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FAMILY INCLUSIVE TEAMWORK IN MENTAL HEALTH

COLLABORATIVE WORKING PARTNERSHIPS BETWEEN THE PATIENT, FAMILY AND STAFF, ESPECIALLY FOCUSED ON AN ACUTE ADULT MENTAL HEALTH SERVICE IN DUNEDIN

by

Ivan M Criglington

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ABSTRACT

This research explores the concept of best practice working relationships between family, patient and staff in the context of acute adult mental illness. In the formal mental health services of New Zealand this concept is acknowledged as being founded on models from Europe. However services changed in response to the ideological grand theories and the realities of life in New Zealand.

Theories of best practice relationships have ranged from the separation of the patient from family and community to a commitment to relationships of collaboration and inclusive partnerships.

This study seeks to add to the theoretical knowledge about best practice in the era when the Blueprint for mental health services and the Third Way ideology advocate that services are to be responsive to needs and inclusive of the aspirations and resources of all stakeholders. The case study describes and explains the experience of small groups of ex-patients, family members and clinical staff. The case study explores the relational processes involved in building knowledge, interaction and decision-making.

The analysis of the case study provides theory that enables refinement of the Recovery Approach principles of the Blueprint. Previous theory has supported the inclusion of family but as a supplementary resource to the needs of the patient and staff. This study accepts that the needs and aspirations of all stakeholders can be identified and responded to in a way that is complementary to patient focussed intervention.

The findings of the study are focussed on providing principles for action at the macro, meso and micro levels. These principles provide direction for inclusive teamwork in which the patient, family and staff are full members of the collaborating team.
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PREFACE

The role and the voice of family and patient have changed over the years since the early 1850s, the time when the first formal mental health services were established. For many years the mentally disordered person was separated from family and community and managed in large institutions where the lives of patients were directed by staff who were agents of the state.

The current philosophy of intervention that guides services is the Blueprint and the principles of the Recovery Approach. This requires that the patient and family are actively included in the processes of assessment, care and treatment.

This investigation explores the extent to which the experience of participants matches the ideals of the Blueprint. The study aims to add to theory in which family and patients are integral to the intervention team and in which policies and practices are a real reflection of the Blueprint’s Recovery Approach.

The researcher is a clinical practitioner in the acute adult mental health service and is committed to interventions that reflect the aspirations, needs, knowledge, resources and influence of the family as well as input from the patient and staff.

There is rhetoric about services being collaborative and inclusive. However there is little theory that guides how to implement this rhetoric at the meso and micro levels. This study focuses on the relationship processes that occur in the interactions between patient, family and staff. It explores the relational processes that are experienced in the building of knowledge and decision-making and adds to best practice theory on how to maximise the inclusion of the patient, family and staff so that collaborative teamwork is a reality.

The thesis is divided into chapters to enable a chronological exploration of the role and relationship of family in response to an episode of mental disorder in the context of mental health services.
Chapter one explores the historical background to the provision of formal mental health services in New Zealand. It details the sources of influence that impact on the development of service provision. Attention is given to the perception of the patient and family and their place in the building of knowledge and making decisions.

Chapter two reviews the literature on the grand political theories and the way that these theories exerted influence on the policies and practices of the mental health services. Again, attention is paid to the place of family and the way that knowledge is created and decisions made.

Chapter three is a discussion of methodology. The researcher is an insider to the mental health service and the strengths and weaknesses of this position are discussed. Attention is given to the debate about the use of qualitative methodology as that is not favoured in health research investigations.

Chapter four details the views of interview participants. These responses are grouped in order to represent the collective response of each group. The respondents all had recent experience of the topic of investigation and were ex-patients, family members or clinical staff members. They responded to questions on the themes of knowledge building, processes of interaction and decision-making.

Chapter five compares the discourses of the respondent groups. The responses were categorised into four relational dimensions that highlight the common ground and differences between the experiences of the respondent groups.

Chapter six analyses the results of the research. It compares and contrasts the responses of participants within the theoretical framework of best practice. Tools of analysis are used to examine the dominance in power relations and to develop strategies for change so that relationships are flexible and responsive to needs rather than based on the fixed dominance of the staff and patient relationship.

Chapter seven summarises the research investigation and highlights the opportunities for changes at macro, meso and micro levels. The change strategies are opportunities
to align the policies and practices in the mental health service with the ideals of the Blueprint and the Recovery Approach.

The conventions used in this thesis are that Maori words and phrases are in normal script and this reflects that Maori is an official language in Aotearoa/New Zealand and all respondent quotes are indenting from the margins and right justified.
Chapter One

HISTORICAL CONTEXT

Introduction
Mental health services reflect the philosophy on which the society is based. At the beginning of the twenty first century the policy emphasis in New Zealand is based on the Third Way philosophy which promotes services that endorse community participation, community care and collaborative partnerships between those who experience the service and those who fund and provide services (Commission, 2005; Mason, 1996).

This study of the interaction of family with the patient and staff begins in this chapter by outlining the historical background to the provision of formal mental health services in New Zealand. It details the sources of influence that impact on the development of service provision. Attention is paid to the interaction of the patient, family and staff and the power relations that occur in the building of knowledge and making decisions.

The chapter begins with an outline of the traditional Maori response to illness and then describes the ways New Zealand, since the beginning of organised European settlement, has responded to issues of ‘unreason’. The major influences are from the English model of asylum care and the social and economic restraints of a new colony. The founding principles of institutional care, separate administration and state provision were the framework until the era of de-institutionalisation. Social, political and economic forces combined to create a new framework based on the Blueprint and the principles of the Recovery Approach.

Traditional Maori Health Response
Maori health concepts are based on public health principles designed to ensure the safety and well-being of the group rather than the desires of the individual. The process for maintaining the health and survival of the group is centred on the concept of dividing people, places or events into either tapu or noa. Traditionally it was
considered that unwellness was the result of an infringement of the laws of tapu (Durie, 1994; Makereti, 1986).

At its simplest, tapu situations were off limits. After appropriate ritualistic incantations, it soon became general knowledge that contact with a particular object or activity could be unsafe, either in physical or spiritual terms. ... Likewise, it was well known that transgressions of tapu earned rebuke, ridicule, or intense mental suffering. .... In contrast to tapu, the term noa denoted a state of relaxed access, requiring no particular protective mechanisms or restrictions. .... Thus, when danger had passed or scarcity gave way to abundance, a tapu restriction was replaced by the freedom of noa (Durie, 1994: 9-10).

Durie describes the principles of tapu and noa as being concerned not only with spiritual dimensions but:

In fact it was an all-purpose force which also served to regulate more secular and social community behaviour. Interaction between members of the same and different communities, and between people and their environment, was to a large extent governed by the laws of tapu (Durie, 1994:9).

A state of tapu resulted in a period of forced separateness from the group at a time when vigilance and focused attention was necessary (Durie, 1994: 9-10).

A principle of Maori health was the maintenance of balance between the forces that impacted on the wellness of the person and their group (Durie, 1994).

Traditional Maori made a distinction about the probable cause of illness. The term of mate atua described illness for which there was no obvious cause.

Much of the work of the traditional healers depended on drawing distinctions between tapu and noa and re-establishing balance between
the two. While the symptoms and signs were regarded as outward manifestations of the problem ....as the superficial aspects of an illness ......the underlying cause was thought to relate to imbalance at a more fundamental, spiritual level. Skillful practitioners addressed both (Durie, 1994: 16-17).

The treatment responses of traditional Maori healers involved activities

[At] spiritual, psychic, physical and ecological levels ..... Among the karakia connected with sickness, there were special rituals for a variety of ailments. Whakapiki mauri was recited to support the depressed or demoralized (Durie, 1994: 19).

Mason Durie emphasizes the holistic view that Maori hold about any form of unwellness and dysfunction. He compares Maori health traditions with those introduced by the early European settlers.

In one sense the holistic Maori tradition has been ahead of the Western preoccupation with individual pathology as if simple cause and effect relationships existed between host and disease. But, in another sense, Maori traditional practices have much in common with pre-industrial emphases on religion and moral behaviour as explanations for illness (Durie, 1994: 24).

**Early Influences from Europe**

Publicly funded services began to develop once organised European settlement was established. These services followed the tensions and practices of Europe as well as were shaped by the issues unique to a sparsely populated country peopled by many recent immigrants.

A well-established practice in Europe was to exclude and to confine anybody who was perceived as a threat to the established social order. Foucault describes that
Madness was no longer allowed to flourish as part of the community as it had in Renaissance times (Foucault, 1988: 64).

The insane in Europe were expelled from cities in a way that had previously been the fate of the sufferers of leprosy. The insane were transported about on the high seas in the ‘Ships of Fools’ and were finally contained in specially built houses (Foucault, 1988).

At the beginning of the seventeenth century Shakespeare portrayed madness as beyond human help. In Macbeth Act 5 Scene 1 he writes:

Foul whisp’rings are abroad. Unnatural deeds  
Do breed unnatural troubles: infected minds  
To their deaf pillows will discharge their secrets,  
More needs she the divine than the physician. -  
God, God forgive us all! Look after her;  
Remove from her the means of all annoyance,  
And still keep eyes upon her, - So, good night:  
My mind she has mated, and amaz’d my sight,  
I think, but dare not speak  (Muir, 1964: 146).

In the seventeenth and eighteenth centuries the insane were not treated any differently from those regarded as deviant. All socially maladjusted were imprisoned or confined, with the criminal, indigent and insane being housed together. Any moves to separate the three groups were based on moves to protect others from madmen. The insane person was the community scapegoat and excluded so that others were protected. He or she was perceived to have characteristics dangerous to social order and there was no way to restore the insane to a state of reason (Foucault, 1988).

In New Zealand the first publicly funded responses to mental illness were influenced by the traditions of Europe. Since the Middle Ages the insane were identified as deviant and a risk to social order. Governing authorities of European cities developed institutions in which the insane, poor and criminal were confined and excluded from the community (Foucault, 1988). The process of protecting the general population by
excluding and containing those who were socially deviant by reason of their status as bad, mad and indigent was formally recognised in 1656 by the founding of the Hospital General in Paris. This institution was semi-judicial rather than medical. The Hospital General had complete control of the lives of the people it confined. The detainees were required to work to sustain the facility and work became an integral part of their life. Foucault described work as having a valued place in the institutions.

Work also had a moral virtue as idleness was regarded as a sin. Idleness was perceived as a scourge that put the social order at risk and as the insane were least able to work and remedy themselves they were perceived as the greatest threat to social order and therefore needed to be contained (Foucault, 1988: 57).

The confinement of the indigent, criminal and insane served the purpose of protecting the sane, law abiding, hard working citizen and the commercial viability of the city. The institutions of confinement became places of work. Foucault describes the purpose of the institutions of confinement as punitive, corrective and economic (Foucault, 1988).

It was no longer merely a question of confining those out of work, but of giving work to those who had been confined and thus making them contribute to the prosperity of all. The alteration is clear: cheap manpower in periods of full employment and high salaries; and in the periods of unemployment, re-absorption of the idle and social protection against agitation and uprising (Foucault, 1988: 51).

Work was regarded as a moral virtue as idleness was regarded as a sin. Idleness was perceived as a scourge that put social order at risk and as the insane were least able to work and redeem themselves they were perceived as the greatest threat to social order and therefore needed to be contained (Foucault, 1988: 57).

In the Renaissance period the insane were regarded as having animalistic characteristics that imbued them with special knowledge. However by the
seventeenth century these animalistic characteristics were regarded as dangerous and therefore the insane needed to be restrained and confined. Foucault states that the insane were the subject of public curiosity and inhuman treatment. In 1815 a report to the House of Commons stated that Bethlehem Asylum had raised four hundred pounds during the year by public viewings. At a cost of a penny a viewing this meant there were ninety six thousand viewings. The most seriously disturbed people were chained up and managed as though they were wild animals.

This model of animality prevailed in the asylums and gave them their cage like aspect, their look of the menagerie (Foucault, 1988: 72).

The conditions of confinement, especially for those indigent by reason of insanity, were a source of concern. This led to movements to reform the conditions of confinement and management. In the late eighteenth century the reform movement generated models of best practice. An example was the Retreat, an asylum supported by the Quaker philanthropist William Tuke. The reforms advocated less use of restraint and prohibition of violent treatments such as ducking patients in cold water. The conditions in model asylums were based on creating a therapeutic environment that provided good living conditions with fresh air, outdoor work, a generous diet, activities like reading and comforts such as warm baths (Bloomfield, 1979).

The asylums became places of medical intervention and oversight, formalised in 1774 by the Act for Regulating Madhouses.

[The act] attempted to put some control on these establishments by requiring medical certificates for patients (Bloomfield, 1979: 2).

Bucknill, a physician writing in 1858 about ‘Lunacy Law Reform’ said that:

I affirm that the conditions of patients, even in the worst managed private asylums, is in every way superior for their present comfort and well-being, and for their prospect of recovery, to the insane who are scattered over the country as single patients (Scull, 1996: 187).
In the nineteenth century there was a significant rise in the number of patients who were confined in asylums. This population growth was caused by the relocation of the mentally disordered from the family and the poorhouse to the asylum (Shorter, 1997). Other factors that influenced the rise in the asylum population were ones of social change.

Thus one component of the rise in asylum admissions was lessened family willingness to tolerate mental illness. Psychiatric illness once treated in the family now became assigned to the Asylum (Shorter, 1997: 51).

The separation of the mentally disordered person was based on the European belief that it was protective for the community and therapeutic for the patient.

It was the notion that institutions themselves could be made curative, that confinement in them, rather than merely removing a nuisance from a vexed family or the aggrieved village elders, could make the patient better (Shorter, 1997: 8).

Two aspects of life in the asylum were regarded as therapeutic.

The setting itself with its orderly routines and communal spirit, and the doctor-patient relationship. ... A particular form of this relationship was often called ‘moral therapy’ (Shorter, 1997: 18).

The tensions that marked the development of the asylums in Europe were present in New Zealand. In the early years of European settlement the provision of services was constrained by the small population and reliance on public funding. As in Europe people were initially confined together whether they were insane, indigent or criminal.
THE NEW ZEALAND MODEL

Early Colonial Responses
In 1850 Governor Grey authorised the spending of two hundred and fifty pounds from Dunedin Customs’ funds to build a hospital that was completed in 1851. The first three patients were psychiatric cases (Blake-Palmer, 1956). The more severely disturbed persons were confined in gaol. The early themes in mental health were about security and protection of the sane part of the population rather than treatment of the mentally ill patient (Bloomfield, 1979). One of the first specialised facilities for the insane was an asylum built by the Otago Provincial Council in 1864.

In these early years it was considered that the causes of mental illness were moral and environmental issues (Brunton, 1972). The asylums were based on the best humane European traditions where

The abolition of restraint was accompanied by a threefold activation programme, manual work, religious instruction and recreation enough to hold the attention of patients and divert their deluded thoughts. By moral methods such as regular habits, cleanliness, industry and obedience, it was hoped to restore the patient’s reason (Brunton, 1972: 7).

Asylums were envisaged to be therapeutic communities that would bring order and restoration to the patient’s life. This hope however was not fulfilled and asylums were soon overcrowded. They because places of containment, isolation and despair (Bloomfield, 1979). It was anticipated that in providing proper conditions the asylum would ensure a sixty per cent recovery rate and enable people to return to ordinary community living. The high admission rate was influenced by New Zealand’s high proportion of single men who had no family connection and support (Brunton, 2001). The Superintendent of the Dunedin Asylum also identified that people who had a weak intellect, problem behaviour or some peculiarity that would generally pass unnoticed in Britain, were sent to the asylum because they drew attention to themselves in the small communities of New Zealand. The Superintendent also referred to the practice of families shipping out to New Zealand family members who had a history of previous admissions to asylum care and treatment. Low rates of
recovery were associated with the overwhelming numbers of patients and the lack of resources to do anything other than provide humane containment (Brunton, 1972; Bloomfield, 1979; Fennell, 1981; Sainsbury, 1946). New Zealand did not have wealthy philanthropists capable of or interested in endowing asylums so services were dependent on the provincial and central governments (Brunton, 2001).

Changes occurred only as a result of the influences of new treatment options, overseas trends, public opinion, politic ideology and economic circumstances.

**Founding principles**

New Zealand built its mental health services on three foundational policies:

- Institutional care of the asylum was based on the concept that this provided progressive and humane treatment for the moral management of people afflicted by thoughts and behaviours of unreason.
- There was a separate service based on the recognition that mental disorder was different from other diseases and social problems. This policy generated separate mental health legislation, separate facilities, separate administration and distinct procedures of admission and discharge from the service.
- Government management of asylums was based on there being no other way of providing for the needs of the mentally disordered. This made the services vulnerable to social, economic and political forces that impacted on provincial and central governments (Brunton, 2001).

The development of the mental health system was constrained by difficult choices. The new colony had only government resources, and public and political views required caution, uniformity, cost control and containment (Brunton, 2001).

The asylums were based on the principles of separation, public provision and a Victorian concept of moral management (Brunton, 2001). Asylums were isolated from main centres and they provided a basic environment that was directed by staff intent on creating an ordered world that emphasised physical and mental hygiene (Brookes, 1990). This isolation and the view of the patient as a burden and security
risk restricted the amount of contact with family. The attitude of staff, that family and community were potential sources of contamination to the physical, mental and moral well-being of the patient, also limited contact of the patient with family and community (Brookes, 1990; Bloomfield, 1979; Brunton, 1972).

The 1911 Mental Health Act signalled a move to more open facilities. Voluntary admission became possible and terms such as ‘lunatic’ and ‘asylum’ were dropped and replaced by language that was hospital orientated (Brunton, 1972). However, control still lay firmly in the hands of the central government Department of Health and the Medical Superintendent. Brunton describes the mental health services of the 1930s and 1940s as:

> [E]ssentially a club ruled by an authoritarian Director-General. Superintendents were medicalised barons controlling nursing staff who already had their own hierarchical organisation and protocol (Brunton, 1972: 22).

**Protection of privilege**

Voices of dissent against the uniformity of large institutions that were centrally controlled were becoming organised. In 1946 Sainsbury, on behalf of The Mental Health Reform Association of Auckland, formally petitioned the government, proposing that each community had a local small-scale mental health facility. These facilities would be part of the local community under the control of local boards, as happened for other publicly funded health services. Sainsbury believed that the only way to break the cycle of misery and low rates of recovery was to end control by staff and the Department of Mental Hygiene (Sainsbury, 1946). The Mental Health Reform Association believed that family, friends and regular contact with the community were essential to recovery.

