Mental Health Uncertainty & Inevitability

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Chapter Overview

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

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

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

Uncertainty & Inevitability

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

These themes are discussed further below, with the added inclusion of mental health and fieldwork evidence from this book's internal chapters.

Inevitability of the social

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

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

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

An appeal to devote increased research and development funds to mental health studies with micro-sociological and tacit foci seems a fitting recommendation here. (See Livingston

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

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

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

Uncertainty of social agent action

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

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

Inevitability of identity work

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

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

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

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

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

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

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

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

Uncertainty of illness experience

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

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

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

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

Chapter Conclusion

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

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

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