether my what your what your question is asking whether my values fitted with what Clinical Psychology (I: yeah) is (I: yeah) because I'd found that it was a lot of box ticking (I: mm) and erm erm I didn't feel there was much, it it's it's aimed at it it's supposed to be helping people but I just found that there was it lacked humanity I think, I didn't feel (I: yeah) that there was the humanity in it that you could have a conversation with someone erm and I I mean I was in sort of I'd done CBT placements and things like that where I just felt that the the passion and the energy and the things that make people people the I I talk about glints in the eye (I: yeah) you know that (I: yeah) that kind of spark that people have are, maybe it was the way I was doing it, but it just feel felt very drained out of the room when you tried to do certain things with people (I: mm) erm, and it tended to be the more complex the problems got the more that it drained away because there was always another 'but' erm in the you know, but what about this and what about this (I: yeah) so I felt quite constrained in terms of my my I wanted to get into this to help people to provide people with a voice (I: yeah) to talk, I know it sounds pithy but to talk about what they they feel and you know if I could help I could help and (I: mm) maybe I can't (I: mm) so I was quite open to that erm but I felt that I think my value is that there is a one of my values is that there is benefit in talking you know (p) erm to anyone, you don't have to be qualified (I: mm) in psy Clinical Psychology (I: mm) to be able to talk to someone and for that to be therapeutic (I: mm) erm and actually there are therapeutic relationships going on (laughs) everywhere (I: mm) and that's very key to what I believe (I: mm) and I

value of mine, so I think that that when I got into Clinical Psychology, I went through initial period of feeling like, oh wait a minute that might th those values might be wrong, and actually I need to use this language to say, this is actually what is making people better (I: yeah) erm and then went through and I thought no it's not (laugh) it's not clicking really (I: yeah) and so I come to came here and I felt a little bit fed up with it all and I had a very good supervisor here who kind of helped me to stop up a bit and say what's important to you (I: mm) and that essentially give me permission and say well you can actually use the skills you've got and you don't need to do all of the things that, you don't have to feel pressure to use them, (I: mm) erm there's a very good women who writes called Sheila MacNamee t very much into Social Construction (I: right) and certain stuff and she talks about using erm charade that psychologists have as well (I: yep) but like using a tool kit and you have your tools (I: oh) but actually it's fluid it's not like you pick a tool and then 'psh' CBT 'dlllll' (I: yeah) you know you, it's a moment by moment intricate, interpersonal (I: yeah) kind of interaction (I: yeah) and erm it was like opening my eyes, actually I could do the humanity bit, I could do the sort of ethical, what I felt was important for someone (I: mm) erm and it could fit within psy Clinical Psychology (I:mm) so that really kind of re re informed reinforced reinvigorated what I valued (I: yeah) and made me think I can do it and I can do it in an environment where people really struggled (laugh) to do that (I: yeah). Humanity is one of the things that sometimes is glaringly absent from er er inpatient units, so (p) in terms of ma yeah and in answer to your question, that that value was sort of reborn here I think and and I stick with it, that's, I think if that's your if that's one of the key things that you hang what you do on it makes you, I'm not fearless but it it's very it's a very strong base to come from (I: yeah) because no one will criticise because every from my perspective you might have a very glib way of working (I: mm) or way of doing things and I'm not gonna take that down but equally (I: mm) I have my rationale and everything else (I: mm) what I do why I'm doing it it does what it does and I probably sounds quite contrary to NICE guidelines and stuff like that but (p) in the alongside the peer support here I think that value, part of it, has been the key to (I: yeah) being able to work here (I: yeah) erm

I: I was just I was just thinking erm whether it's that kind of philosophy that you bring into the inpatient ward which might be threatening for other people

P: yeah

I: who work on the inpatient ward because going in with that belief and that way of working isn't an easy option

P: mm

I: Erm, and maybe requires more of you like you say you give a lot

P: mm

I: of yourself to your work and if somebody isn't prepared to do that or put

P: mm

I: not making yourself vulnerable but just giving more of yourself than

P: mm, well, pro pro probably I I

I: I guess I was thinking sometimes working on an inpatient unit, maybe it's easier to shut yourself off