The Minister of Health dismissed the proposal of the Auckland Mental Reform Association for the establishment of locally controlled, recovery-focussed facilities as impractical (Sainsbury, 1946).
However changes in medical and psychological intervention led to optimism that greater numbers of patients would recover. The dominant discourse remained that of the medical profession but movements were beginning to enable the voices of patients and families to be heard. Rudimentary services that established links between the hospital, community, staff, patients and family were created.

By 1948 four psychiatric social workers were attached to psychiatric hospitals. They visited homes to provide support for families, acted as a link between hospital and home, investigated patients' backgrounds, and offered support upon discharge (Grant, 2001: 236).

In the late 1950s the commitment to the three foundational principles of institutional care, separate administration and state provision were questioned more frequently and the first steps towards de-institutionalisation were considered. In the post war decade of 1945–1955 there was a significant gap between the optimistic rhetoric and the reality of the experience of most patients and their families (Grant, 2001). However the medical professionals, families and the public still maintained a separation between their world and the world of those labelled as psychiatric patients.

Gradual steps were taken to trial alternatives to the large rurally located base psychiatric hospitals. By 1948 there were twelve small treatment units associated with general public hospitals. In addition the medical staff of psychiatric hospitals began to conduct outpatient clinics in the larger towns and cities associated with the base psychiatric hospitals.

Gradual change
Fourteen years after the Department of Health had dismissed the demands of Sainsbury as impractical, it incorporated his proposal into its policy review. The 1960 Department of Health review wanted mental health services to be managed the same as other public hospital services with no more development of base psychiatric hospitals (Health, 1960).

During the 1960s there were moves to enable closer involvement of family and community, with hospitals becoming more open to accepting contact from community
groups. Psychiatrists provided mental health education to general practitioners and the public. The Mental Health Amendment Act of 1961 made provision for day wards in general hospitals and the Board of Health made policy recommendations supporting the development of outpatient clinics, domiciliary services and specialist child psychiatry services (Kavanagh, 2001; Health, 1960). However, the involvement was still controlled by staff who maintained the position of expert. For example an information pamphlet from this time given to family and friends identified their role as an aid to staff and a source of detailed history to be used in the patient’s intervention. The family was reassured that its family member would not be made worse by contact with other patients. In fact patients could be comforted to know that other patients were worse off than them. Thus the dominant position of the staff was reinforced (Hospital, 1969).

A turning point
In 1972 the Department of Health transferred responsibility for psychiatric facilities to local hospital boards. This signified a departure from the three founding policies of institutional care, separate administration and state provision. Over the next few years reports and investigations such as the Jeffrey and Booth survey moved mental health services away from these policies. They identified that a large proportion of patients domiciled in base psychiatric hospitals were capable of living in the community, provided adequate accommodation, support and purposeful activity were provided (Walker, 1982).

De-institutionalisation
During the 1970s and 1980s the process of integrating mental health services into the community imposed burdens and concerns as well as opportunities for contact between the patient and his or her family. Families reported that they had financial, emotional and practical burdens associated with their family member’s discharge from hospital and that services in the community did not adequately meet these needs. The negative consequences of de-institutionalisation for some family were stress, disruptive behaviour and relationships, financial cost and social isolation that resulted from providing the patient with care and support. Positive consequences experienced were the strengthening of family relationships, opportunity for involvement in decision-making and participation in the patient’s recovery (Tilbury, 2002;
Muhlbauer, 2002; Kuipers, 1990; Kavanagh, 2001; Dixon, 2000; Cashwell, 2000; Bernheim, 1985).

There was intense public debate about the movement of patients into the community. The public were critical of changes and protested about the risks associated with integrating mentally ill patients into their neighbourhood. Debate occurred about issues of safety and the best way of meeting the needs of patient, family and the public (Times, 1989). Attempts to reassure the public began to focus attention on the right of the patient to be regarded as a citizen with full rights, including the right to be different, respected and not to need paternalistic protection. Professor Michael Cooper, chairperson of the Otago Area Health Board, said:

[J]ust because a released psychiatric patient did things that were considered abnormal to ordinary people, it did not necessarily mean that they were not coping (Kavanagh, 2001: 181).

He assured people that:

[M]oving patients into the community is not a cost cutting measure, and that community care was designed to give patients liberty and dignity (Kavanagh, 2001: 181).

Nevertheless public pressure to maintain the separation between the sane and the insane persisted. In 1992 the politician Dr Michael Cullen described the public reluctance to accept mental health services as ‘nimbyism’ ‘not in my back yard’ (Brunton, 2001: 412).

Debate and attempts at reassurance were features of the 1970s and 1980s associated with the dismantling of the three foundational principles of New Zealand’s publicly funded mental health services.

1980s - the decade of inquiry
The Government responded to public anxiety and professional dissatisfaction about the issues of safety and lack of support services by setting up commissions of inquiry.
The 1988 inquiry chaired by Judge Ken Mason was a response to the death of a patient and the adequacy of services. It brought the issues of safety and adequacy of community services into clear relief and was the impetus for significant service development. The report recommended the establishment of regional forensic services that would best manage the issues of assessing and treating the mental health needs of those who were also offenders (Mason, 1988). This recommendation was promptly implemented and funding was tagged specifically for the establishment and running of regional forensic services.

The 1988 report and the 1985 survey of the Mental Health Foundation both concluded that:

Nowhere in New Zealand has the development of community services kept pace with the growing needs that have resulted from de-institutionalisation (Mason, 1988: 147).

1990s - the policy decade
The 1990s was a period of intense policy and service development with institutional care services being rapidly dismantled. However services in the community were not adequate to meet the expectations of the public, professionals, patients and advocacy groups. Reviews acknowledged that community services were inadequate and that there were significant service gaps for specific at-risk groups such as children and young people, substance users, Maori and Pacific people and patients experiencing their first episode of psychosis. ‘Looking Forward’ was the first strategic planning document developed to respond to these issues (Mason, 1996; Health, 1994).

Looking Forward
The 1994 Looking Forward policy document marked significant change from the foundational principles that Brunton, (2001) identified. The goals were:

To decrease the prevalence of mental illness .... within the community and to reduce the impact of mental disorders on consumers, their families, care givers, and the general community (Health, 1994: 9).
Looking Forward set out the key strategic direction of the mental health service so that the two broad goals of reducing the prevalence and impact of mental illness would be attained. The mental health service responses that were to give shape to this strategy were based on principles of:

- Community based services
- Participation in society
- Protection of personal rights
- Quality of life for consumers
- Quality of service provision
- Increase in participation of Maori
- Responsiveness to the needs of consumers and family
- Empowerment of the individual and the family
- Provision for addressing alcohol and drug concerns
- Cost effectiveness and value for money
- Equity of service provision (Health, 1994).

These principles were developed from issues identified in service reviews, surveys of needs and Committees of Inquiry, such as the 1985 survey of the Mental Health Foundation and the 1988 Committee of Inquiry chaired by Judge Mason (Mason, 1988). The consensus of these reports was that support services required to meet the needs of patients discharged from institutional care were not sufficiently available. Service provision was recognised as being very under-resourced in particular parts of New Zealand and for specific groups of citizens who had high levels of unmet need (Mason, 1988).

The policy aims identified in the Looking Forward document and the issues raised by the 1996 Mason Report were developed into the 1998 Blueprint action plan. The Blueprint focussed on the provision of community rather than institutional care and followed a Recovery Approach that empowered consumers. It advocated a comprehensive range of services that responded to needs so that access and relevance were improved for targeted groups and under-resourced locations (Commission, 1998).
The catalyst

The 1996 Mason Report headed by Judge Mason was asked to examine the recommendations of recent inquiries and consider relevant international reports that would advance the goals identified in the Looking Forward strategy document. The report paid attention to issues of privacy, rights of patients and family as contributors to the care and treatment plan. Special attention was paid to issues relevant to Maori, service co-ordination and the impact of drugs and alcohol on mental disorders. It provided opportunity for expressions of concern and hope that were to shape the implementations of the Mental Health Strategy (Mason, 1996).

The concerns were taken seriously and the Mason Report became the impetus for the creation of The Mental Health Commission which had the key task of ensuring the implementation of the mental health strategy as outlined in Looking Forward (Pearson, 2001).

Rights enshrined in law

Within the Mason Report (1996) the voice of the consumer rights' movement was clearly heard. The Ministry of Health described the consumer rights' movement as a powerful voice for reform and used a quote from Valentine and Capponi (1989) to explain the phenomena:

Much as in the civil rights' and women's movements, consumers of mental health services are exercising a new found consciousness, a new sense of personal dignity arising from recognition of their basic rights and the opportunity to participate in decisions that affect them (Health, 2005: 2).

Advocacy groups for marginalized citizens were given recognition for the first time. Codes of rights and statutes were formulated so that the rights of all citizens were protected and breaches of rights could be remedied by legal sanctions. The advocacy groups were able to highlight the need for service providers to change the ways of delivering interventions. The aim was to make services responsive to the needs of consumers and to ensure consultation was no longer a token gesture. Full participation
was required and decision-making was shared and subject to review and scrutiny. The legal framework consisted of:

- Code of Health and Disability Services Consumers’ Rights (1996)
- The Privacy Act (1993)
- The Health Information Privacy Code (1994)
- Mental Health (Compulsory Assessment and Treatment) Act (1992)

In the next few years additional codes and standards were defined so that all parties had formal measures by which interventions could be judged, including:

- The Mental Health Standards (1997)

The Mental Health Commission began its work in September 1996 and was established as a separate crown entity in 1998 and given the functions:

- To monitor and report to Government on the performance of the Ministry of Health and District Health Boards in terms of implementation of the Government’s National Mental Health Strategy.
- To work with the mental health sector to promote a better understanding by the public of mental illness and to eliminate discrimination.
- To strengthen the mental health workforce (Commission, 2005).

**Moving Forward**

The 1997 Moving Forward document marked the next phase in refocusing mental health services. It was an extension of the Looking Forward policy paper. The Minister of Health defined his intention:

What we have to do now is stop refining objectives and strategies and speed up action (Health, 1997: 3).
This paper confirmed the principles of the Looking Forward document and added the following principles:

- Services that enabled individuals, families and communities to increase their control in order to improve mental health and well-being.
- Creation of supportive social environments.
- Working intersectorally (Health, 1997).

There was a reinforcement of the desire to involve families and caregivers, with the funder/purchaser monitoring to ensure that they had processes for involving and informing caregivers (Health, 1997).

In addition the annual report of the Mental Health Commission for the 2004 year confirmed that consumer and family had a means of participation.

Consumer and family advisor positions are now firmly established and the importance of consumer and family participation at all levels of mental health policy, planning and delivery is widely accepted (Commission, 2004: 5-6).

The non-government organisation sector became a significant provider of community support services, managing contracts for services such as purposeful activity, supported living options, supported employment, respite care, family support projects and community workers who facilitated the patient's participation in ordinary activities of living. A number of these organisations actively recruited consumers to be part of their paid work force (Commission, 2004).

The Government maintained control and accountability through the Ministry of Health that funded the District Health Boards. These Boards were responsible for purchasing services from the provider arm of public health services and non-government organisations. The Ministry of Health had to sign off the annual business plan, including targets for service development, cf each District Health Board before that Board received its annual financial allocation (Health, 2004).
The Mental Health Commission had specific roles of monitoring the progress of the implementation of the Blueprint and of advising parliament on the state of mental health services in New Zealand. It gave an annual report to the Minister of Health that provided accountability of financial and staff resources, service availability and the quality of mental health services (Commission, 2004).

Change agent

The Mental Health Commission was given the responsibility for developing the means of implementing the objectives of the policy documents Looking Forward and Moving Forward. It set about this task by developing the Like Minds Project, a public education programme designed to eliminate stigma and discrimination. It informed the public that mental illness impacts on the lives of ordinary and high profile citizens alike and that attitudes of stigma and discrimination limit the lives of individuals and the community. Further, it promoted non-discriminatory attitudes that enable those with mental illness to participate fully in society. The Mental Health Commission’s education and development project aimed to highlight the principles of the Recovery Approach.

BLUEPRINT – THE MAP OF THE MENTAL HEALTH COMMISSION

In 1998 a new set of policy principles was established with the adoption of the Blueprint centred on the Recovery Approach.

Historically, mental health services have failed to use a Recovery Approach. Recovery could never take place in an environment where people are isolated from the community, where power is used to coerce people and deny them choices, and where people with mental illness are expected to never get better (Commission, 1998: 1).

The Mental Health Commission saw the Recovery Approach of the Blueprint as the way to implement strategies outlined in the policy documents of 1994 and 1996.

The focus of the Blueprint is on the Recovery Approach to service delivery. This approach is consistent with the guiding principles of the
strategy, which states that services must empower consumers, assure their rights, get the best outcomes, increase their control, their mental health and well-being, and enable them to fully participate in society. This focus on recovery reflects a shift in thinking which is happening throughout the sector (Commission, 1998: vii)

The Blueprint defined recovery as:

[H]appening when people can live well in the presence or absence of their 'mental illness. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them (Commission, 1998: 1).

Mary O'Hagan, a Mental Health Commissioner, described the principles of the Recovery Approach as relevant for New Zealand as they were fully compatible with the principles of the Treaty of Waitangi (O'Hagan, 2001). These principles are:

- Partnership
- Participation
- Protection

The Recovery Approach was seen to be more compatible with community than institution-based services. However the Recovery Approach was not a model of service delivery but could be applied to any model of service delivery. The Blueprint and Recovery Approach valued partnership relationships including those between family, patient and staff. The Blueprint valued the involvement of family and considered family an integral ingredient in recovery.

Interventions that only include the individual with mental illness are making only a partial response and therefore can only ever be partially effective. Fully effective interventions acknowledge and access the needs of everyone affected by the illness (Commission, 1998: 9).
The Blueprint and the inclusion of family

The Blueprint defined that a Recovery Approach to intervention needed to include family and should:

- Attend to the emotional, educational, social and clinical needs of the whole family
- Access the strengths, problems and goals of the person with a mental illness and key family members.
- Formulate a plan that co-ordinates all elements of a person's treatment and support so that all involved, inside and outside the family, are working towards the same goals in a collaborative and supportive relationship.
- Provide the family with the skills and strategies required to cope with the illness, to facilitate recovery and to maintain good relationships within the family.
- Provide the person with the mental illness and key family members with information about the illness and its treatment (Commission, 1998: 9-10).

The Mental Health Commission had seventeen guiding principles, three of which encouraged services to engage in active partnership with family. The guiding principles were a restatement of the principles of the Moving Forward strategy document. These principles were that services:

- Empower individual consumers and their families and caregivers
- Contribute to the best possible outcomes for consumers and their families
- Enable individuals and families to increase their control over and improve their mental health and well-being (Commission, 1998: 14-15)
Blueprint made real

The Mental Health Commission set about implementing the National Mental Health Strategy through provision of educational material, policy guidance, identifying best practice, influencing the allocation of funding, setting priorities for service and workforce development and auditing and monitoring the programmes of service providers. The Mental Health Commission stated that its vision would be achieved by ensuring that:

- The Recovery Approach is standard practice in all services.
- ‘Best practices’ are identified and routinely incorporated in all services.
- The national mental health standards are achieved in all services.
- Funding and contracting processes are in place which promote comprehensive and integrated services and collaborative approaches.
- Service users and mental health workers understand health consumers’ rights and are partners in all decision making that affects service users (Commission, 1998: 2).

Reviews of progress

The Mental Health Commission review of progress to June 1999 reported that partnerships were a key issue in making real the Recovery Approach and in improving the responsiveness of mental health services to families and caregivers. They acknowledged that:

Progress is being made, with increasing consultation with families and caregivers. There is still some way to go, particularly in relation to treatment processes (Commission, 1999: 110).

It reported that it was implementing the Blueprint by maintaining pressure on the government to provide adequate funding for service providers to recruit the desired level of staff and to develop the range of services advocated in the Blueprint.
In the following report the Commission acknowledged that in the years 1999 and 2000 there had been:

- a significant growth in expenditure in the mental health sector
- real growth in services provided and the number of staff employed
- greater involvement of families in services
- piloting of a family advisory project where two part-time workers concentrated on implementing the National Mental Health Standards
- collaboration with the Australian and New Zealand College of Psychiatrists, which produced the publication Involving Families – Guidance Notes (Commission, 2001c).

However the report of the Mental Health Commission for the years 2001 and 2002 was more subdued about the progress of implementing the Blueprint (Commission, 2003).

It acknowledged the limitations in its monitoring and reporting, signalling changes in the way it implemented the vision of the National Mental Health Strategy. The concern about reporting is described:

This Report of Progress continues its focus on monitoring bed numbers and funded F.T.E. positions. Increasingly the reliance on this information as a measure of progress is being challenged as not keeping pace with the shifts in service philosophy and practice (Commission, 2003: 3).

The report made brief comments about the involvement of family, reporting that almost all the District Health Boards now had paid family advisors who presented a family perspective on issues of service planning, audit, evaluation of services and staff training. These family advisors were actively involved in assisting with policy development, reflecting the requirement of the National Mental Health Standards that family and consumers should be participants in shaping services. The report noted some District Health Boards were failing families, not meeting the legal requirements
of the Mental Health Act and not supporting families as the Blueprint prescribed. The report acknowledged a tragedy where staff failed to consult with the family of a patient who was committed under the Mental Health Act. The report confirmed that:

Very few DHBs (District Health Boards) offered support or services to families under stress (Commission, 2003: 42).

The annual Mental Health Commission’s report to Parliament dated 30 June 2004 emphasised its work to enable inclusion and participation of consumers into society. The Like Minds programme and the intersectoral work of the Ministry of Social Development and Housing New Zealand had the goal of consumers participating in paid employment and living in affordable accommodation. Many families, contrary to the vision of the Mental Health Commission, remained peripheral to mental health interventions and had no specific plans focused on the family (Commission, 2004).

Future of the Mental Health Commission
The Mental Health Commission was established as a Crown entity in 1998 and was expected to complete its work in three years. Several extensions of time have been given. In June 2005 it defined a statement of intent for the period 2005 – 2006. The goals are to:

- Report on progress since the Mason Report and describe what is required for the decade ahead
- Describe a recovery-orientated paradigm which consists of three parts:
  1. Describe recovery-orientated services
  2. Make substantial progress on a monitoring framework that will replace the Blueprint. This is due for completion in June 2006.

In a statement of intent in 2001 the Mental Health Commission said that by 2004 it wanted to see:
Providers, funders and policy makers who are committed to developing services that are innovative, accountable and responsive, and that promote recovery (Commission, 2001b: 8).

Obviously such an evolving service can never be easily pinned down to a definitive timetable.

The Mental Health Commission – partnerships and families

The Mental Health Commission put effort into publishing information about the Recovery Approach. A theme in these publications is that recovery is linked to partnerships. In the 2001 publication ‘Awhi, Tautoko, Aroha’ which celebrated the recovery focused work of mental health workers, David Lui wrote:

Recovery, in my view, is about pathways and partnerships. Relationships provide pathways for people to recover (Commission, 2001a: 6).

Many contributors wrote about the place of dialogue and multiple sources of knowledge coming together to develop a recovery response. Linda Simpson, a consumer advisor, said:

Mental illness and mental health are not precise sciences. Wouldn't it be so easy if they were, because it's about people. Usually there is no one expert or no one way, but with dialogue and a will, good things do happen. I think that the best individual outcomes, the most innovative and responsive services happen, when we acknowledge and understand each other's realities and work together (Commission, 2001a: 14).

The Mason Report had identified the rightful place of family as a participant in intervention especially when the family was involved as a care provider. The rights of the family were made explicit in the 1999 Code of Family Rights published by the Schizophrenia Fellowship of New Zealand. This group advocated for a family-centred approach to care and treatment. This involved partnership where the family was informed about goals, needs and plans. The group was committed to help for
families because of the burden associated with caring for a family member with mental illness (Supporting Families, 1999).

The Mental Health Commission worked to implement the National Mental Health Standards. Only standard ten referred specifically to family participation and that was in planning, implementation and evaluation of services. Although the standards were focussed on the needs of the service user, they made reference to family as being involved at the point of entry to services and to enabling the family to be part of the patient’s discharge and community care plans (Standards, 2001).

The Mental Health Commission worked in collaboration with the Australian and New Zealand College of Psychiatrists to publish a booklet Involving Families. That publication encouraged staff to value partnerships and outlined practical ways to create and sustain partnerships with families. It aimed to facilitate family involvement in the processes of care, assessment and treatment. In addition the guide recognised that the principles of partnership meant that staff worked alongside, rather than did for or did to, the patient or family (Commission, 1998).

Failure of partnership with family
The Mental Health Commission in its report of 2001 and 2002 amongst others made reference to the Burton Inquiry by the Health and Disability Commissioner who found that the Southland District Health Board and its mental health service failed the patient and family. The rights breached included the rights to services that provide reasonable care and skill, that comply with legal, professional and ethical standards, and the right to co-operation amongst providers so that quality and continuity of service are assured (Paterson, 2002). The services provided did not meet the vision of the Blueprint and did not embrace the Recovery Approach that requires active partnerships that are responsive to and inclusive of the needs of all parties.

The Health and Disability Commissioner identified significant discrepancies between the policy and practices of the Southland District Health Board’s mental health services. The Code of Patient Rights was breached and standard ten of the National Mental Health Standards was not adhered to. This standard states:
Families and carers are involved in the planning, implementation and evaluation of the mental health service (Paterson, 2002: 52).

The Commissioner stated that failure to take into account relevant knowledge and failure to make and sustain appropriate partnerships led to incompetent practice and fatal errors in decision-making. Mr Paterson summarised:

There is however little evidence that the inpatient team responded positively to this clear evidence of a family who were interested in the welfare of Mr. Burton. The family was provided with insufficient information for them to participate meaningfully in decisions about plans (Paterson, 2002: 188).

The Health and Disability Commissioner noted a failure to implement policies rather than an absence of policies.

In particular, the most important deficits are found in implementation of policies in regard to clinical assessment and treatment planning, risk assessment, discharge planning, and documentation. There are deficits in operation of policies for consumer and carer participation in services, and in relation to incident reporting and review (Paterson, 2002: 209).

Recovery and partnerships
The Mental Health Commission declared that the delivery of services could be effective only when services were based on the Recovery Approach. However few publications detailed how to develop and sustain the relationships critical to the recovery process. The Mental Health Commission collaborated with the Australian and New Zealand College of Psychiatrists to publish guidance notes for working with families. This publication, as well as the 1999 publication of the World Fellowship of Schizophrenia entitled ‘The Principles of Family Work’, described the principles relevant to working in partnership with family but did not outline the issues in detail. The Mental Health Commission in its Statement of Intent (2005) recognised that one of the risks for the mental health service was that the Recovery Approach would not
be adequately understood and therefore not become the driving force for service delivery (Commission, 2005).

Important ingredients of a sustainable Recovery Approach would be the development of clinicians’ skills and the establishment of service delivery contracts where the Recovery Approach is standard practice. Whiteside offers a New Zealand example that points the way for training of clinical staff as partners in the Recovery Approach.

If we are going to work successfully with families, we must develop a common goal of acting in the best interest of clients. If we listen to families, we have a better chance of having them hear us. ... If we are going to include families effectively in assessment and treatment, we need to address their issues as well as our own [clinicians]. In that way, everyone is working towards a common goal rather than to their own agendas (Whiteside, 2003: 14).

After the Mental Health Commission
The Ministry of Health is developing a plan that will succeed the Blueprint. This New Zealand Mental Health and Addiction Plan is: ‘Te Tahu’u: Improving Mental Health. It outlines government policy and priorities for mental health and addiction services for the years 2005 to 2015 and provides an overall direction for investment in mental health and addiction services. It builds on the current mental health strategy contained in policy documents of Looking Forward, Moving Forward and the Blueprint (Health, 2005). This document maintains the focus on a Recovery Approach and puts emphasis on primary level services that are responsive to users’ needs. The strategy values health promotion and prevention models of service delivery. There is commitment to broader services to Maori, addiction services and the need to work inter-sectorally.

Current model of mental health service
The current response to mental illness is based on the concept of partnership relationships. The Mental Health Commission that has oversight of service provision uses the Blueprint policy document and its Recovery Approach as the gold standard. The Recovery Approach is based on concepts of inclusion, partnership and
participation (Commission, 1998). The policy documents from the Ministry of Health (Health, 1994; Health, 1997; Standards, 2001) highlight the benefit of including and the need to include family and patient in the processes of intervention, evaluation and shaping the work of service providers. This is based on the belief that patient and family desire to be included and work in partnership as this enhances the meeting of needs and provides positive outcomes for quality, efficacy, prevention, recovery and cost effectiveness (Health, 1997; Health, 1994; King, 2000; Masters, 2000; Commission, 1999; Commission, 1998; Standards, 2001; Supporting Families, 1999).

Over the last two to three decades the movements that have been influential in the push for partnerships and participation within the community are varied and include:

- Consumer rights’ movement
- Political and economic focus on choice
- Individual and family responsibility
- Reduction of state intervention and public services
- Mental health recovery movement
- Professional pluralism and community care

These movements have shaped services in the post-de-institutionalisation period of the mid 1970s to the mid 1990s (Mason, 1996). The political climate of this period focussed on the principles of a market economy. This political ideology sponsored the movement of responsibility for care and management onto the patient, family and community agencies and endorsed the concept of consumer rights, including the right to choose from competing service providers.

The concept of mental health recovery is a natural outcome of a philosophy that emphasises the growth of personal power. The recovery movement advocated that services should be configured in ways that enabled the people whose lives were impacted by mental disorder, to gain control over their life and participate in their community. The Recovery Approach to mental illness embraced multiple pathways for the management of and recovery from the symptoms of mental disorder. The forces of change of the past two or three decades mark departure from the founding
traditions of New Zealand's mental health services. The founding principles in both Maori and European traditions involved a separation between the affected person and other members of their community.

Conclusion

The response to issues of mental disorder in New Zealand is driven by the changing perception of what is therapeutic, safe and affordable and what is publicly and politically acceptable.

Historically both Maori and European settlers separated the mentally disordered from their community. However they used different pathways to recovery. The Maori tradition placed emphasis on the health and survival of whanau rather than the interests of the individual. The European settler community developed the asylum to separate the mentally disordered person from the community.

The formal mental health services of New Zealand developed the policies of institutional care, separate administration and state funding. These founding policies were in place for over one hundred years until 1972 when the first of these policies changed. In that year mental health services were integrated into the publicly funded general health services so that local hospital boards managed all publicly funded hospital services. Contemporaneously, de-institutionalisation began. Over a twenty-year period the founding policy of institutional care gave way to a service based on maximising community care.

The mid 1980s to mid 1990s was a decade of inquiry into public and professional concerns about the adequacy of de-institutionalisation. Judge Mason’s 1996 report initiated a period of active change and planned development. The Mason Report resulted in the establishment of the Mental Health Commission and the Blueprint for service development.

The aim of the Mental Health Commission is to create a positive environment in which citizens whose lives are influenced by mental health concerns are able to be participating members of their community. The Commission has based its work on the Recovery Approach which values multiple pathways by which inclusion and
participation in society can occur and which advocates for services that are responsive to the issues of all sectors of society. The Blueprint advocated for multiple responses focussed on the needs of youth, adults, elderly, Maori, Pacific and Asian people, the forensic service and substance users.

Dominant political ideologies have shaped the mental health services of New Zealand, beginning with the influence of the colonial power and European models of practice. The expectations of European settlers for an egalitarian society and the limited resources of a sparsely populated and undeveloped country also shaped the practice of New Zealand’s mental health services.

In chapter two literature will be reviewed and models of mental health service provision will be examined. The literature that will be discussed will be the political, public, professional and pragmatic forces that contributed to the development of the mixed models New Zealand has experienced since the establishment of formal services following European settlement.
Chapter Two

LITERATURE REVIEW

Introduction
This chapter reviews literature relevant to the theories that have shaped New Zealand's mental health service. It begins with an examination of the influence of the political grand theories and the impact of these theories at macro, meso and micro levels. Ideology influences the interactions between patient, family, staff, public and the state and influences the authority and manner in which human needs are met and social order is maintained. In this chapter the theories will be discussed in terms of practice models that evolved and how these grand theories are expressed in the clinical practice of intervening staff.

Issues of social order and economics as discussed in chapter one influenced the newly established settler communities in New Zealand. These two factors modified the ideological stance of the colonial government which took the Classical Liberal position that the family and individual had the responsibility for meeting needs.

THEORIES AND MENTAL HEALTH SERVICES IN NEW ZEALAND
In New Zealand the mental health services developed as a reflection of multiple influences, not solely as a social policy response to the predominant political and economic theory of the period. Although the New Zealand mental health services were based on the prevailing European beliefs, the circumstances of a newly founded colony required adaptation. Brunton says that in the period after the provincial governments, the mental health services developed three foundational policies. These policies of institutional care, separate administration and state provision have been discussed in chapter one (Brunton, 2001).

The changes that occurred to these three founding policies were gradual and were frequently associated with a dilemma within the service such as the poor rates of recovery and overcrowding in the asylums.
When problems arose, the core policies were adjusted incrementally in the light of overseas trends, new medical knowledge, changes in the population, social attitudes, political ideology, economic circumstances and government administration (Brunton, 2001: 407).

**Grand Theories**

The grand theories reflect and shape the discourses of their time. The theories shape the discourse by defining who can take part in making statements that develop the discourse.

The political/ideological theories of Classical Liberalism, Industrial Society, Neo Liberalism and the Third Way have exerted influence on the social policies of New Zealand since the beginning of organised European settlement.

**The period of Classical Liberal theory 1840-1935**

Issues of social order and economics influenced the newly established settler communities in New Zealand. These two factors modified the ideological stance of the colonial government which took the Classical Liberal position that the family and individual had responsibility for meeting needs.

Policy directed by Classical Liberal theory reduces the power of the state so that it does not directly intervene in the economy or provide services. The state’s role is limited to creating and maintaining the legal framework in which the economy offers unencumbered choice to citizens. Locke, Hobbes, Mill and Smith founded the principles of Classical Liberal theory in the eighteenth century. The theory is based on the belief that the creation and maintenance of a free market economy enables the forces of supply and demand to form contractual relationships through which expressed human needs will be met (Walker, 1997). These forces maintain a balance that regulates quality, quantity, efficiency and cost effectiveness. The Liberal theory predicts that health services develop in a manner that meets the needs of people. Competing professionals and organisations in the health market will provide the services. In reality the theory has not provided an adequate basis for meeting the needs of the mentally disordered let alone the expectations of the society (Brunton, 2001; Shannon, 1991).
The unique circumstances of the new colony inhibited the market forces of Classical Liberal theory from being fully implemented. Several factors made state intervention inevitable. There was no source of funding apart from those controlled by the colonial governor and the provincial and central governments. The settler population had a high proportion of single adult males who were at greater risk of mental disorder and lacked the alternative source of help, care and support from family.

A high level of state provision of services was established because most European settlers were poor. They came to New Zealand as assisted immigrants and had the expectation that the settlement company would provide an infrastructure that would support a safe and productive life. Money for the settlers was scarce, there were no charity funds and the settlement companies were virtually bankrupt. For most of the nineteenth century the only source of reliable revenue was customs duty which went to the governor and central government (Bassett, 1998).

The circumstances of the new colony resulted in the state being more involved in the provision of services than would be expected for a society whose settlers were familiar with the prevailing ideology of Classical Liberalism.

By 1856 a fairly sizeable bureaucracy was in place throughout the country..... By now many of the institutions and attitudes to government of a century later were falling into place. ... Powerful executives existed both provincially and centrally. They were expected to regulate, assist, police and finance many aspects of the colonial economy (Bassett, 1998: 40).


Services provided are demand driven
As stated earlier the colony of New Zealand developed services for the mentally disordered that were shaped by beliefs that prevailed in Europe. The demand was that the mentally disordered be treated in a humane manner that enabled a cure to be
effected and that the insane be placed under the expert care of a physician and housed in the ordered environment of an asylum. In keeping with Classical Liberal theory the rise of the asylum in England was a reflection of the forces of supply in response to demand from the public, family and the medical profession (Shorter, 1997).

Clinical practice of the nineteenth century reinforced a change in the locale of power. Expert knowledge and decision-making control was vested in the physician and the specialist facility of the asylum rather than in the family and community. Dr Esquirol, a leading advocate of humane and respectful treatment and right thinking, expressed the ideas that influenced the demand for asylums and the changing relationships between the mentally disordered person and their family and community.

Esquirol believed in the salutary effects of ‘isolation’ from the outside world in the institution, and felt that the removal from family and friends would contribute greatly to diverting the patient from the previously unhealthy passions that had ruled his or her life (Shorter, 1997: 13).

Response of the Free Market
The Classical Liberal theory prescribed low-level state intervention that enabled voluntary and commercial sectors to respond to the demand for services. The state provided the legislative framework and services when there was no other source of provision. This minimal service was needed so that social and economic order was maintained.

There was no special provision for the mentally disordered in the first years after the establishment of the colony (McLintock, 1966: 525)\(^1\).

The provincial governments controlled the establishment and maintenance of asylums (Blake-Palmer, 1956). The colonial government made provision for the licensing of asylums in 1868 but it was not until 1882 that the first private asylum of Ashburn Clinic in Dunedin was established. Ashburn Clinic was the only private provider for many decades and struggled to be viable (Brunton, 2001).

\(^1\) Pages 525-526 of the Encyclopaedia of New Zealand were written by and attributed to Dr Blake-Palmer, the Deputy Director, Division of the Department of Health.
The services were minimal and admission to the asylum was through the legal process of committal. The central government, from the time of the abolition of provincial governments in 1876, extracted financial contributions from the patient and family where this was possible (Brunton, 2001).

Weakening of the Classical Liberal model
A low level of state intervention and service provision occurred at least until the end of the provincial government era. The first specialist facilities in Auckland and Wellington were funded by public subscription. The lack of provision from provincial governments and private providers left many mentally disordered people without care and treatment (Brunton, 2001).

In keeping with the Classical Liberal ideology the provincial governments were reluctant to spend local resources on the care of the mentally disordered and service provision was very limited even though there were inspectors who reported on issues of quality and quantity. The power of the inspectors was restricted to the giving of advice (Brunton, 2001).

The attitudes of the colonial settlers that favoured an egalitarian society and abhorred the British institutions associated with the traditional madhouses and workhouses, weakened the likelihood of adoption of service provision that would develop from the Classical Liberal ideology (Brunton, 2001; Bassett, 1998). By the end of the provincial government era the three founding policies of institutional care, separate administration and state provision of the mental health services were formed and became the model of practice. This model of service delivery illustrates the move from the ideological influence of Classical Liberalism towards a service delivery model associated with the social democratic theory of the Industrial Society.

Development from Classical Liberalism
In 1871 a public inquiry into mental health policy and practices concluded that central government was the only body that could address the issues of variable and poor standards in the asylums administered by provincial governments. In 1876 the provincial governments were abolished and the involvement of central government
became more influential. Centralisation was made possible because of the development of physical and organisational infrastructure (Brunton, 2001).

The mental health services developed the characteristics of a bureaucratic service that is associated with Industrial Society theory. The development and management of the mental health service was left in the hands of the central government bureaucracy (Brunton, 2001; Bloomfield, 1979; Brunton, 1972; Blake-Palmer, 1956).

Throughout the period of Classical Liberalism the service for the mentally disordered was becoming increasingly centrally planned and the state, through the bureaucracy of the Lunatic Asylum Department, had a controlling voice in policy and provision. The state rather than the market responded to the needs and issues raised by the mentally unwell.

**The organisation of a mental health service under Classical Liberal theory**

In the early years of European settlement the colonial government did not directly provide mental health services. Provincial governments established a small number of beds in the general hospitals and asylums. The level of service provided was true to Classical Liberal ideology in that the state should only be involved at a minimal level (Bloomfield, 1979).

Variability of provision is characteristic of Classical Liberalism. While variation allows alternatives to develop, the problem in early New Zealand was that there was little provision other than from the provincial governments and their services were of a low standard. This resulted in poor rates of recovery and a lack of public support (Bloomfield, 1979; Blake-Palmer, 1956). The risk associated with variable standards was recognised by the Otago Provincial Government which responded by adopting rigorous rules for staff of the Dunedin asylum. These rules, known as the ‘obligation,’ gave the employer control of employment relationships, a characteristic of Classical Liberal theory (Blake-Palmer, 1956).