P: yes

I: from that side of things, just to be able to get on with your work

P: mm

I: and what you are facing everyday

P: mm, and you just kind of go through the, yeah, I mean I don't know, obviously I don't know how it would be if I didn't, if I didn't if it wasn't like this erm (p) it's kind of impossible to say erm I quite

frequently find myself wanting to make things simpler than they are (I: mm) and and er having to kind of again again stop yourself and say no it is this complex (I: mm) we don't need to simplify it we just need to explore it and find out the complexity (I: mm) and it's we have it in our minds and everything therapists need to make sense of everything and now you must be must lead B and to C and when people have lives that go A, Z, F, G you know all over the place (I: mm) it's very difficult to not to not try and make it ABC and then you force that in (I: yeah) force the sort of persons (I: yeah) world into that erm system erm and that does, yeah, I spose I spose just thinking about what your saying about with other staff the threat of bringing that perspective in. I think it's those people that really value power that are the most threatened (I: yeah) erm and those people that are kind of, the smiles I've seen from staff who tentatively say something and are really anxious about whether they're saying the right thing and you give them positive feedback and say you know and it could be something like, oh, so we have like erm, a large population of erm sort of African people from African origins (I: mm) erm Caribbean origins, Indian and we have the staff mix, is far more black/Asian than it is white or at least it's, I don't know what the exact split is but it's probably, if anything it's less white than anything else (I: mm) and so you know so you might get a member of staff coming forward and saying, oh he you know talked someone was talking about witchcraft or something and then someone will come forward and sort of tentatively say oh, oh back where I'm from, the village I'm from this is the sort of thing that we would talk about and or you know someone will come in whose Muslim and saying well the jin that we believe in, possession and (I: yeah) the the, and you say excellent, so what would you do in your village, what would that what would help there, could we be bringing some of that into here (I: yeah) and those sorts of conversations I would tend to try to do at the moment I'm doing it more one to one with staff because to do it in a public space I think for one thing those comments don't come up at the moment because it's certainly on the rehab ward it's too much of a threatening space (I: mm) erm and you can (I: mhm) and I think it's one to one is a bit more able to feed it a bit better (I: mm) but erm but yeah there's someone taking a risk in bringing something (I: mm) innovative and you can

you can feed it (I: mm) so I think it depends on how people, what their relationship with power is (I: yeah) on the one hand and how willing they are to put aside the work hat and put on a sort of personal hat, and I think the more you feed it the more smiles you see and the more people are engaged in (I: mm) comes back ff motivation thing more people are motivated to do the thinking (I: mm) than than erm than the trying to fit people into ABC (laughs) (I: mhm, laugh) but yeah

I: Erm, I'm aware that times running out

P: That's alright, don't worry

I: Erm to finish I'll just quickly throw you two questions (laughs)

P: Yeah, that's fine

I: First, the first one's, what your hopes are for the future, and the second one I often find that I'll record an interview and a lot of interesting stuff is said (P: mhm) afterwards, so to ask you if there's anything that you would've liked to have talked about that we haven't talked about

P: mm

I: other things that haven't come up that

P: Well I've definitely talked about the bits that I feel most strongly about, definitely

I: Good

P: Erm, it's boring things like the you know, how you you know some of the challenges like referring people into services where there aren't services, that kind of thing you know (I: yes) you find a need on the ward but the person who could benefit from some sort of therapy, even if it's something short term right now erm has to wait a year to get something in the community (I: yes) that's a frustration and a challenge, but I mean

I: and a hope for the future maybe

P: Well yeah but

I: (laughs) that they would be there

P: They would be there, I mean, I can't think of anything that was vitally important erm, my hopes for the future at the moment are getting through this period of change on the rehab ward and just seeing what the ward looks like at the end of it, cause at the moment it's quite it's in a massive state of flux (I: mm) and so erm it's it feels a little bit like a week at a time at the moment just to see what's happening at the next (I: mm) you know the next week erm trying to be as much involved in that as possible but erm, yeah, (p) and I think mmm I would say that that the politics is part of what makes the job ss a challenge er not a challenge, rewarding, but actually if you see the politics part of it cause with all this change at the moment the politics are coming out more and more (I: yeah) people people are jostling for power because it's not really clear what the power structure is because the whole things changing (I: yeah) so there's a lot of jostling going on at the moment and actually it is challenging but it you you see the value of things you know your relationship with other members of the team you see things that you wouldn't of seen otherwise and so it is very rewarding as well as spose I would've said that erm yeah, in terms of my future, err, I don't know, I'd never, mm, I like working inpatient, I don't think I'll do it forever, erm, (p) I don't know what, I would like to set up some sort of specialist unit for people erm with severe and enduring mental health problems who are repeat admissions you know there's a there's a (I: yeah) very clear, that's one thing that I could have talked about a bit more, is the k kind of, is the sort of erm, what do you call it, there's a kind of