**Clinical relationships**

The relationships in the Classical Liberal period were based on contracts aimed at ensuring social order. The state used its authority to support these contractual
relationships (Walker, 1997). The asylum was the focus of how European and New Zealand communities managed the issues raised by mentally disordered persons. The family was no longer seen as the patient’s protector. Protection was perceived as being achieved by placing the mentally disordered family member into the therapeutic care of the asylum (Scull, 1996).

In 1774 England passed legislation that endorsed the central role of the physician and this influence was adopted in New Zealand (Bloomfield, 1979). The asylum was seen as providing a healing environment by giving order to the person’s chaos. The relationship between staff and the contained person was believed to be therapeutic and healing. These two beliefs created demand for services and shaped relationships during this period. These beliefs gave staff power as staff knowledge was recognised as being superior and gave hope for the regaining of sanity (Shorter, 1997; Scull, 1996).

Family
In the Classical Liberal period there was a significant increase in the number of people who moved into asylum care. Shorter believes that this was due to transfer from family and poorhouse care rather than an increase in the number of mentally disordered persons. This was partly due to a change in the nature of family relationships. The family increasingly became an emotional unit, so disruptive relatives at home became less intolerable (Shorter, 1997).

The providers of asylums supported the concept that families should give over care and management to the physician and staff of the asylum. This clinical justification endorsed the growth of the market for the care of the mentally ill.

Indeed it was a kind of isolation cure that Battie [physician] recommended, in which the patient was to receive no visits from friends (or spectators) and to be attended not by his own servants but by the asylum orderlies (Shorter, 1997: 10).

Two aspects of life in an asylum were regarded as therapeutic - orderly routines and communal spirit, and the doctor-patient relationship (Shorter, 1997).
The building of knowledge and decision-making in Classical Liberalism

The theory of Classical Liberalism is that a contract for service is between equal parties. However the contractual relationships positioned the medical profession as the expert. They held the knowledge on which the services were founded and this gave the medical profession a dominant role in power relationships between patient, family and staff. The claim of Classical Liberal theory that all parties to the contract are equal and willing participants does not recognise that the relationship is based on the dysfunction and incapacity of one of the parties.

Another source of imbalance was that most service receivers or their family could not pay for the service. The only source of funding was the public purse of provincial or central government. The purchasers of the service were not the direct users and they wanted to provide service at the least cost. The funders set the rules that defined the means of access to and discharge from the asylum. This commitment to the least cost resulted in services that were minimal and did not fulfil the initial hoped for levels of recovery. Failure to meet expectations reduced support. The Classical Liberal theory assumption that needs would be met and satisfaction provided to the greatest number of people was not fulfilled.

The marketplace ideology of Classical Liberalism was tempered by public opinion and social mores which during the early colonial years were shaped by egalitarian ideals and the demanding realities of a new society (Fennell, 1981).

**The period of Industrial Society (Institutional) theory 1935-1984**

This theory views the free market as being erratic in its capacity to deliver equitable services and to make efficient use of resources. Therefore a planned approach to the economy and political decision-making is required so that the excesses and inadequacies of the free market are avoided. The principal economic theorists of Industrial Society theory are Keynes and Galbraith (Shannon, 1991). This theoretical model provides the state, through its elected representatives, with the active role of balancing tensions between the interests of experts and the community.

The balancing of forces and interests can only be done by the state in the longer term greater good of everyone (Shannon, 1991: 51).
Industrial society theory advocated planning and consultation between experts and democratically elected representatives to ensure that resources were effectively used for the benefit of all. Under this model, health services were to be developed by experts who were responsive to the needs of the community and its democratically elected political representatives (Shannon, 1991). This theory provided the theoretical underpinning of the welfare state with its emphasis on the role of the state as a service planner, funder and provider.

The Classical Liberal period ended in 1935 when Michael Joseph Savage formed the first Labour government. The dominant political and economic theory then became Institutional or Industrial Society theory. This theory views society as developing services and systems by actively planned choice rather than by a balance of forces of supply and demand. In Institutional theory society is driven by the ideas of people. Where differences occur the conflict of interest is settled by the ability to impose ideas on others (Shannon, 1991).

The theory poses a constant tension between the two systems embodied in the struggle between dominant political ideas (expressed through elected politicians) and the requirements of economic efficiency and progress (expressed through experts or technicians) (Shannon, 1991: 50).

Shannon recognises that the social service needs of people do not get met when social policy is based on the Classical Liberal principles of supply and demand and personal choice. Classical Liberal theory exposed the society to economic instability which proved not to be self correcting nor able to deliver the majority of citizens with choice and the assurance of the promised balance of service quality and quantity. The market system failed to direct economic resources to needs (Shannon, 1991).

A principal feature of Institutional theory is the active role of the state. The state through processes of formal planning based on advice from experts, manipulates the structures of society to achieve what is perceived to be the public interest. The state therefore sets up procedures
to moderate the interests of groups who would use their economic power to advance their interests for short-term gains (Shannon, 1991: 51).

Institutional theory espoused the idea that independent long-term planning and directing of investment into the correct areas achieves the resolution of social problems. If bureaucratic inflexibility and mistaken goals impede the delivery of social services that are designed to meet needs then the solution is not to reject public planning and direction but to improve it (Shannon, 1991).

The organisation of mental health under the influence of Institutional (Industrial Society) theory
The social policy, which developed under the period of Institutional theory, balanced competing political and economic forces. The state took an active role in planning and directing systems and services so that the resources of finance and labour were efficiently and effectively used to meet needs. The planning, managing, monitoring and intervening in the political and economic systems of the society created a central role for a state bureaucracy (Shannon, 1991).

Nineteenth century
Initiatives consistent with Institutional theory were undertaken in the later years of the nineteenth century. These involved steps aimed at bringing consistency of service provision, management and clinical practice to the asylums. The central government began this process soon after the abolition of provincial governments in 1876. In 1877 the Lunatic Asylum Department was established and inspector generals sought to make change (Brunton, 2001).

The central government department became the dominant force in mental health services. The department developed a bureaucracy of advisors who directed the services on behalf of the responsible government minister who was usually of low rank and frequently changed (Brunton, 2001).

Early twentieth century
By the early years of the twentieth century the psychiatric services of New Zealand were almost totally absorbed into the activity of central government consistent with
Institutional theory. The state actively intervened in the legal, labour and infrastructure issues and responded to the voice of experts and the public (Brunton, 2001).

In 1911 the Mental Health Act was passed renaming asylums as mental hospitals and making it possible for the first time for a citizen to be admitted to a mental hospital as a voluntary patient rather than committed as a compulsory patient. These changes reflected the current thinking of medical experts and the public sentiment (Brunton, 2001; Fennell, 1981).

The mental health service evolved from a centralised government department in which government experts were involved in detailed planning. These characteristics of social policy, consistent with the model of Institutional theory, were in place decades before the first labour government of 1935 began the political period of Institutional theory (Brunton, 2001).

Mid twentieth century – the political era of Industrial Society
The Board of Health was the government planning and advisory agency. It aimed to reduce demand for inpatient services and the prevalence of mental illness. In 1960 the Board of Health advocated that education be provided to General Practitioners and the public on the factors that caused mental illness and on how to maintain mental health. It also planned for greater use of psychiatric outpatient clinics at the general hospitals. The provision of domiciliary staff who supervised the return of patients to community living and the care of their family was another strategy to reduce demand for inpatient beds. The Board advocated for the development of specialist child psychiatric services so that children with mental health difficulties were less likely to graduate to become part of the long-term inpatient population (Health, 1960).

Weakening of Institutional theory
Because of the inadequacies of any pure political theory, services began to develop according to the subsequent political theory. The features of the Institutional model developed many decades before Institutional theory became the dominant ideology. In a parallel manner the organisational patterns of Neo Liberal theory impacted for over a decade before the Institutional theory period formally ended.
De-institutionalisation and grand theories
The process of de-institutionalisation was a service response influenced by the theory of the Industrial Society as well as the theory of Neo-Liberalism. It foreshadowed the emphasis on collaborative partnerships that is a feature of Third Way theory. An example of such a service that spanned the Institutional and Neo-Liberal period was the joint venture of the Otago Hospital Board and the Corstorphine Baptist Community Trust. This rehabilitation and community living project began in 1975 and enabled patients who had spent many years as inpatients at Cherry Farm Psychiatric Hospital to be able to live in the community. The service was community orientated. It involved patients and community groups taking responsibility for managing community living. There were elaborate processes of consultation to manage the tensions between the aspirations of the large and well-established institution of the Hospital Board and the small fledging community group that was a service outreach of the Baptist Churches of Otago and Southland. All the participants in the project appreciated that they were creating new relationships that challenged the standard ways of operating. No partner of the joint project was so dominant that the needs of the other participants were ignored. Co-operation rather than competition were features of the project (Criglington, 1985).

Clinical relationships
Clinical relationships during this period were characterised by the dominant position of staff, especially medical staff. The medical superintendent was the senior psychiatrist who was in the position of expert and responsible for the care and control of the institution, staff and patients. The position of dominance of medical staff was a continuation of the practice associated with asylums. Institutional theory put an emphasis on order and consistency which reinforced the idea that control should lie firmly in the hands of the Department of Health and medical superintendents of the institutions (Brunton, 1972).

In the later part of this period the absolute control of the psychiatrist and staff was weakening. This was made possible because more patients were in hospital on a voluntary basis and treatment interventions made recovery more likely (McLintoch, 1966).
The other trends that focussed clinical relationships away from the routines and disciplines of the psychiatric hospital have been discussed - for example the increasing use of outpatient clinics at the general public hospitals. Trends that took staff outside the walls of the main psychiatric hospitals began to alter clinical relationships with patients, family, professionals and the public outside the psychiatric hospitals but there was little change in clinical relationships for the patients who remained in the base institution (Health, 1960).

Family
The focus during the period 1935 to 1984 was on the prospect of recovery and return of the patient to family and community (McLintoch, 1966). However in the early part of this period the aspiration that family and community become involved in the care and recovery of the patient was rejected. The Mental Health Reform Association of Auckland and its advocate Arthur Sainsbury made submissions for reform which were rejected by the Minister of Health.

The mental health service recognised the value of contact with family even though the Medical Superintendent and the staff remained in control. In 1969 Porirua Psychiatric Hospital issued a guide for relatives that set out the nature of the relationship between staff and family. They were perceived as an adjunct to the work of staff who maintained clear control of the relationship between family and patient and the processes of treatment and care (Hospital, 1969).

The period is characterised by the desire for family contact and involvement but this was organised on terms that maintained staff control. Voices of protest were raised by the Mental Health Reform Association of Auckland and later by a wider public. The opportunity for change and community influence was increased when the Mental Hospitals were transferred from the Department of Health to the control of locally elected Hospital Boards that were responsible for managing all the other public hospital services (Grant, 2001).

Institutional theory period and the building of knowledge and decision-making
Institutional theory gives equal weight to the political and economic voices of the community (Shannon, 1991). In New Zealand these voices were expressed through
the centrally planned and managed activity of the Department of Health. As discussed in the previous section, the voice of the state and its experts was dominant in the early years of this period.

Towards the end of the 1935 to 1984 period there was an emerging awareness that the patient and the family had independent thoughts and feelings that were relevant to building knowledge and decision-making. However, the emerging awareness of the patient’s and family’s thoughts and feelings did not develop into an equitable partnership (Bazley, 1973).

**Period of Neo-Liberal theory 1984 - 1999**
This period occurred from the time of the election of the third Labour Government headed by David Lange until 1999 when the National Government led by Jenny Shipley was defeated. Neo-Liberalism is a modern restatement of the principles of Classical Liberalism and had the political and economic aims of reversing the dominant role of the state and giving pre-eminence to the place of the economy through the free market (Walker, 1997).

In the Neo-Liberal period the mental health services were opened up to a range of providers, on the assumption of giving consumers choice. The non-government sector became a significant provider of community-based services due to the contracting out of services. The Neo-Liberal period was marked by the rise of the consumer and family advocacy movements that expected services to meet their perceived needs. This period saw the weakening of the dominance of groups that had held power during the period of Institutional theory.

During this period there were major inquiries into mental health services and how resources were used. A major inquiry was the Mason Report which enabled the place of community services to be emphasised and the voices of the consumer and family to be heard. The report advocated a more prominent role for non-government organisations and was the foundation stone that supported the formal growth of indigenous mental health services and services targeted to specific at risk groups such as children and adolescents. The Mason Report proposed that planning and monitoring of service provision and service quality be overseen by an independent
group rather than remain embedded within the state through the Department of Health and the Area Hospital Boards. This independent body was the Mental Health Commission (Mason, 1996; Health, 1994).

The rhetoric of the Neo Liberal period included liberating the patient and resources so that choice was possible. This was to be achieved by having services responsive to the needs of the patient, family and community. These services would be focussed on responsiveness, quality and cost efficiency. This would enable the patient to be a responsible citizen who, with the support of his or her family, would participate in the community as an ordinary citizen (Mason, 1996; Jack, 1995; Health, 1994).

**Mental health service organisations under Neo-Liberal theory**

Neo-Liberal theory viewed that the role of the state under the Institutional model had become too large. Liberal theorists considered that the state had become an impediment to the responsibility, initiative and capacity of individual citizens and their family. Therefore the task of the state was to reduce its direct involvement in service provision and to open the door to non-government service providers (Bassett, 1998).

**Economic downturn influence**

In the 1980s, government deficits and high interest rates became problematic and Neo-Liberal theory provided for the restructuring of New Zealand society. Theory on social policy changed to the belief that social policy expenditure hinders, rather than helps, economic growth and market development.

Resource constraints became the justification for the reorganisation of the education and health sectors, moving towards greater private provision and community involvement but stopping short of a full move to market mechanisms (Shannon 1991: 6).

**Free market influence**

In the Neo-Liberal period, contracts were based on the language and processes associated with a competitive market place. The mental health strategy documents Looking Forward (1994) and Moving Forward (1997) set out the basis of contractual
relationships with services providers. These documents defined that service providers would be required to meet specific targets (Health, 1997).

Non-government sector growth
The reduction of the state in service provision is illustrated by the 1999 report of the Mental Health Commission that states that during the period 1994 to 1999 the number of non-government organisations that were providing Kaupapa Maori services increased from twenty-three to sixty. In the same period there was a 105% increase in the number of high dependency community beds. Most of this increase was provided by the non-government sector. The report made a feature of Richmond Fellowship, a significant non-government service provider. In 1992 the Richmond Fellowship provided services in only one area of the mental health service, a residential therapeutic programme for eighty people. However in 1998 the Richmond Fellowship provided services to one thousand people. The range of service provision had expanded from residential therapeutic programmes to services of home support, recreational and vocational programmes, home detoxification programme services to young people with special needs and patients with multiple diagnoses, as well as research and education services (Commission, 1999).

Change in dominance of knowledge and decision-making
Contracting out of services established a new group of private practitioners as well as strengthened the role of the non-government sector. Contracting out reduced the voice of hospital based professional staff. An example of this was how community care and support plans were developed. A new service of facilitated needs assessment and service co-ordination was created so that service users and their families could define the shape and provision of their community care support packages. This needs assessment and service co-ordination service was independent of hospital professionals and community service providers. This was achieved by all the Regional Health Authorities using a process of competitive tendering so that patients had a robust means of shaping their own community care plan (Authority, 1995).
Clinical relationships
In Neo-Liberal theory illness is viewed as an issue for individual concern that requires a contract between the patient and the doctor so that a cure can be effected. This creates a medical view of health (Shannon, 1998).

Medical model
The emphasis of clinical staff was on improving the outcomes for the patient. The health professional, especially the doctor, directed the resources of intervention. Contact with family was managed by the staff who were the experts. They developed the capacity of the family to contribute to the well-being of the patient. In mental health services the interventions favoured during this period were case management and a programme of psycho-education. The psycho-education programme was based on providing information to educate the family and gave skills training so increasing the family’s capacity to cope with their adversity (Dixon, 2000).

Market model
Neo Liberalism had its most extreme impact on New Zealand health services in the early 1990s. The health reforms of 1993 established four Regional Health Authorities. The Authorities purchased health care from providers on a basis of competitive tendering. The public hospitals became the provider of services and were managed by people with a competitive business orientation. This set up a challenge to the authority of health professionals. This Neo-Liberal period was unpopular with health professionals and the public and cemented a partnership between health professionals and service users (Easton, 2002).

Partnership
In this period forms of intervention emerged that focussed on partnerships between health professionals and the service users (Dixon, 2000; Friedman, 1995). Case management, psycho-education and narrative therapy all emphasised the need for partnerships. Narrative therapy required an active partnership where the therapist focussed on re-interpreting the story of the patient into one that constructed hope and recovery from adversity (Friedman, 1995).
Rights

A further rhetoric of this period was about patient rights and empowering the consumer (Commission, 1998; Health, 1997; Mason, 1996; Health, 1994). The experience of the patient and family was that consultation and efforts to empower could mean anything from manipulation and degrees of tokenism to forms of partnership where power, control and responsibility were shared (Grant, 1997).

Clinical contracts and risk management

Neo-Liberal theory emphasised contractual relationships in which the patient had the right to receive competent treatment and be a participant in the processes of care and treatment. Clinical relationships could be audited against the contractual standards for participation and clinical practice was subject to audit and varied from rigid defensive processes to creative inclusive practice (Health, 1997). The requirement to involve service users meant that some health professionals focused on the passive meeting of obligations and the making of decisions to ensure social control. This was done through the processes of assessment, management of risk and the allocation of resources (Jack, 1995).

Risk versus need

Social policy placed the emphasis on assessing risk rather than need and this emphasis shaped clinical relationships. The role of the health professional as the expert responsible for maintaining social order through the process of continual risk assessment was reinforced (Kemshall, 2002).

Integration of sources of expertise and responsibility

Clinical relationships were subject to contrasting and conflicting influences with staff being required to be the knowledgeable experts (Kemshall, 2002; Jack, 1995). Clinical relationships were also required to reflect the principles of recovery that embodied the ideals of shared control and maximising consumer choice (Commission, 1998).