I: Revolving door kind of

P: There's revolving door ss sort of people

I: It's not a very nice expression (laughs)

P: No

I: No

P: Erm, there's sort of revolving door people, er, (sigh) who (p) who who are marginalised largely. I mean the ward here the rehab ward, which is now complex care, obviously sees people who would fit that term (I: mm) criteria, or definition I suppose, but I do wonder if it would be possible to set up some sort of, I don't know, a kind of community based therapy centre that would, I've spoken to a few people who have got some ideas about it, but not not yet, but in the future maybe setting something up like that that was funded by possibly, I don't know, I don't know (laughs, I: laughs) it's a bit, but you know something like that, possibly going have, I don't know how much you've read about the 'open dialogue approach'

I: Nnnot much (laughs)

P: name dropping like a , but there's an open dialogue approach in ah it's Scandinavia somewhere, might be Norway actually

I: Oh really

P: Must be, but the main chap is a guy called Seikkula, SEIKKULA, something like that, erm and they do this really, it's only a small part of whichever Scandinavian country it is, not Sweden, I don't think it's Finland, but it might be either Norway (I: oh) or Denmark can't remember (I: right) and they do this this very much high intensity kind of involvement work with people and and it's all done in collaboration with the system that the persons in (I: right) so you in, you bring, so ra, in your ward round for example (I: yeah) the family and the service user would have just as much right to say we don't wanna take medication (I: right) and and then that would have to be negotiated (I: right) and so the service user would have you know, that could be negotiated so (I: yeah) everyone's on an equal footing (I: yeah) and things like ward round are you know held in places outside of hospitals (I: yeah) and erm it's just a much more erm kind of equitable (I: yeah) (p) er ss ss way of doing things (I:

yeah) and that's, I don't know how it would work here and I don't know the practicalities of how I would do it but it's a sort of

I: That sounds really interesting

P: quite an inspired (I: yeah) kind of way of doing things, so, that that's, it's a possibility in the future (I: yeah) but we'll see

I: It sounds

P: It's early days yet

I: Yeah, it sounds really interesting

P: It's worth a read

I: An alternative way of working

P: mm, they've got two main papers which are the kind of methodology and stuff and then the actual practicalities of how they've set up their service, and they're well worth a read

I: Yeah, I'll look them up (P: mm) definitely.

(p)

P: Sh yeah, I won't ask you questions

I: (laughs) erm, thank you very much

P: That's alright, pleasure

Appendix 9

Individual interview storylines

| | since qualifying | Themes | My impression |
|----|------------------|--|--|
| N | >10 | Changed over time – wiser, effective. Fighting the system. Politics necessity. Importance of Clin Psy – wider therapy. Atmosphere wards. Training – common sense. SC Critical of medical model – apathetic/ uncaring staff. NHS. Special– inpatient. Future. Intimidation. Humanity, solidarity. Drugs. Battle with culture. Hierarchies. Tired of fighting. | Passionate, anger, frustration, Dry humour Highly experienced Non-conformist, Fighting |
| A | >10 | Against idealism – realism. System can't change. Difficult environment. Common Sense Primitive psychological level. Psychology presence, important. Unconscious decisions. Containing safe space. Critical of team. NHS. Strategic. Future of Clin Psy. | Tension, irritation. Hopeless. Dry humour. Warmth. Defensive. Accepting. |
| F | <5 | Connecting staff/ patients, relationships. Special inpatient work. Peoples experience. Trauma. Vulnerability. Trust. No time – so much to do. Love of inpatient work. | Compassionate, open Enthusiastic. |
| E | <5 | Impossibility of achievement. Failure – realism. Depression. Confidence. Language. Relationships. Systems. Culture. Intimidation. Nurture. Institutionalisation, society. | Personal account – confessional Bitter humour. Frustration. Belief. |
| G | <5 | Lone psychological voice. Quality of life. Job roles. Plans for future. Engagement with patients. | Lacking in depth – job interview. Medical model – working with. |
| Av | <5 | Confidence. Work – tough- lonely. Critical of staff/ medical model. Compassion. Relationships. Strategic. Importance of psy. Moving towards acceptance. Social Construction, appropriate? | Overwhelming. Either/or Frustrated. Fighting. |
| O | <5 | Power – working against it/ with it. Politics. Hierarchies. Clin Psy. Towards humanity. Curiosity. Culture. Open Dialogue approaches. Peer support. | Compassionate/ human |
| I | <5 | Critical of medical model/ culture. Thinking and feeling. Importance of psychology (more than therapy). Supervision, hierarchies. Politics. NHS. Future of Clin psy. Lonely. | Frustration, anger. Fighting. |

Appendix 10

UNIVERSITY OF HERTFORDSHIRE
HEALTH AND HUMAN SCIENCES

MEMORANDUM

TO Mary Bentley

CC Dr Saskia Keville

FROM Dr Richard Southern, Health and Human Sciences, ECDA Chairman

DATE 9 July 2013

Protocol number: LMS/PG/UH/00090

Title of study: Clinical Psychologists experience of working in an acute mental health inpatient setting.

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 9 July 2013

To: 31 October 2013

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Appendix 11

If— BY RUDYARD KIPLING

If you can keep your head when all about you
 Are losing theirs and blaming it on you,
 If you can trust yourself when all men doubt you,
 But make allowance for their doubting too;
 If you can wait and not be tired by waiting,
 Or being lied about, don't deal in lies,
 Or being hated, don't give way to hating,
 And yet don't look too good, nor talk too wise:

If you can dream—and not make dreams your master;
 If you can think—and not make thoughts your aim;
 If you can meet with Triumph and Disaster
 And treat those two impostors just the same;
 If you can bear to hear the truth you've spoken
 Twisted by knaves to make a trap for fools,
 Or watch the things you gave your life to, broken,
 And stoop and build 'em up with worn-out tools:

If you can make one heap of all your winnings
 And risk it on one turn of pitch-and-toss,
 And lose, and start again at your beginnings
 And never breathe a word about your loss;
 If you can force your heart and nerve and sinew
 To serve your turn long after they are gone,
 And so hold on when there is nothing in you
 Except the Will which says to them: 'Hold on!'

If you can talk with crowds and keep your virtue,
 Or walk with Kings—nor lose the common touch,
 If neither foes nor loving friends can hurt you,
 If all men count with you, but none too much;
 If you can fill the unforgiving minute
 With sixty seconds' worth of distance run,
 Yours is the Earth and everything that's in it,
 And—which is more—you'll be a Man, my son!

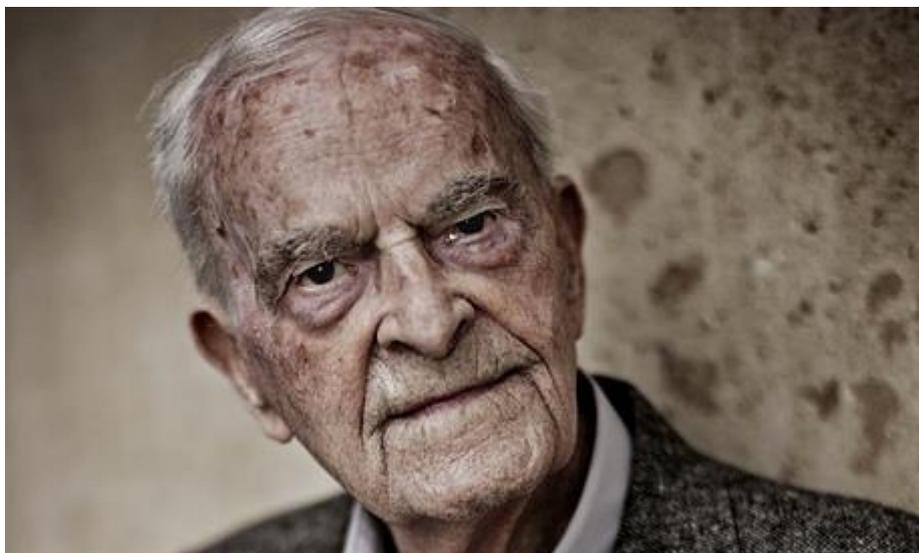
A Choice of Kipling's Verse (1943)

Appendix 12

The Guardian, Wednesday 4 June 2014

A eulogy to the NHS: What happened to the world my generation built?