The aspirations of the Blueprint and its focus on the Recovery Approach that emphasised collaboration and consumer control became an expectation. The Recovery Approach foreshadowed the ideals of clinical relationships in the Third
Way period rather than reflected the reality of service delivery in the Neo-Liberal period.

Family
In the early part of the Neo Liberal period family participation was seen as a desirable adjunct. In the latter part of this period the rhetoric described family participation in service planning, evaluation and clinical interventions as standard practice. Staff and family relationships changed from interactions that were dominated by staff as the expert to relationships where knowledge creation and decision-making were more equitable and shared. These changes were reflected in the types of clinical interventions with an emphasis on case management and staff-directed psycho-education programmes at the beginning of the period and an emphasis on the strengths model, narrative therapy and the development of the recovery model at the end of the period.

*Psycho-education dominated by staff*
In a psycho-education programme the staff are the experts who provide education and guidance to the family. The focus is on responding to issues of the patient and the goal is to reduce relapses that would require hospitalisation. Clinicians help by providing information about the illness, treatment options and the mental health system. The staff offer direct guidance and clarify with family the tasks and behaviours which are helpful in meeting the patient’s care and treatment goals. Staff provide support and reassurance to family members who are acknowledged as experiencing significant and comprehensive burdens. The focus remains on the issues of the patient rather than on the needs of the family (Atteneave, 1986; Baird, 1986; Bernheim, 1985).

*Recognition of family resources*
In the mid to late 1980s some authors acknowledged that families had significant resources and resilience. They recognised the usefulness of staff identifying and promoting these coping resources. Resourceful families were acknowledged as possessing non-anxious leadership and flexibility in response to family issues so that a sense of proportion was retained. Staff encouraged family grieving so that family accepted the reality of their circumstances. The emphasis of the working relationship
began to change from the staff being the only expert to the staff eliciting the expertise of others (Friedman, 1986; Strauss, 1986).

**Research findings**

Research evidence supported the usefulness of family involvement, reporting a twenty percent reduction in relapse and hospitalisation. Active involvement with family was shown to reduce the overwhelming impact of family burden. Benefits reported were improved family knowledge about illness, improved compliance with medication, better social adjustment of the patient, improved quality of family life and a reduction in the financial cost associated with the care and treatment (Rolland, 1993).

**Psycho-education that responds to family issues**

During the Neo Liberal period psycho-education programmes developed to a second stage in which families were recognised as having their own issues. Staff engaged the family to help them process their own issues rather than the family being recognised only as a supplementary resource. Work with the family was seen as an investment that enabled it to be more resourceful and resilient. The family intervention work was frequently perceived as grief work. Staff enabled families to work with their feelings so that their strengths and resilience were accessed. The Neo-Liberal model reinforced the belief that families had rights to their own life and family could willingly be harnessed as a resource of choice for the care and support of the mentally unwell person (Tilbury, 2002; Byng-Hall, 1995).

**Illness in context**

In the later part of the Neo-Liberal period, it was acknowledged that mental illness did not occur in isolation but within a social context that often involved family. Clinical interventions that were applied to the patient were adapted to be relevant for family. Staff intervention with family focussed on identifying strengths rather deficits that the staff sought to correct. The focus of attention in the interaction between family and staff was not on how families had failed but on how they could succeed. Walsh identified three dimensions that formed the basis for resilience in family functioning: the belief system, organisational patterns and processes of communication. Walsh believes that resilience is strengthened by interaction between all parties - the family, the patient and the professional staff (Walsh, 1998).
Co-operative partnerships

At the end of the Neo-Liberal period, clinical practitioners, advocacy groups and policy makers all supported co-operative partnerships as benefiting the patient, the family and the staff. Co-operative working partnerships were able to use the resources of all the parties and had outcome benefits of an improved mental health service and improved quality of life for the patient, family and clinical staff (McCubbin, 1999; Stawski, 1999; World Fellowship for Schizophrenia, 1999).

Advocacy groups and policy makers highlighted the place of family. The Code of Family Rights was created by a non-government organisation and enshrined the right to services that were responsive to family needs (Supporting Families, 1999). There was rhetoric from policy makers that staff and family should work together in comprehensive partnerships. Families were represented at service organisation levels by family advisors. The Mental Health Commission reported that a significant achievement during the period of 1994 to 1999 was that many of the mental health service providers had advisory groups of both consumers and family members. However it was still the exception that families were significant participants in the clinical processes of knowledge building and decision-making for the patient's intervention plan (Standards, 2001; Masters, 2000; Commission, 1999; Supporting Families, 1999).

Family rights

Policy documents emphasised the importance of family collaboration if the mental health service was to be fully responsive to the needs of family, patient and community. The Blueprint stated that family held a central place in the process of recovery.

People with serious mental illness are not ill in isolation. Their families, extended Whanau, and significant others .... cannot escape from being affected by it. .... Beyond the immediate family are other relatives, friends, neighbours and workmates who may have a role in the life of the person and need, therefore, to be part of the healing or maintenance programme (Commission, 1998: 9).
The policy documents published by the Mental Health Commission foreshadowed the strengthening of the place of family as the mental health service moved from the historic focus on patient and family deficits towards the creation of a service that was centred on the Recovery Approach (Commission, 1999; Commission, 1998).

Knowledge building and decision-making in the Neo-Liberal period

Staff voice dominates

During the Neo-Liberal period there was progressive change in the way that knowledge was built and decision made. In the early part of the period staff, especially doctors, were dominant in defining the issues and educated the patient and the family about the nature of mental illness. This was achieved through the first version of psycho-education and case management. Staff acknowledged that the family was an essential part of the life of the patient and could make a contribution to his/her care and well-being provided that the family was helped to undertake this task. In these interventions the staff dominated knowledge building and decision-making (Bernheim, 1985).

Voice of patient and family

The Neo-Liberal theory supported choice and the rights of the consumer and family which gave room for the voice of the consumer and family to be heard. Pearson acknowledges that McKnight wrote about the importance of people retaining the capacity to define their own issues (Pearson, 2001). The Mason Inquiry (1996) acknowledged the right of family who were closely associated with a patient to be actively involved in determining the care and treatment plan (Mason, 1996).

The response of professionals now included the need to help family with the process of grief and adaptation (Tilbury, 2002; Byng-Hall, 1995).

Limitation of partnerships

The Mental Health Commission in its report on progress in the years 1994 to 1999 acknowledges that the building of knowledge and decision-making processes were more inclusive of the voices of the consumer and the family but not at the level of full partnership, with consumers and families having opportunity to make general
comment on services rather than having involvement at the level of individual intervention plans (Commission, 1999).

The voice of family was beginning to be heard at the higher levels of policy input. This was piloted in the Southern Regional Health Authority by the introduction of a family advisor who was paid to provide a family perspective on issues of policy and planning (Commission, 1999).

**Rhetoric of inclusion**

In the last years of the Neo-Liberal period, the rhetoric advocated strongly for family inclusive practices and therapies focussed on the consumer that encouraged the re-writing of family stories. In 1999 the Code of Family Rights was published which advocated that mental health service providers had an obligation to provide treatment and support that embraced a family centred approach. This code emphasised that family be treated with respect and be assumed to be competent unless they showed otherwise (Supporting Families, 1999).

Professionals began to advocate family inclusion. The Royal Australian and New Zealand College of Psychiatrists produced a policy guide for best practice which urged practitioners to adopt the concept of ‘working alongside’ families in the processes of care, assessment and treatment. The belief was that this would give support and empowerment to family, assist the patient’s recovery, reduce the distress of family and help to gain family participation in service planning, development, evaluation and staff training. The College of Psychiatrists supported its arguments in a manner consistent with Neo-Liberal theory. The argument was that the provision of family inclusive mental health services was shown by research evidence to be of significant clinical, social and economic advantage (Masters, 2000).

The emphasis on the need for collaboration foreshadowed the focus of the Third Way period.

**The period of the Third Way Theory (1999 to present)**

Third Way theory is based on a compromise between Liberalism and Industrial Society theory. The compromise aims to meld the best features of each theory. The
Third Way operates within the framework of a market economy but the role of the state is more prominent in that it creates alliances and partnerships between itself and the market. This theory is used to describe the ideology of the British Labour Party under the leadership of Tony Blair. Eichbaum quotes Hutton, a major writer about Third Way theory, who describes Britain under Third Way theory as:

a more inclusive, fairer, higher-investing Britain with a well functioning democracy. It is a vision of a stakeholder economy and society, but constructed by a contemporary state in contemporary conditions.... the response is not to call for the socialisation of capitalism, big government or a new corporatism, rather it is to design institutions, systems and a wider architecture which creates a better economic and social balance, and with it a culture in which common humanity and the instinct to collaborate are allowed to flower (Eichbaum, 1999: 40).

Under the Third Way, health services are responsive to the issues of local stakeholders. Decision-making for the health service involves local input. The mechanism of the market continues to provide choice and there is competition between providers. A characteristic of service provision is that there is a focus on meeting needs in a sustainable manner rather than on services responding to short-term concerns. The relationships between stakeholders at all levels of policy development, funding, accountability and clinical practice involve collaborative partnerships. These relationships are responsive to the context and content of stakeholders (Eichbaum, 1999). A virtue of the Third Way is the emphasis on local and innovative partnerships that can tap into resources such as the family and community in ways that are not available to the state or the market (Harris, 1999).

Balance of forces
Third Way theory aims to create a better balance in social policy between competing political and economic forces. The Third Way also aims to enhance the voice and participation of service users so that services reflect choices that are based on the local context and collaborations (Eichbaum, 1999).
Partnerships
New Zealand had not been well served by the extremes associated with the social and economic policies of Neo-Liberalism nor by the conservative and protectionist social and economic policies associated with Institutional theory. The Third Way is a response to the need for innovation and so provides the means of balancing social and economic factors that impact on New Zealand (Harris, 1999).

The key element in finding better ways of delivering is through dynamic social and economic partnerships (Harris, 1999: 224).

Under Third Way theory the task is to enable the stakeholders to have both rights and responsibility for how services are developed and managed, rather than having services respond only to central political direction or the forces of the market (Harris, 1999).

The strength of the Third Way is partnerships that go beyond what the market and government can provide. Stakeholders in partnership know local needs and capacity and what works best in each context. A service that responds to the issues of the stakeholders will generate energy, motivation, innovation, commitment and resources beyond what can be accessed by the market or the government (Harris, 1999).

The organisation of mental health services under Third Way theory
There continues to be a strong non-government sector and an emphasis on community rather than institution based services. The voices of consumer and family are becoming established as a regular part in the shaping and evaluation of services (Commission, 2005).

Macro level collaboration
Partnerships are embarked on especially between government departments. The purpose of the intersectoral collaboration between Work and Income, the Ministry of Health and Housing New Zealand is to enable the resources of several government agencies to facilitate independent community living. This provision of funding and service contracts enables local groups to deliver community focussed services which
include affordable housing, purposeful activities and programmes to support patients in open market employment (Commission, 2005).

State contribution
The Third Way theory accepts that the contribution of the state may increase. In the later years of Neo-Liberalism and early years of the Third Way there was significant increase in government funding. In the years 1993 to 2002 there was an inflation adjusted increase in expenditure of one hundred and thirty seven percent. In spite of this increase there remained limitations - shortfalls in access to services, a lack of specialist staff, an incomplete range of services especially for children and young people, a lack of culturally based services for Maori and Pacific populations and a deficit in addictions services (Commission, 2003).

Consumer contribution
The Mental Health Commission emphasised that the voice of service users was officially recognised in service planning and practice. Service users also contributed to the 2003 annual report (Commission, 2003).

Family contribution
The same report acknowledged that family input in service planning took place especially at the level of District Health Boards. Family advisors worked at the senior management level but family influence was limited at the clinical level (Commission, 2003).

State responsibility
Third Way theory makes provision for the state to create and maintain the infrastructure that sustains order and accountability and allows for flexible service provision. The role of the Ministry of Health is to implement government policies that are monitored by the Mental Health Commission. The Ministry manages the processes that verify funding, contracting and accountability between the government and funder arm of District Health Boards which are responsible for implementing government policy at district level. The District Health Board provider arm, non-government organisations and private practice practitioners provide services at the district or local level.
Managing risk or need
In this period service provision and organisation continue to focus on managing risk rather than need. The emphasis is on risk assessment and risk surveillance with the mental health services seen as activities of high risk and risk exposure (Kemshall, 2002).

Under Third Way theory the ideal way of managing risk exposure is through partnerships. Risk exposure is reduced because of shared responsibility of family, patient and clinical staff. All the stakeholders contribute to the knowledge on which risk assessment is based and contribute to decisions about management of risk. The rights and responsibilities of the stakeholders have been enshrined in regulations such as the Code of Patient Rights (Kemshall, 2002).

Inquiries such as the Burton Inquiry highlight the Third Way ethos in which family, patient, clinical staff and service provider have rights and responsibilities (Paterson, 2002).

Clinical impact of risk management
Management of risk generates two contradictory forces. One response is to focus on intensive intervention with high-risk populations which aims at containing risk. Clinical staff control interventions and dominate the knowledge and decision-making in the processes of assessment and surveillance. Staff retain responsibility and authority so helping the employing organisation limit its risk exposure. The other way of managing risk exposure and liability is by sharing risk which reduces the vulnerability of any one party. The sharing of responsibility through collaboration and teamwork reduces risk exposure and enables interventions focussed on recovery (Kemshall, 2002).

Blueprint and Mental Health Commission oversight
The Blueprint was formulated at the end of the Neo-Liberal period and has guided service development and practice in the Third Way period. The guiding policy document for the ten years from 2005 to 2015 is Te Tahuhu and it remains based on Recovery Approach principles. The principles of Te Tahuhu are based on valuing
diversity. It supports participation in everyday relationships with family/whanau and community. Te Tahuhu and the Blueprint reflect their Neo-Liberal origin in that services are to provide choice, promote independence and be responsive to needs while using resources in cost efficient ways (Health, 2005).

The vision of mental health services focused on the Recovery Approach is not restricted to New Zealand. The visions of the Blueprint and Te Tahuhu are found in policy documents of the United Kingdom. New Zealand and the United Kingdom share a commitment to the social and economic policies that are shaped by Third Way theory (Association of Directors of Social Services, 2006).

Teamwork and partnership
The Third Way emphasises partnerships that are responsive to stakeholders’ needs. Opie (2000) contends that inclusive teamwork is the basis of interconnecting partnerships. When the perspective of all stakeholders is taken into account, action plans are open to modification, challenge and development. This model of teamwork is consistent with Third Way theory. It requires the process of collaborative partnerships at all levels, from the development of policy to the management of service delivery systems and the clinical relationships between those who deliver and those who receive a service (Opie, 2000).

Clinical relationships
Third Way theory impacts on clinical relationships by its emphasis on teamwork and valuing the contributions of all stakeholders. Opie (2000) describes the focus of teamwork within a clinical team as more about interactive relationships rather than the contesting of separate viewpoints.

Teamwork is a dynamic outcome of the intersection of professional and organisational discourses and objectives. (Opie, 2000: 111).

Discourse and teamwork
There are three factors that have a critical influence on whether teamwork results in an effective collaborative partnership. Opie identifies these three factors as:
• Access to members' differently positioned knowledge
• The different accounts and questions that [potentially] team members are able to ask about the development of a team member's and the team's work
• The ways the team works with these different knowledges about the client (Opie, 2000: 119).

In Third Way theory the concept of mental illness is formed by acceptance of multiple views and sources of expertise that require collaborative partnerships to respond to the issues of mental disorder. Mental illness is viewed not just as a biological illness that impacts on a helpless patient. Several writers emphasise the importance of recognising that mental illness occurs in a personal and social context and that context is relevant to enable recovery (Barker, 2001; O'Hagan, 2001; Masters, 2000; Commission, 1998; Walsh, 1998). Barker describes the clinical relationship as needing to engage with the person rather than the illness (Barker, 2001).

**Threads of team discourse**

Narrative therapy, which enables the person to become an expert about their mental illness, is a therapeutic intervention that is consistent with Third Way theory. The narrative therapy approach involves clinical relationships that provide validation of the experience of those involved. This approach is based on a collaborative inquiry that constructs a new view about ways of managing needs and issues so that an ordinary life can be lived (Barker, 2001).

Walsh (1998) believes that staff can facilitate the development of resilience in the patient and family. Resilience in the face of adversity requires a focus on strengths rather than on deficits. Clinical relationships that support resilience develop from working in an interdependent manner. Collaborative partnerships that are based on shared beliefs and flexibility in the ways that life issues are organised, promote resilience and recovery (Walsh, 1998).

The management of risk exposure is achieved by sharing the tasks of risk assessment and risk management. The service user benefits by normalising the issues of ordinary
community living. This involves risk taking and risk management. The process of normalising risk for all parties requires that the working relationship of staff and patient focuses on each party having self-responsibility and the need to make prudent choices so that the person minimises his or her risk liability (Kemshall, 2002).

Empowerment
Collaboration and partnerships strengthen recovery and are a source of empowerment that enables the patient to participate fully in the community (O'Hagan, 2001).

The Health and Disability Commissioner advocates that adherence to the Code of Rights is empowering. The Code of Rights is committed to the view that the best interest of the patient is served by recognising that each person has a social and relationship context. The patient has the right to receive safe and good quality assessment, care and treatment. This requires active collaborative relationships inclusive of family and others so that there is effective co-ordination of safe and competent care (Paterson, 2002).

Mental illness is acknowledged as having a significant impact on family. The process of collaborative partnerships is recognised as a means of strengthening the patient’s support network. This benefits the patient and enhances the strengths, resilience and well-being of all the people in the patient’s network (Whiteside, 2003; Saleebey, 2002; Masters, 2000; Walsh, 1998).

Family
The importance of family participation in the care and recovery of the patient has been highlighted since the 1996 Mason Report. The Third Way policy framework acknowledges and accommodates the needs and issues of family and maintains focus on recovery of the patient.

Rhetoric increases
In the Third Way period statements about the involvement of families became more explicit. Concepts of collaborative partnerships and working alongside families were proposed as the means of resourcing family so that their burden was reduced and
family would be enabled to assist in patient recovery and contribute to planning, policy development, evaluation and management of services (Masters, 2000).

In the first years of the Third Way period the focus was on perceiving family as an additional resource for the work of patient recovery. Little attention was paid to the role of the staff in responding to the needs and issues of the family (Bustillo, 2001; O'Hagan, 2001; Pitschel-Walz, 2001; Standards, 2001; Dixon, 2000).