In 1926, Harry Leslie Smith's sister died of TB in a workhouse infirmary, too poor for proper medical care. In 1948, the creation of the NHS put a stop to all that. In an extract from his new book, *Harry's Last Stand*, he describes his despair at the coalition's dismantling of the welfare state



Harry Leslie Smith: 'The creation of the NHS made us understand that we were our brother's keeper.' Photograph: Sarah Lee for the Guardian

A midwife with a penchant for gin delivered me into the arms of my exhausted mother on a cold, blustery day in February 1923. I slept that night in my new crib, a dresser drawer beside her bed, unaware of the troubles that surrounded me. Because my dad was a coal miner, we lived rough and ready in the hardscrabble Yorkshire town of Barnsley. Money and happiness didn't come easily for the likes of us.

Considering the hunger, the turmoil and the squalor in Britain during the early years of the 20th century, it was miraculous that I lived to see my third birthday. That I survived colic, flu, infection, scrapes and bangs without the benefits of modern sanitation, hygiene or health care, I must give thanks to my sturdy peasant genes. As a baby, I was ignorant of the great sorrow that enveloped England and Europe like a damp, grey fog. The nation was still in mourning for her dead from the world's first Great

War. It had ended only five short years before my arrival. Nearly a million British soldiers had been killed in that conflict. It had begun in farce in 1914 and ended in bloody tragedy in 1918. In four years, that war killed more than 37 million men, women and children around the world.

Even when the guns across the battlefields were made dumb by peace, the killing didn't stop. Death refused to take a holiday and a pestilence stormed across the globe. It was called the Spanish flu. The pandemic lasted until 1921 and erased 100 million people from the ledger book of the living.

Like most people in Barnsley, my family occupied a terraced house. They were built back-to-back and in a row of 10 units. There was little space, privacy or comfort for us or any of the other occupants. It was just a place to rest your head after spending 10 hours hacking coal from the side of a rock face hundreds of feet below ground. Three walls out of four were connected to another household.



Barnsley covered in snow, 1930. Photograph: Fox Photos

The floors were made of hard slate rock and were sparsely covered with old rags that had been hand-woven into coarse mats. The interior walls were comprised of wet limestone coated in a gruel-thin whitewash that never seemed to look clean.

In summer our home was hot, in autumn damp, and in winter bitterly cold, while spring was as wet as autumn again. The house had no electricity and only the parlour and scullery possessed a gaslight fixture. After sunset, it sputtered and hissed a gloomy yellow light that illuminated our poverty. I shared a room with my older sister, Alberta. We slept together on a straw mattress that was host to many insects and reeked of time and other people's piss. Its covering was made from a rough material

that was as uncomfortable to me as the occasions when my father tickled my face with his moustache. Depending on the season, I slept in my undershirt or remained fully clothed. During the cold months, Alberta and I nestled together and shared our body heat to stave off the chilling frost beating against the windowpane. Our parlour had no furniture except a stool and an upright piano that had come as part of my dad's legacy from his father. But it stood mute against the wall because the room was occupied by my infirm and dying eldest sister, Marion.

At the age of four she had contracted tuberculosis, which was a common disease among our class. Her ailment was caused because my parents were compelled to live in a disease-ridden mining slum at the end of the Great War. Eventually my parents were able to leave the slum but by then the damage had already been done to my sister's health, and the TB spread into her spine. It left her a paraplegic with a hunchback. For the last 12 months of her life, Marion was totally dependent on my mother to be fed, bathed and clothed. In those days, there was no national health service; you either had the dosh to pay for your medicine or you did without. Your only hope for some medical care was the council poorhouse that accepted indigent patients.



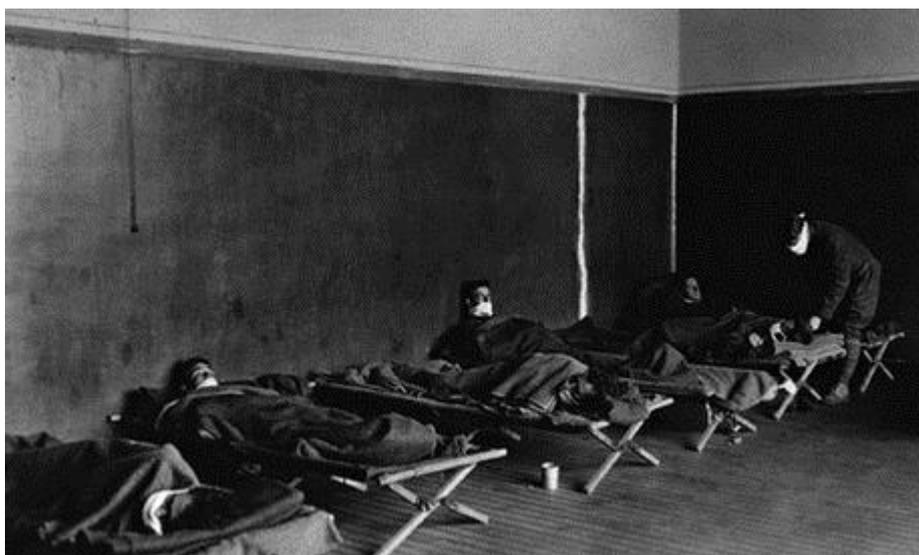
Miners leaving a Yorkshire pit after an explosion, 1930.
Photograph: Associated Newspapers/Rex

As a young lad, I was encouraged by my parents to spend time with my ailing sister. I think it was because they knew that she was dying and they wanted me to remember her for the rest of my life. I didn't comprehend illness or death because I was only three, so I contented myself with playing near her sick bed. On some occasions, I told her nonsense stories, but my sister couldn't respond to my kindness because the disease had destroyed her vocal cords.

Even though she was in extreme pain while the TB ate away at her spine and invaded her vital organs, she was silent. My sister always seemed to be looking past me with her large expressive eyes. Perhaps she was waiting for death, or perhaps she found the gaslight casting shadows on the opposite wall an appealing distraction from the monotony of the pain that consumed her 10-year-old body.

TB was known in the 19th century as the poet's disease, but I saw no lyricism in the way it killed Marion. As the autumn days grew shorter in 1926, so did the time my sister had to live. Her last weeks were unbearable but she still fought death. She thrashed her arms about in defiance against the coming end to her life. My parents tried to calm her by stroking her hair or singing to her, but she wasn't pacified. Instead, Marion wept silent tears and continued to struggle with so much ferocity that in the end my dad reluctantly restrained her to her bed with a rope.

My parents decided that there was nothing more that could be done for Marion in their care, so they arranged for her to be placed in our local workhouse infirmary. It was the last stop for many people who were too poor to pay for a doctor or proper hospital care. The workhouse in our community was a forbidding building that had been constructed during the age of Dickens. In the century before I was born it was used to imprison debtors, house orphans and provide primitive health care to the indigent. By the time Marion was sent there, it was no longer used as a prison. However, orphans, the sick and those with communicable diseases were still incarcerated behind its thick, towering black walls.



Spanish flu victims.

Photograph: Everett Collection Inc/Alamy

On one of the last days in September my mother pawned her best dress and my father's Sunday suit and hired a man with an old dray horse and cart to come to our house and collect Marion. When he arrived, my dad

carried Marion outside and carefully placed her into the delivery carriage where my mother was waiting for her.

Alberta and I stood on the side of the street and waved goodbye to Marion. I asked my dad where my sister was going and he mournfully replied: "She's going to a better place than here." Afterwards, he put his arms around me and Alberta and we watched the horse-drawn carriage slowly plod down our road towards the workhouse infirmary.

That was the last time I saw my sister alive.

Marion died a month later in the arms of my mother. There was no wake, no funeral service and even much later there was no headstone erected to mark her brief passage in life. My family, like the rest of our community, was just too poor to afford the accoutrements of mourning. We relied on my dad's minuscule salary just to keep us with a roof over our heads and dry in the perpetual hard luck rain of Yorkshire. Even my dead sister's landau was quickly dispatched to the pawnbroker's shop where it was swapped for a few coins to help feed her hungry living siblings.

My sister's body was committed to a pauper's pit and interred in an unmarked grave along with a dozen other forgotten victims of penury. My parents didn't even have a picture to remember their daughter's life. To the outside world, it was as if she was never there, but for our family her life and her end profoundly affected us. My father never mentioned Marion's name again. It wasn't out of callousness or disrespect, but because her death festered in his soul like a wound that never healed. For the rest of his life my dad carried with him an unwarranted guilt that he was responsible for Marion's tuberculosis, and it cut him deep. As for my mother, she often talked about Marion. As my family stumbled from misery to calamity, through the pitch dark of the Great Depression, my mother invoked my dead sister's name as a warning that the workhouse awaited each of us, unless the world and our circumstances changed.