However there was an acknowledgement that involving family and patients in choices and decisions about health care plans altered power relationships (Opie, 2000).

Involvement at service and/or individual level
The involvement of family was focussed on the service management level rather than on decision-making at the individual clinical level (Commission, 2004; Commission, 2003; Commission, 2001; Standards, 2001). The Health and Disability Commission acknowledged in its 2003 Annual Report the inadequacy of response to the needs of families in many services, even though the Code of Patient Rights gave a formal right to family being involved at the individual clinical level.

In the Mark Burton inquiry the Commissioner was critical of the efforts of staff to implement the right of the patient to have his care and treatment occur in a manner that embraced contact and co-ordination with family (Paterson, 2002: 188).

Involvement of family aids risk management
The presence of the family is an expression of family support and belief in the person and the journey that they are embarking on (Lapsley, 2002; O'Hagan, 2001). The participation of family increases the tolerance for risk taking. The sharing of responsibility reduces the likelihood of blame and fault finding. Family involvement in the creation of knowledge and decision-making about the care, treatment and recovery plan enables greater risk taking to occur (Kemshall, 2002).

Family resilience
Walsh (1998) highlights the significance of family having its needs and issues addressed rather than being viewed as simply an additional resource. She was
concerned with strengthening family resilience with the family acknowledged as being adversely impacted by the consequences of chronic illness. The strengthening of resilience was a process of intervention that enabled the family to survive and thrive in spite of the adversity caused by the chronic unwellness and dysfunction of a family member (Walsh, 1998).

Collaborative partnerships enable staff to help families meet challenges. Such partnerships are based on programmes of psycho-education which provide information and guidance on managing the behaviour connected with illness and accessing social support. Unlike traditional psycho-education programmes, expertise is not located only with the staff. The expertise of family is recognised and supported so that family become the experts in managing their own issues as well as contributing to the well-being of the patient family member (Walsh, 1998).

To strengthen resilience staff need to be comfortable in, and have skills in creating, a relationship environment in which families are supported in their efforts to heal, assess concerns and create useful responses that use their resources as well as the resources of other people and agencies (Whiteside, 2003; Saleebey, 2002; Campbell, 2001; Silberberg, 2001).

Knowledge building and decision-making in the Third Way period

*Relationships*

The partnership model of the Third Way is based on collaborative relationships that build knowledge and make decisions. The Tidal Model is an example of clinical intervention that builds knowledge through a collaborative inquiry. The purpose of collaboration is to understand the person's current situation, to validate their experiences, and to evaluate services and supports so that the person can live an ordinary life (Barker, 2001).

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2 The Tidal model of Barker views mental illness as not only a biological phenomenon. Recovery requires an exploration of self and the experience of illness. The Tidal model is about self and one's own life experiences as a means of making sense of one's experience. This is a process that involves discourse with family and significant others, aiming to make sense of the experience (Barker, 2001).
Knowledge is built when interventions are based on the strengths model. Strengthening resilience enhances the capacity of the patient and family (Saleebey, 2002; Walsh, 1998).

**Management of risk**

The process for assessing and managing risk influences how knowledge is built and decisions made. Where reduction of risk is the focus, as is customary with high-risk people, the emphasis is on the professional experts as holders of knowledge and as decision-makers. Where the Recovery Approach is used and risk is acknowledged as part of normal living, the building of knowledge is based on the reflections and dialogues of the patient, staff, family and significant others (Kemshall, 2002).

The involvement of family allows greater risk-taking because the exposure to blame is reduced when there is an active partnership between patient, staff, family and community groups who share the risk taking and share in the creation of knowledge and decision-making about the intervention plan (Kemshall, 2002).

**Relationships and the intervention journey**

Knowledge was built through dialogue and the most important relationships were between the patient, clinical staff and family. Staff had an important role in creating a safe place that conveyed hopefulness. This helped to spark the recovery process and enabled the patient to express himself or herself emotionally and begin the process of self-exploration. Family enabled the patient to engage in recovery and building knowledge through the provision of support and practical strategies for living. This demonstrated that the family had faith in the patient and supported the patient to make needed changes in his/her environment and his/her personal stance (Whiteside and Steinberg, 2003; Lapsley, 2002).

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3 The Recovery Approach is the central philosophy for the mental health services that was established by the Blueprint policy document (Commission, 1998). The Recovery Approach is highlighted by the Mental Health Commission and advocates that services have a shift of focus so that service users feel empowered and attain mastery of their circumstances so that they live in and participate in the community of their choosing (Health, 2005; (Commission, 2001b).
The research of Muhlbauer (2002) has shown that families who have a family member with a chronic mental health disorder experienced consistent themes in the phases of the care, treatment and recovery process. These consistent themes impacted on the building of knowledge and the making of decisions. The issues that were consistently experienced included significant problems in communicating with staff. Other issues were identifying the helping resources, a strongly felt need for all participants to access information and the desire to use comprehensive knowledge as the basis for the development of all the participants and to direct the management of the patient's symptoms (Muhlbauer, 2002).

Recovery competencies
The following competencies are basic to enabling staff to support the building of knowledge that leads to recovery-focussed decisions:

- Skills in identifying and eliminating discrimination and the multiple forms of social exclusion.
- Capacity to work with a person's resourcefulness.
- Knowledge and support of the perspectives and participation of the patient and the family.
- Knowledge of community resources and how to access them (O'Hagan, 2001).

Consumer rights and knowledge building
The Health and Disability Commissioner identified that the Third Way concepts of collaborative partnerships are essential in order to fulfil the Code of Patient Rights. In his inquiry into the murder of Mrs Burton, the Commissioner considered that a breach of the Code of Patient Rights occurred when information and knowledge generation did not belong to all the parties but were held by only one or two parties such as the doctor and the patient (Paterson, 2002).

Strengths perspective and knowledge building
Strengths-based practitioners consider that collaborative partnerships are basic for building knowledge that contributes to decision-making. These practitioners believe that the most useful realities for patients are constructed through collaboration
between clients and staff. It is essential that the stories of the patient and their personal and social resources are not subjugated by the knowledge and stories of the professionals. It is collaboration that brings out the most useful realities for the patient in their managing of their adversity (Saleebey, 2002).

**Critique of the grand theories**

The theories that have shaped the mental health services of New Zealand have varied since the signing of the Treaty of Waitangi. No theory has been implemented in its pure form. The realities of the New Zealand environment, the social and political expectations of the population and the limitations of the economy have influenced the evolution of New Zealand’s mental health services.

During the Classical Liberal period there were shortfalls in the quality and quantity of asylum services. The expectation at the beginning of this era was that a humane service would develop which would lead to significant levels of recovery. This expectation was not realised. The impeding factor was that there was no reliable source of funding other than the state and provincial authorities were unwilling to invest in legal, manpower and capital infrastructures that enabled viable and competent services to develop (Brunton, 2001; Bassett, 1998; Bloomfield, 1979; Blake-Palmer, 1956).

The mental health services soon took on the characteristics associated with Institutional theory. Brunton (2001) identified that by the time of the demise of provincial governments in 1872, the state had become the main policy driver and provider of mental health services and the three founding principles of institutional care, separate administration and state funding were established (Brunton, 2001).

No theory generated services which met the aspirations of the patient, family, professional or political and economic interest groups in terms of quality, quantity, location, flexibility, cost and effectiveness (Brunton, 2001; Bassett, 1998; Mason, 1988; Sainsbury, 1946).

The Institutional theory exerted influence for a longer period than any other theory. It was influential before the Institutional period formally began in 1935 and continued to
have an impact after its abandonment in 1984. The characteristic of being reliant on processes of central planning that result in a uniformity of service provision has been criticised as being unresponsive to needs. Centrally planned and managed services were criticised for the power that they gave to technical and professional experts who managed the services. This control was deemed to stifle the initiative, rights and responsibilities of the patient, family and community. The voices of the patient and family were overpowered by the expert knowledge of staff who took a privileged position of making choices about the patient's care and treatment (Brunton, 2001; Bassett, 1998; Mason, 1988; Sainsbury, 1946).

The Mason Report of 1996 was a turning point in the way services were focussed. The influence of Neo-Liberal principles was evident in that services were no longer to be monopolised by the state. The report emphasised the need for patient and family inclusion, participation and decision-making. Services were now to be provided by the state, public hospitals, non-government community agencies and private practitioners. The state distanced itself from direct control of planning, promotion and evaluation of services. These roles were handed to an independent authority, the Mental Health Commission.

The criticism of Neo-Liberal theory was that market based contracts were not sufficient to develop services that reflected the issues and met the needs of service users and those who were affected by mental illness. There remained a need for targeted policy and service delivery initiatives that responded to groups that were already marginalized. The groups targeted for direct intervention included children, young people, Maori and ethnic minorities. Issues targeted for specific attention included staff shortages and alcohol and substance misuse (Standards, 2001; Supporting Families, 1999; Commission, 1998; Shannon, 1998; Mason, 1996; Mason, 1988).

The Third Way theory, like other theories, seeks to establish the truth about what principles to follow and what knowledge is privileged. The Third Way theory does not base decisions solely on either the principles of Liberalism or Industrial Society but on a contextual balance between ideological forces. The balance of forces is
moderated through the process of partnerships where the parties are engaged in collaboration so that decisions are negotiated to best fit the needs of stakeholders.

The Blueprint that established the framework for services is based on the Recovery Approach. This approach recognises that partnerships are needed and that inclusion and partnership are consistent with the theory of the Third Way and the Treaty of Waitangi (Health, 2005; Masters, 2000; O'Hagan, 1999; Stiglitz, 1999).

The reality in New Zealand since the development of a formally funded mental health service is that no one theory has been a satisfactory guide for the creation and maintenance of mental health services that meet the diverse needs of service users, service providers, family, funders and the community. Theories that define what is the truth are under constant change and are socially constructed (Walker, 1997).

The knowledge that is derived from the study participants' social construction of their partnership experience will be examined by me and compared with the knowledge from the literature reviewed in this chapter.

The research question of this study is to describe and explain best practice partnerships that involve the family, patient and staff as they interact in response to an acute episode of mental illness.

The study aims to define best practice processes within the parameters of Third Way theory. The study findings endeavour to make known what the participant groups identify as the processes that inhibit or enable collaborative working relationships to be established and maintained.

The Place Of Knowledge
People and institutions that define what knowledge is accepted as the truth are the dominant sources of power. McHoul says that Foucault identifies four disciplines for maintaining power through the control of knowledge. These disciplines are spatial, control of activities, expert knowledge and decision-making (McHoul, 1993).
Spatial
This is achieved by creating a distance between the subject and others. The subject is separated from the community and rank is used to create distance between the subject and the observer. This method was used in the mental health services in New Zealand. A founding principle was that institutions were used to separate the mentally disordered from the wider community (Brunton, 2001).

Control of activities
This technique is achieved by requiring activities that take the subject’s time and labour. The mental health service in New Zealand, from the time of establishment to the time of active de-institutionalisation, put an emphasis on controlling the time and activities of the patient. The regimes of the institutions of care, treatment and containment focussed on structure and routines. Manual work was valued as a means to enhance well-being and restore order to the life of the mentally disordered person (Brunton, 2001; Caldwell, 2001; Brookes, 1990; Fennell, 1981; Bloomfield, 1979; Blake-Palmer, 1956).

Expert knowledge
This technique is achieved by retaining control over what is valued as knowledge and the stages of training for acquiring this expert knowledge. This control defines who holds expertise and creates a hierarchy of privileged knowledge. In the mental health services the expert knowledge lies with the medical profession which has the power of committal. The psychiatrist holds the expert knowledge to define a person as being of unsound mind. The consequence of this expert knowledge is that committal can impose a limitation to the liberty of the patient and force containment, care and treatment so that sound thinking is restored. The hierarchy of knowledge has served to constrain the power of patient and family (Mühlbauer, 2002; Barker, 2001; Scull, 1996; Brookes, 1990; Bernheim, 1985; Hospital, 1969; Blake-Palmer, 1956; Sainsbury, 1946).

Decision-making
This technique is based on the use of privileged knowledge. In the mental health service power is exerted by control of assessment, care and treatment choices. The last decade has been a period of intense challenge over how knowledge is used and
power is exercised in the processes of decision-making about care and treatment (Paterson, 2002; Masters, 2000; Mason, 1996; Health, 1994).

These four disciplines identified by Foucault will be used for reviewing how the grand theories distribute power in the New Zealand mental health service. Special attention will be paid to the issues of inclusion in knowledge building and decision-making.

Foucault identifies that the most effective challenge to the use of power is resistance to the techniques that allow for the exercising of power. Therefore resistance to the processes of knowledge building and decision-making is a fruitful site to examine (McHoul, 1993).

Danaher recognises Foucault’s concept that knowledge is the product of a web of influences that derives from the particular context. The body of knowledge reflects the period in history and the dominant discourses of the professions or institutions that produced the knowledge which becomes accepted as the truth (Danaher, 2000). Danaher acknowledges these discourses as directing choices.

They are the ground on which we base everything, so we more or less take them for granted (Danaher, 2000: 17).

**Tools of analysis**

The experience of the participants will be analysed to generate an understanding of what constitutes best practice working partnerships. Two tools of analysis will be used to assess power relationships and to develop strategies for change. The work of Kelly, (2001) will examine power relations. It uses trialectic logic to understand the tensions that exist in any field of inquiry. The work of Bunch, (1983) examines experiences of adversity and uses a four-step process for theory building. The theory generates strategies for change so that best practice relationships result for the interaction of the parties.
Trialectic logic and holding the tensions of the wider view

The method used for analysis of power relationships is trialectic logic (Kelly, 2001). It provides a framework for assessing a matrix of relationships which can build effective and inclusive teamwork.

It is less a matter of opposites, such as good/bad, right/wrong, friend/enemy, with us/against us, included/excluded, but more a fabric of connections which make up a whole; ... within this wholeness of thought, action and relationship, we need to stay open, flexible and honest (Kelly, 2001: 2-3).

Collaborative relationships aim to engage all parties in mobilising the resources of the wider community of interest. The analysis of power relationships identifies relationship limitations and strategies how to minimise obstacles to teamwork.

The direction of the action comes from the analysis, and the particular relationship we have to the problem is the conduit for the action (Kelly, 2001: 6).

Trialectic logic, as opposed to other forms of social logic, develops a synthesis or coming together of three or more understandings. Trialectic logic holds in creative tension three or more factors and sees the factors as a whole rather than as separate factors that may be competing for dominance ⁴ (Kelly, 2001: 22-23).

Feminist theory and strategy for change

The work of Bunch, (1983) is based on feminist theory. It provides a basis for visioning and strategising how to create an improved social reality for people who are oppressed by their current experience of power relationships.

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⁴ A discussion of the five forms of social logic occurs in chapter two of the book 'With Head, Heart and Hand' written by (Kelly, 2001).
Bunch, (1983) asserts that the description of experience is a necessary step in the change process. From the description of experience the theory can provide a naming and interpretation of oppression.

The analysis phase focuses on ascertaining why the oppression exists, both in terms of its origin and the reasons for its continuation. Bunch cautions against the temptation to restrict analysis by ascribing everything to one factor.

In developing an analysis, I think it is useful to focus initially on a phenomenon in a limited context and consider a wide range of factors that may affect it (Bunch, 1983: 252).

The vision phase is concerned with defining the desired outcome that embodies the values or principles the analyst operates from.

The strategy phase develops a hypothesis that will change the experience of people. It is based on understandings that have arisen from the preceding steps of description, analysis and vision.

**Research question**

The literature review has discussed how best practice in the field of mental illness has been defined in New Zealand. The current rhetoric emphasises the importance of the Recovery Approach and that partnerships enable those whose lives are affected by mental illness to participate in the community.

The gap in the literature that this research seeks to respond to is to identify what actions would enable the theory of the Recovery Approach to be made actual in the current interventions of an acute adult mental health service in New Zealand.

This study attempts to describe and explain relationship practices that enable partnerships of inclusion, participation and collaboration. The focus is on the processes of building knowledge and decision-making. The study asks the research question of what are the best practice strategies that reduce exclusion of family and patient from full collaborative partnership. The study context is the psychiatric day
hospital where a family is involved in actively working with an adult family member who has experienced a significant episode of mental unwellness.

Attention will be paid to the way that theories and models of practice influence how power is expressed. The study findings have been generated from an examination of the issues and processes used for establishing and maintaining an active partnership. The literature review will be used to inform the analysis of the qualitative data collected. It will compare and contrast the models of clinical practice in terms of the extent to which the theories and models of practice enhance or restrain collaborative relationships. The analysis of findings will be discussed in chapter six.
Chapter Three

METHODOLOGY

Introduction
I investigated the development and current position of family as it interacts with staff in response to an episode of mental illness of a family member. The investigation occurred through the analysis of historical and policy documents and in-depth interviews with a small group of people who had recent involvement with the adult acute mental health service. An exploratory research design was used to describe and explain the phenomena of interaction between family, patient and staff. I investigated the perceived relationships, responsibilities and roles that occurred as people exchanged information and made decisions about the intervention plan for the patient and family.

In this study it was necessary to engage with the discourses of people involved in providing, receiving and participating in care and treatment interactions. It was a complex and at times problematic task to identify a small group of ex-patients, family and staff members to interview and analyse their views. The investigation was multi-layered because forces of influence from macro, meso and micro sources shaped the experience of interviewees. The matrix of influences included national policy and political ideology at the macro level, the policies, practices and priorities of service delivery organisations at the meso level and individual experiences of participants at the micro level.

The first research design decision was the choice of quantitative or qualitative methodology. The health sector that was the site for investigation is committed to the use of the quantitative method of scientific inquiry as this method is perceived to produce objective findings that are value free (Miller, 2000).

Justifying the methodology
Presenting the research proposal to the Otago Ethics Committee involved an extended discussion about the appropriateness of qualitative methodology in the health services, as well as discussion about ethical concerns. Some members were concerned
that the research design would not produce findings that were reliable. The focus of concern was that a small number of cases do not offer a sound basis for reliability and generalisation of findings. Another concern was that the data would be biased because of the intense subjectivity of the participants' stories and the existence of a prior clinical relationship between the person researched and the researcher. The Ethics Committee members were not accustomed to research proposals that focussed on the interaction between the receiver and provider of services. They had difficulty identifying with qualitative research methods that used an exploratory research design to gather subjective data. I was required to articulate the view that a multiple case study design was recognised as appropriate methodology for qualitative research in the health services when the topic of investigation focussed on relationships.