It would be almost 20 years before, in 1948, the NHS was formed, and for the first time in my civilian life I went to a doctor's surgery and was treated for bronchitis with antibiotics that assured me a speedy and safe recovery. The cost to me was nothing, and I was grateful because I was skint, having just started back in the civilian working world.



An NHS immunization van in the 50s.

Photograph: Popperfoto

As I convalesced, I was gobsmacked at the great consequences of free health care and the potential it offered to improve our society. It was a transformational shift in how we as a country viewed our fellow citizens. The creation of the NHS made us understand that we were in truth our brother's keeper, and that taxation benefits everyone through maintaining not just our roads and sewers but the health of our children, workers and elderly.

To me, the introduction of free health care was the first brick laid on the road to the social welfare state. So it has always been difficult for me to listen to politicians, proud possessors of health insurance and shares in private health care companies, when they talk about how the health service that we fought so hard to build must change. The coalition government's Health and Social Care Act will create a two-tier health care system. This act will see the NHS stripped down like a derelict house is by criminals for copper wiring.

Ukip has even proposed that A&E patients should have the right to buy their way to the front of the queue, while in Merseyside a private for-profit cancer clinic has set up shop under the NHS umbrella. Where will all of this end? What will be given the greatest priority in a new health care system that sends every service, from blood work to chemotherapy, out to the lowest bid tender?

It ends where I began my life – in a Britain that believed health care depended on your social status. So if you were rich and insured you received timely medical treatment, while the rest of the country got the drippings. One-fifth of the lords who voted in the controversial act – which

provides a gateway to privatise our health care system – were found to have connections to private health care companies. If that doesn't make you angry, nothing will.

Sometimes I try to think how I might explain to Marion how we built these beautiful structures in our society – which protected the poor, which kept them safe at work, healthy in their lives, supported them when they were down on their luck – only to watch them be destroyed within a few short generations. But I cannot find the words.

Harry's Last Stand by Harry Leslie Smith is published by Icon Books

Appendix 13

AFTERMATH

Siegfried Sassoon (1919)

Have you forgotten yet?...

*For the world's events have rumbled on since those gagged days,
Like traffic checked while at the crossing of city-ways:
And the haunted gap in your mind has filled with thoughts that flow
Like clouds in the lit heaven of life; and you're a man reprieved to go,
Taking your peaceful share of Time, with joy to spare.*

But the past is just the same-and War's a bloody game...

Have you forgotten yet?...

Look down, and swear by the slain of the War that you'll never forget.

*Do you remember the dark months you held the sector at Mametz—
The nights you watched and wired and dug and piled sandbags on parapets?*

Do you remember the rats; and the stench

Of corpses rotting in front of the front-line trench—

And dawn coming, dirty-white, and chill with a hopeless rain?

Do you ever stop and ask, 'Is it all going to happen again?'

Do you remember that hour of din before the attack—

And the anger, the blind compassion that seized and shook you then

As you peered at the doomed and haggard faces of your men?

Do you remember the stretcher-cases lurching back

With dying eyes and lolling heads—those ashen-grey

Masks of the lads who once were keen and kind and gay?

Have you forgotten yet?...

Look up, and swear by the green of the spring that you'll never forget

Appendix 14

A extract on compassion by Professor Paul Gilbert (2011)

Research shows that the more compassionate we are towards ourselves, the happier we are and the more resilient we become when faced with difficult events in our lives. In addition, we are better able to reach out to others for help, and feel more compassionate towards other people, too.

Compassion can sometimes be viewed as being a bit 'soft' or 'weak' or 'letting our guard down' and 'not trying hard enough'. This is a major mistake because, on the contrary, compassion requires us to be open to and tolerant of our painful feelings, and to face up to our own problematic emotions and difficulties. Compassion does not mean turning away from emotional difficulties or discomforts, or trying to get rid of them. It is *not* a soft option. Rather, compassion provides us with the courage, honesty and commitment to learn to cope with the difficulties we face and alleviates our anxiety. It enables us to do things that help us to flourish and take care of ourselves – not as a demand or requirement, but to enable us to live our lives more fully and contentedly.