Case study research excels at bringing an understanding of a complex issue and can add to what is already known. Case studies emphasise detailed contextual analysis of a limited number of events or conditions and their relationships. Researchers have used the case study research method for many years across a variety of disciplines. Social scientists, in particular, have made wide use of this qualitative research method to examine contemporary real-life situations and provide the basis for the application of ideas and extension of methods (Soy, 1997: 1).

Considerable discussion occurred about the issue of how to describe the research proposal and therefore how to evaluate the appropriateness of the design. The Committee evaluated the proposal as a clinical trial.  

Ownership dilemma

A consequence of the research being defined as a clinical trial was that the Otago Ethics Committee required the Otago District Health Board to take responsibility for accessing research subjects. The basis for this decision was that the study

5 The Health Research Council describes a clinical trial:

[A]s any research on human participants conducted to gain new knowledge into mental and physical health and disease (Council, 2005: 7).

6 Email from the Unit Manager of the Psychiatric Day Hospital giving information that the Otago District Health Board would not sign off part v of the ethics approval application form. The basis for
participants all had involvement with services of the Otago District Health Board. This requirement was not acceptable to the Group Manager of Mental Health Services. She was insistent that as the Otago District Health Board had not commissioned the research, the organisation should have no involvement in supporting or resourcing the study. The Otago District Health Board’s decision to disassociate the organisation from the research required me to indemnify the organisation from all costs and consequences of the investigation (Bleach, 2003). I formally indemnified the Otago District Health Board from any costs that were a direct consequence of the research investigation. I also provided a formal commitment to privately fund an independent counselling service that would meet the counselling needs of any participant if his/her need was a result of participation in the study.

The question of responsibility for issuing the invitation to participate was resolved by a compromise. This was based on a precedent established by a member of the medical staff (this issue is discussed further in the section on ethics).

Qualitative design and the topic for investigation

The investigation required a research design methodology capable of gathering data that captured the thoughts, feelings, issues, meanings and individual sensitivities of participants. Qualitative methodology was used because it suited the purpose of the study and type of data sought. The empirical data sought was the exploration of the participant’s perspective of the interaction and relationships of family, patient and staff as they worked to create knowledge and make decisions.

Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasise the value-laden nature of the inquiry. They seek answers to questions that stress how social experience is created and given meaning (Denzin, 2000: 8).

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this decision was that the Otago District Health Board would not accept the responsibility that the Otago Ethics Committee required, that invitations to participate in the study must come through the Otago District Health Board (Bleach, 2003).
Quantitative methods are unsuitable for the analysis of the social reality of interactions, as these cannot be counted like the incidence of variables as though the responses of participants represented an objective reality (Denscombe, 2002).

Social reality is something that is constructed and interpreted by people – rather than something that exists objectively “out there”. ... It is a social creation, constructed in the minds of people and reinforced through their interaction with each other (Denscombe, 2002: 18).

I was aware of the subjective nature of the empirical data and that each participant’s response was a representation of the social reality of family, staff and patient interaction. In order for qualitative research to have credibility and to build theory there is the need to generate multiple representations.

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations...Qualitative research involves the studied use... of a variety of empirical materials...that describe routine and problematic moments and meanings in individuals' lives (Denzin, 2000: 3).

In this investigation the multiple representations were the discourses of participants, discourses from policy documents like the Blueprint and historical accounts such as the Mason Report. Of the discourses, more emphasis was placed on those that came from the in-depth interviews. The interviews provided rich detail about participants’ experience of the relationships and processes that occurred during the care and treatment interaction. I examined the content and context of constructed discourses for how knowledge is built and decisions made and for the nature of power relations. This evaluation followed the knowledge/power construct of Foucault (Foucault, 1980).

In the analysis I acknowledged that power relations from macro, meso and micro sources of influence shaped the representations of reality.
Validity

A specific design feature used to strengthen validity was the use of triangulation. Triangulation occurred when data was sourced and viewed from multiple perspectives and sources. Therefore the findings were more plausible because they were derived from multiple sources.

Validity was strengthened by:

- Multiple participants in each case study
- Multiple case studies
- Multiple sources of data - case studies, policy documents and literature on the history of mental health services and therapeutic interventions
- Credibility of the researcher as an informed and experienced practitioner
- Multiple sources of analysis
- Data from interviews that was a rich description of the experience of knowledgeable participants

These issues will be discussed more fully later in this chapter.

Researcher relationships

I have worked for fifteen years at the site of the investigation, the Psychiatric Day Hospital at Dunedin. All the participants knew me. The staff were colleagues and the patients and family members were people with whom I may have had significant clinical involvement in my professional role as social worker. I was an ‘insider’ in that I knew about the personalities and personal stories of many participants. I was also an insider as I knew about the history and structure of the mental health service and the Otago District Health Board as I have worked for the Health Board for over thirty years in clinical, professional advisor and service director roles. I have taken part in the transformation of mental health services from an institutional to a community care focus and more recently the move to focus on the Recovery Approach. This familiarity with participants and the structure of mental health services provided me with opportunities and access that would not have been available to an outsider.
The privileged insider position generated caution from the Otago District Health Board. That felt to me like resistance to the topic of investigation. The Otago Ethics Committee expressed the view that my insider position compromised the research by blurring the role of researcher and provider of clinical services. It considered that the research design where potential participants would be selected by convenience sampling at my invitation allowed the bias of the researcher to intrude.

However I was also an outsider as the research was part of personal academic study and not part of my role as an employee of the mental health service. The change in my relationship and role with all participants was acknowledged in writing and in conversation. No participant had any current clinical relationship with the Psychiatric Day Hospital or myself. There was an interval of at least six months between the time of clinical involvement and the invitation to participate in the study. This separation of roles was clearly acknowledged and the time period between clinical and research involvement enabled the participants to engage in the research as a separate process. The participants accepted the invitation to participate in the research on the basis that the findings aimed to contribute to knowledge of best practice for staff working actively with family. A couple of participants wondered if their experience and their contribution would be relevant as they viewed their perspective as atypical. The results are my interpretation of participants’ constructions. As such the findings are open to challenge that they are credible and the interpretations plausible.

Exploratory design

I began with the idea of exploring the place of family in the care and treatment processes. I was interested in the power position of family in interactions with staff and the patient. I wanted to explore how power relationships influenced the building of knowledge that was used in decision-making. Further, I wanted to find out if there was similarity or difference in how sub-groups viewed the relationship between staff and family and what best practice for the partnership interaction of family, patient and staff would look like. To achieve this goal it was necessary to interview participants who had real and recent experience of working in response to an episode of significant mental illness of a patient who was in an active relationship with his/her family.
The interview questions were based around the three themes of knowledge, interactions and decision-making. Questions centred around the theme of knowledge asked about what information was shared at particular times, such as the initial assessment and other specific times considered crucial to intervention plans. Questions also asked if information was shared at other times and whose needs and issues were being attended to.

Questions on the theme of interactions sought to understand the role and responsibility of the parties. The questions focussed on whether the strengths, needs and context of the family were identified and responded to. The questions asked how this was done and by whom. In questions about the experience of interaction, information was sought about the degree of comfort experienced and the extent to which the participant felt he/she was in partnership.

Questions on the theme of decision-making focussed on the participant’s perception of being included or excluded from decision-making. These included whether the participant defined the issues of concern as well as influenced the choices made.\(^7\)

I used a multiple case study format. Each group of participants who had the same role [family/patient/staff] formed a case study. I was able to make cross comparisons from each case study as well compare data from historical and policy documents.

The questions were initially developed and refined in consultation with my supervisor. A pilot study was used to test out the clarity and usefulness of questions. I found that questions enabled participants to tell about their experience. However I modified them to have a tighter focus on the relational processes of interaction, rather than the content of interactions. The reason for this change is that the process, rather than the content, of interactions was the dimension of the study critical for shaping working partnerships.

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\(^7\) There were eleven questions asked in the semi-structured interviews. These questions are included in the appendices.
Case study

The case study is a method of investigation that fits well with an exploratory process that asks participants to describe and explain their experience of a real life situation. The exploratory case study design does not begin with a proposition because this would limit the purpose of appreciating the comprehensive issues of a topic or of particular groups (Alston, 1998; Yin, 1984). The exploratory design has a clear purpose of guiding the study.

Interviews

The focus of the interviews was on eliciting the views of ex-patients, family members and clinical staff on the processes they experienced in building knowledge and making decisions. The scope of the interviews allowed participants to reflect on their experience of inclusion or exclusion. The questions enabled participants to talk about the roles, relationships and events that shaped their reality of responding to an episode of mental illness. The interview asked participants to concentrate their responses around their experience of times when major choices were made in the intervention plan. These times were the initial assessment, reviews of progress and discharge from the Psychiatric Day Hospital. The themes and processes that participants were asked about can be described as:

- The creation and building of knowledge
- The sharing and exchange of information
- The making of decisions

Grouping of participants into sub-groups of participants who had the same role allowed for comparisons to be made across the groups. In the analysis the views of the participants were compared and contrasted with the views expressed in national policy documents such as the Blueprint and viewed against the historical context and existing theoretical texts about family, patient and staff interaction.

The interview process and questions were piloted with a person who was an active family member of a patient in another service and who was ineligible to be a potential
participant in the study. Feedback enabled the questions to be focussed more explicitly on the processes of knowledge building and decision-making.

The concept of the study was discussed with two people who were mental health family advocates. That consultation was confirming of the process of involving families in the topic of investigation but challenged the scope of the study because it did not include the in-patient service, regarded as a priority area of concern.

The participants were asked to respond to the same areas of inquiry. The questions were shaped so that they were consistent with the person’s role. The summary of each sub-group gave a separate discourse for each group. The discourses were compared and contrasted. From these were generated themes and the four categories that form the basis of the findings of the investigation.

Tools of analysis
The work of data analysis occurred in two stages. The first stage involved the use of grounded theory to reduce the interview data into categories. These were based on themes and patterns that emerged.

At the second stage, two tools for analysis were used to view the data from the case studies and the texts that illustrated the history and current policy of the mental health service. The perspectives from varying sources were analysed through the framework of trialectic logic. Kelly, (2001) describes this logic as bringing a holistic view rather than setting up alternate views to compete for dominance.

Trialectic holds three factors together, and it is out of the context of their interdependent relationships that new insights into social realities can emerge, and hence new ways to problem solve (Kelly, 2001: 22-23).

The desired end result of data gathering and analysis was to contribute to theory and practice knowledge of what factors make for best practice in the working relationship between family, patient and staff. The work of Bunch, (1983) provided the analytic framework for transforming the description of a phenomenon into a plan for change.
Bunch, (1983) describes her theory of analysis and change as consisting of four phases.

I divide theory into four interrelated parts: description, analysis, vision, and strategy (Bunch, 1983: 251).

Data reconstruction and theory development
The concept present throughout the empirical data was the nature of relationships. The data was categorised according to patterns that emerged. The patterns illustrated the issues that bound people to an active working connection or placed people at risk of exclusion from active interaction.

Categorisation of the data was organised into four relationship dimensions of:

- Establishing the relationship
- Strengthening the relationship
- Experiencing the relationship
- Foundations of relationship

*Establishing the relationship*
During the establishment of the relationship participants positioned themselves into particular roles. The perceived roles shaped the power relationships. The agenda created at the time of establishing relationships was a reflection of who initiated contact. The issues of how relationships and agenda were established were compared with the policy guidelines from the Ministry of Health, Mental Health Commission and Otago District Health Board.

*Strengthening the relationship*
This dimension focussed on the consolidation of the initial relationship as well as whether the relationship responded to the evolving needs and issues of the parties. As the story of the participants unfolded, the focus of the investigation centred on the relationships of the parties. The exchange of information that built knowledge for decision-making became the essence of the relationships. Holliday, (2002) stated that
qualitative methods provide for research design that is well suited to eliciting the themes that emerge from the stories of participants.

The interviews are open-ended, allowing relevant topics and themes to be developed. ... rather than controlling variables, these studies are open-ended and set up research opportunities designed to lead the researcher into unforeseen areas of discovery within the lives of the people she is investigating. Also, they look deeply into behaviours within specific social settings rather than the broad populations (Holliday, 2002: 5).

This dimension brought together the themes of common focus that were acknowledged as the reasons for maintaining contact and critical to enabling collaborative relationships.

**Experiencing the relationship**

This dimension is where the participants expanded on the way that their personal, clinical and professional issues were responded to. Particular attention was paid to whether the experienced relationship was similar to or different from the relationships described by the Mason Report and academic papers that reported on issues of family burden and the use of psych-education programmes.

In this dimension the focus was on power relations. Viewing the perception of participants about where expertise lay did this. A companion theme was the membership of the dialogue groups and whether participants experienced themselves as being included in or excluded from the processes of dialogue.

**Foundations of relationship**

This dimension distilled participants' experience into themes associated with an active working partnership:

- Staff set the framework for interaction
- Staff facilitation shaped the interaction between the parties
• The common ground that gave priority to the patient and focused on needs, enabled and sustained active working relationships
• The exchange of information was the basis for a working partnership
• Collaboration in dialogue was the foundation of an active working partnership
• Relational resources enhanced recovery and management of family adversity
• Family meetings enabled the parties to build knowledge and make intervention decisions that acknowledged and responded to participants’ needs

These themes point to the strategies that will add to the theoretical understanding of what participants believe makes best practice working relationships.

Theory development - grounded theory
The purpose of analysis was to recombine the data so that it contributed to the development of theory about best practice interactions. The technique used for recombining data was influenced by grounded theory. This theory uses inductive logic to develop theory from empirical data. Grounded theory is concerned with strategies of analysis and not with the methods of collecting data (Charmaz, 2000). Edwards and Talbot (1994) described grounded theory as:

[Theory] in which explanations of events are developed from detailed analysis of those events. The key feature of this approach is that explanations are driven to a great extent by data or phenomena rather than the imposition and narrow testing of a developed theory often from another context (Edwards and Talbot 1994: 9).

The data was broken down into discrete parts. The process used was to compare case studies for similarities and differences and recombine the data into themes that were then developed and consolidated into categories. The process of comparison continued and from that emerged the four dimensions that have been used to describe and explain the relationship experience of participants (Strauss, 1990).

The use of grounded theory concepts allows the data to be a powerful force in the story that is told (Janesick, 2000). Grounded theory has a focus on processes and
interactions rather than on events or activity. The telling of the study participants' stories actively involves the researcher and the researched and portrays the socially constructed meaning given to the topic of investigation (Locke, 2001). The tasks of the researcher using a qualitative research design and grounded theory concepts are to organise and categorise data.

The grounded theorist's analysis tells a story about people, social processes and the situations. The researcher composes the story; it does not simply unfold before the eyes of an objective viewer. The story reflects the viewer as well as the viewed (Charmaz, 2000: 522).

Quality of evidence
In health research qualitative designs are questioned more than the dominant quantitative methodology. The Ethics Committee had concern about the rigour and validity of findings resulting from qualitative research. The Ethics Committee asked specifically about how the design was going to eliminate researcher bias.

In the research design, I used multiple sources of evidence and multiple means of analysis to improve the quality of evidence. I declared my position as an insider and that there was a chain of evidence so that the findings are plausible. I declared that the data was interpreted so that it was a construction that made no claim to be value-free and capable of generalisation to every mental illness situation where there is interaction between family, patient and staff (Yin, 1984).

Attention was paid to the quality of knowledge produced. Staying close to the stories of the interview respondents gave credibility to the data, as it was the story of the participants. The data was 'thick' and provided a rich and complex description of the social reality of the storyteller.

What makes data valid is thickness not quantity of data. ... thick descriptions ... show the different and complex facets of particular phenomena (Holliday, 2002: 78).
A thin description simply reports facts, independent of intentions or circumstances. A thick description, in contrast, gives the context of an experience, and reveals the experience as a process (Holliday, 2002: 79).

The concept of theoretical sensitivity refers to the qualities brought by the researcher. The sources of theoretical sensitivity are literature, professional experience, personal experience and the process of analysis (Strauss, 1990). In qualitative research the data is subject to the construction and interpretation of the researcher. Therefore his or her capacity and knowledge can have a critical impact on the quality of the knowledge. As an insider and experienced practitioner I was aware of the subtleties of meaning of the data and was able to separate out what was pertinent.

The use of triangulation or multiple sources of data and multiple methods of analysis is a strategy to improve the quality and robustness of knowledge (Denzin, 2000; Fine, 2000; Shaw, 1999; Yin, 1984). In this study triangulation occurred by the use of a multiple case study method. This enabled findings to be built through a process of comparing and contrasting the three case study groups.

Documentary data

Historical and policy documents provided another source of data. This information was compared and contrasted with the data from the case studies. Multiple methods of data analysis strengthened triangulation. I used grounded theory concepts to organise and categorise the data and the theories of Kelly, (2001) and Bunch, (1983) to further develop the theory of best practice interaction. The use of these processes and design features enhanced the credibility of the data and the plausibility of the findings.

The quality of the data is dependent on the research design rather than on the type of methodology. Janesick, (2000) cautions the researcher using qualitative methods from being overly concerned with the issues of quality that belong to the realm of quantitative inquiry.

Obsession with validity, reliability and generalisability can occur and needs to be avoided. It is always tempting to become obsessed with methods, but when this happens, experience is separated from knowing.
Over concern with methods is another way to move away from understanding the actual experience of participants in the research project.... Qualitative research depends on the presentation of solid descriptive data, so that the researcher leads the reader to an understanding of the meaning of the experience under study. Therefore the researcher should focus on the substance of the findings (Janesick, 2000: 390).

Sampling
The purpose of a study dictates the sampling method. This study aimed to generate knowledge that would be transferable to other situations where family, patient and staff sought to work together. The type of data required was a thick description. The use of multiple case studies improved the quality of the knowledge (Yin, 1984). The study sought a small number of participants with recent, specific and intensive knowledge of the role of family, patient or staff. It was necessary that the study participants were unconstrained by conflicting relationships with the investigator.

In order to make data collection, collation and analysis feasible within the constraints of a masters degree, three case studies each consisting of three people were decided on. The sample was chosen on a purposeful basis ensuring that the people had expert and detailed knowledge of the topic and participants were able to provide rich and thick data. This would not have been achieved if the sample was large and participants chosen randomly as in quantitative studies (Rubin, 2000).

The staff participants were selected on the basis that they were known to have experience and interest in working with family as full members of an intervention team. The ex-patient participants had to have been discharged from the Psychiatric Day Hospital for not less than six months. The ex-patients also had to have had the experience of active family involvement during their time at the Psychiatric Day Hospital. The family members had to meet similar criteria of recent active involvement with their family member.
Interview process

I invited selected staff colleagues to be research participants. They were given a written description of the study which included information about what was asked of them and how the data would be managed to preserve anonymity.

Clinical staff employed by the Otago District Health Board spoke to potential family and ex-patient participants. This was a requirement of the Otago Ethics Committee and the Group Manager of Mental Health Services of the Otago District Health Board. These potential participants were asked if they wished to express an interest in being approached by me. A written statement was provided explaining the study and what being a participant involved. One week after the initial approach was made to potential participants, I contacted those who had indicated interest and final written permission to conduct the interview was obtained.

The participants chose the venue for their interview. All but one, who was an ex-patient, chose to be interviewed at the Psychiatric Day Hospital. This ex-patient chose to have the interview at a neutral site.

One ex-patient who was approached and initially agreed to participate, later chose to decline on the basis that the interview would bring to the surface issues that she did not want to revisit about a former spouse. All other potential participants readily accepted the invitation. Several participants described their situation as being atypical and wondered if they were ideal people to interview. Each participant was motivated to tell his or her story on the basis that it may be of use to others who would use the mental health services.

The interviews were conducted in May to October 2004. They were spread over this time to accommodate my holiday and personal needs and those of the researched. A semi-structured format was used in the interviews. There were questions around the three themes of knowledge, interactions and decision-making. The questions were the same for all participants although the specific wording differed to fit the roles of ex-patient, family member or staff.
The participants did not express concerns about privacy and confidentiality. The interview data was stored securely at the Department of Community and Family Studies at the University of Otago. In the write up anonymity was preserved in that quotations were identified only by group e.g. ex-patient.

I transcribed the interviews. This made me conversant with each script and was helpful when analysis was undertaken. After transcription the scripts were returned to the participants to check for accuracy and acceptability.

Interviewing style and insider connections
The style of the interview was that of a guided conversation between people who had previously shared significant and life shaping events, including for most participants periods when the illness was life threatening. The family and ex-patient participants found that the interview provoked recall of strong feelings. The majority of participants remarked that the interview provided an opportunity for reflection that was useful in gaining perspective and understanding about themselves, their family and the process of managing illness.

I had the advantage of years of practice of relationships skills. There was acknowledgment of my familiarity with the circumstances of participants. This made the story telling easier as I was able to prompt and clarify issues from my knowledge of the topic as well as my knowledge of the participant’s time at the Psychiatric Day Hospital. I had privileged access to sensitive issues that would not have been available to a researcher who was an outsider.

My long working association with the Otago District Health Board advantaged me. This meant that I was familiar with the history of national and local events and the policies of the mental health service. The insider connections were helpful in interpreting the experience of participants but were a potential source of bias in that I might look for evidence that reinforced pre-existing views. I believed that the research design of open-ended questions and a case study methodology that generated ‘rich’ and thick data, allowed the story telling to be the participant’s voice. I accepted that the interpretation of the data was my construction. However by staying close to the data I enabled the experience of the participants to be known.
Quality

The problem of insider status and researcher bias

The Otago Ethics Committee and the Group Manager of Mental Health Services expressed concern that the investigation would generate biased findings. This was because I was too close to the participants who would not have an unencumbered opportunity to speak out their own views. The research design attempted to limit researcher bias.

- The supervisor was neutral and was not involved with the topic
- A pilot study was used to check out the clarity and appropriateness of the research questions and the interview process
- The research design including the questions was reviewed by two family and patient advocates
- Recruiting of family and ex-patient participants was done through a third party who was a member of the clinical staff of the Otago District Health Board

Ethical issues

The ethical concerns raised by the topic of investigation and the research design have been extensive and trying. My position as an insider was a focus of intense interest and concern for the Group Manager of Mental Health Service. The Manager was appropriately committed to ethical principles. She wanted to ensure that no deceit occurred and that the research was conducted only on the basis of voluntary participation, following the giving of informed consent (Tolich, 1999). It was deemed necessary by the Manager that I made no approach to any ex-patient or family member who had been associated with me at the Psychiatric Day Hospital. She did not accept that the Otago District Health Board had any responsibility for or connection with the research project. The Board's role was to protect people who had been users of its services. I had to organise and privately fund provision for any counselling and professional help that may have been required.

The Otago Ethics Committee took the view that recruiting of participants had to be done through the Otago District Health Board because the research was clinical.
research and potential participants had to have been patients of the Otago District Health Board.

A resolution to this dilemma was obtained after many meetings. The Ethics Committee and the Group Manager had recently agreed to a clinical research dissertation of a staff member of a different profession. This staff member interviewed a number of people who were current patients. A few of these research respondents had a continuing connection with the researcher who was clearly an insider. The resolution for my research proposal that was acceptable to all parties was that other staff members made initial contact with potential participants to ask if they would accept contact from me. This approach met the requirement of sufficient distance between my clinical and research roles.

Questions raised about the appropriateness of qualitative methodology required me to study the qualitative and quantitative debate. This demonstrated that the health services are primarily committed to research using quantitative methods rather than qualitative methods that explore issues of meaning, such as power relations.

People who identified as Maori were excluded from the research. I believed that I did not have the knowledge and resource to enable me to justly encompass the issues of knowledge, power and decision-making from a Maori perspective. I consulted with the research advisor and chairperson of the Otakou Runaka Executive Committee. The Committee endorsed the research proposal that excluded people of Maori ethnicity.

What the researcher would do differently
The investigation has been a long, intense and complicated experience. I would make the following changes:

- simplify questions so that overlap is reduced
- have questions focussed explicitly on relationship processes rather than on the content of interaction
- prepare explicitly for the debate about qualitative methodology
• be aware of recruitment processes for participants for which there are precedents
• allow considerable time for consultation.

Simplification of interview questions could be expected if the pilot study was more extensive, especially with people who had similar characteristics to the participants.

Consultation with Otakou Runaka would have been easier for me if I had appreciated that this could be a lengthy process. This is also true for consultation with the Otago Ethics Committee and the hierarchy of the Otago District Health Board.

Summary
The process of undertaking the research has heightened my awareness of the issues of mental illness. I deepened my knowledge of the history and policy associated with mental illness and gained a clearer appreciation of macro and meso level forces that impact on social and economic policy and clinical practices. I became familiar with the research debate about qualitative and quantitative methodology and the ethical issues and sensitivities associated with the position of an insider researcher.

This research could not have been completed without the generous help of all the participants who willingly gave their time and unconditionally told their personal and professional stories. I experienced significant support and practical help from numerous colleagues who have encouraged the research project at times when it may have foundered.
Chapter Four

RESPONDENTS’ VOICES

Introduction
This chapter details the views of participants and forms these individual responses into three case studies that represent the collective view of each sub-group.

The inquiry was a study of power relations that shaped the processes of interaction as ex-patients, family and staff responded to an episode of mental illness. Each participant was interviewed in-depth and asked a set of eleven questions. The questions centred on themes of information exchange, interactions between family and staff and the nature of decision-making processes. The interview focussed on events and issues associated with the intervention processes of assessment, review and discharge. In the dialogue that arose particular attention was paid to what information was shared and how knowledge was developed and used. In the theme of interaction, attention was given to the processes that defined interaction and those that enabled or restricted interaction. In the theme of decision-making, the dialogue explored issues of power, transparency, involvement and collaboration.

The framework for this chapter is based on the nine topics that emerged as common threads from the coded responses of the three groups of participants. The group responses are formulated into three sub groups: staff, ex-patients and families.

Staff Group
There was overlap in the responses to the nine topics that make up the discourse of staff participants.

Initial assessment
The staff held the view that the initial assessment was a time of relationship engagement when the framework for the relationship between the parties was formed. The assessment provided an important space that enabled people to express how the unwellness impacted on their lives and to say what was needed to regain normal and positive living.
The setting of the framework for working together involved the staff sharing information about their roles and the mental health services and how contact was made and risk managed. The initial assessment and the first contact gave an indication of how needs and issues would be responded to. This created the basis for dialogue and indicated the degree of collaboration that could be expected, especially the extent of staff facilitation for family to influence the intervention plan. The staff believed that they created a culture which encouraged working together to enable change that contributed to the well-being of the patient and family.

Having people a little bit curious about maybe what Day Hospital can do and how they can make changes. It is like opening up possibilities.

Staff viewed the initial assessment as a time when there was a two-way process of information sharing that was helpful to building a good picture of needs and clarifying issues of both the patient and family. The experience, knowledge and strengths of the patient and family were acknowledged as being valid and relevant resources that contributed to the intervention plan. The social context and the relational consequences of the illness were part of the process of assessment.

You have really got to get to know the person behind the illness. The person who has the illness is more important than the illness the person has ..... So that is huge, really looking at the impact. You have got to do that for a good assessment.

The staff considered assessment an ongoing process.

Family contact

Staff believed that contact was based on their commitment to best practice. This involved being responsive to needs, especially at the start and end of an episode of intervention.
We invite families and significant others to be part of the initial process. We try to maintain regular contact. .... We like them to be part of the discharge process.

Any party could initiate contact but staff considered that initiating and supporting contact was a staff responsibility regardless of whether the contact was informal or part of structured events.

Family contact enabled the sharing of information so that family could be part of the therapeutic intervention. It enabled collaboration about problem solving and consultation about crises and safety concerns.

I think that families do want to know what is going to happen. And often they need to be heard and supported because they are after all going to be continuing on the journey with the person.

Reasons for family involvement and exertion of influence
Staff acknowledged that families provided a fuller picture of the social context. Family exerted influence so that the patient and family were understood, their rights protected and needs met. Support and commitment for the patient were demonstrated by family involvement and this strengthened hope which was an important resource for recovery. Family involvement influenced intervention decisions so that they were tolerable and relevant to the capacity, resources and needs of the patient and family. A staff member described family involvement as being based on the appreciation of the patient’s incapacity to represent him/herself.

Some people are so unwell that they ... don’t know how to communicate exactly how it’s affecting their own life so often family tend to put a clearer perspective on it. So information from both the patient and the family is important. ......... I think that they [family] need to actually influence the decisions as they know how much they are able to give and they know the commitments they have got in other parts of their lives.
Critical aspects of active relationships

A fundamental aspect was the recognition of the mutual benefit of family contact. The staff acknowledged that their commitment to and facilitation of family participation was central to attaining an active working relationship. This commitment recognised that family was a source of information and was a potential resource for care and recovery. It was recognised that each family was unique and that an active relationship required staff to validate the experience of patient and family and respond to their issues.

I think that you have got a whole range of service opportunities available … Particularly I think you have got to look at tailoring that to each patient and their family. And I think that one of the issues….. is certainly one of support not only for the index patient but for the family as a whole.

A safe culture enabled active partnerships where collaboration about personal and sensitive work could occur. This required processes that were inclusive of the experience and capacity of all parties. A staff participant who was a doctor recognised that there had been a significant shift in power and dominance especially from medical professionals so that active relationships with family were able to occur.

It has become part of good clinical practice to work with the family. And to recognise that these family members can be an integral part of treatment and care and sometimes [family] make a huge difference in terms of success or otherwise of your treatment plans.

An active relationship required identifying and responding to everybody’s needs and issues. This meant purposeful and focussed work that explored the experience of all those affected.

The goal is for the person to be well and for the family to also be functioning.
The currency for relationships was the sharing of information. A full relationship involved the use of the strengths and resources of the family.

Part of the resource is the [family] information and experience.

Expertise
All staff agreed that in the assessment phase the source of wisdom and expertise lay in the interaction of patient, family and staff.

If people don’t feel they have ownership they are not likely to stick with the follow up or be part of it. The idea of ownership, which is one of having rights, you make decisions around that, but there is also a responsibility.

Staff recognised that recovery from unwellness was based on therapeutic interactions and active responses to the issues of the patient and family.

In terms of patient’s illness and management there will be discussions and negotiations what to do in particular kinds of crises, who takes responsibility for what. Discussions may be helpful in terms of defining the roles that family members play in terms of everyday interactions, but also in terms of managing illness or symptoms.

Partnership and decision-making
The staff preferred a decision-making process where there was full consultation that resulted in agreement. The staff acknowledged that they used support and persuasion so that consent was attained. The exception to this process was where safety was a concern and then agreement wasn’t considered the priority. These directed decisions about safety would be discussed and reviewed if requested. Establishment and maintenance of relationships were the basis for work and decision-making.

You are trying to establish a dialogue or a connection, an ability to work together. ... Apart from them sharing information with you that other
part is establishing rapport and some sort of level of connection with the family.

The staff acknowledged that information exchange and decision-making evolved through the processes of consultation and collaboration.

I think it reflects on the need to be flexible around what is often a changing situation. ... We actually need to get together and be very clear about who is doing what ... there are some formal settings where that occurs.

The staff expressed an awareness that the way of working with families was shaped by influences at micro, meso and macro levels.

So it has come about through families and the public and political arena. ... It comes about increasingly through the training disciplines and ethics of the political practice of various health disciplines. I think it is part of our training. You really need to involve families.

The staff believed that there is equity of power relations. This is a result of the intervention plan being concerned with the complementary needs of the patient and family. The staff saw their partnerships as flexible and responsive to the needs of all parties. They viewed intervention decisions as not dominated by any person but based on the common ground of what is helpful to recovery of the patient and functioning of the family.

I like to think that they [different needs and issues] are looked at specifically. The way that I do that myself is try and set a time to get the family together with the client and try to talk informally about what is happening so that each party gets an opportunity to see the other person’s perspective.
Staff provided
All staff recognised that they were influential in the interaction between family, patient and staff. They recognised that what made a difference to interactions were issues of support, reassurance and validation of the family’s experience and of the strengths and resources of the family and patient. One of the staff placed very strong emphasis on supporting family. This was in recognition of the importance of family relationships to recovery.

To have connection and meaning with people, family or significant people in their life, is ultimately what is going to get you through.

Support and reassurance were developed through staff listening to family and acknowledging the validity of its experience. This validation and support enabled family resilience to be strengthened and enhanced the capacity of the family to contribute to recovery.

Giving people the opportunity to express how it is affecting their lives and what do you see needs to be different for life to be able to go on in a normal and positive way. ... It is helping them to reconnect or identify for themselves what they have got.

All staff acknowledged that they exercised responsibility for facilitating communication and collaboration.

Ideally there is some regular contact with the family. ... To check in to see if there are any concerns. It is very helpful.

The staff provided expert and specialised information focussed on the patient’s illness and family well-being. There was information and advice on the management of symptoms and behaviours. Staff provided an intervention plan and the process for implementing care and treatment. Information was provided on the mental health services and how to access help.

You have to consider the well-being of the family as much as the
A staff member described the choice of working at the Psychiatric Day Hospital as based on being able to emphasise the relational aspects of recovery.

I've come to Psychiatric Day Hospital purposefully because, I believe that this area ... looks at recovery and people's strengths and that is what interests me, not like other areas that seem to be focussed more on illness and diagnosis.

Information exchange process
The more active and comprehensive a working relationship was, the more varied were the contexts for dialogue and information exchange. It was more usual for informal exchanges of information to be one to one contacts. The staff believed that family was most likely to be involved in the formal and structured events of initial assessment, review and discharge meetings.

I think definitely commencing and ending treatment there is more emphasis on the family being involved.

The context that enabled dialogue about crisis issues, problem solving and review of progress was the family meeting.

[Collaboration] is a two way process, it is information we share with the family, it is information that the family shares with us. Trying to clarify what some of the issues are for that person and that family.

Staff recognised the need to be flexible and responsive to changing circumstances. When critical issues and problems occurred, the staff were active about including and informing the family.

Issues of safety, I think that there is certainly a clinical responsibility to contact family members if there are issues of safety affecting them or their children. And that will ideally be done with the patient and in some
cases the issues are so significant that may still happen without patient consent, if safety is a real priority.

The staff acknowledged that information exchange was improved by explicitly meeting agendas and if they took a role to facilitate the partnership and the communication.

I think I have a got a responsibility to make sure that people are aware of all of those things [understanding symptoms and options for management]. So I need to actually take the initiative to raise those issues with people.

The staff perceived that the exchange of information was controlled by issues of mutual benefit and occasionally by issues of safety when the staff needed to advocate for the protection of a vulnerable person.

You may actually ... look at a role of advocacy or protection. ... In some cases you need to protect some specific members who are very vulnerable.

The family meeting was acknowledged as suited to exchange of information.

I think the major vector .... for that [information exchange] to happen is the family meeting. Where we all get together .... and talk things over together ..... So everybody has got a slightly different perspective. .... But the perspectives make a whole view of the person.

Family meetings
The staff described the family meeting as the social context where the needs of the patient and family were discussed, and where intervention plans were developed and refined.
The fact that you [staff] know what the lived experience is for the client and their family and the illness is important. So we know how it is impacting on their lives and what we can actually do to help.

The family meeting maintained a primary focus on the needs of the patient but allowed the issues of family to be responded to in a manner that was complementary to the needs of the patient. A staff member described the family meeting as an opportunity to

[T]alk ..... about what has happened so that each party gets the opportunity to see the other person's perspective.

The staff valued family contact that was safe and supportive and saw it as a positive resource.

I feel comfortable and that may come from the fact that I let people know that they are valued and that I respect the fact that this experience of mental illness is difficult.

**Ex-Patient Group**

**Initial assessment**

The ex-patients experienced the initial assessment as a time when they connected with the reality of their mental illness. The emphasis was on the needs of care, diagnosis and recovery as well as discussion about options for treatment and the managing of risk. The focus was on generating an agreement on intervention.

There wasn’t much discussion in relation to my family. It was more directed to my immediate health needs and how I was feeling at the time. ..... I would say a medical assessment of my condition and my safety ..... assessing if Day Hospital would be appropriate for me.

The staff took the lead by describing their role, what the Day Hospital provided and how the mental health system operated.
I was the focus of attention and particular concern was on the negative impact of my unwellness. The response of the staff was to validate and normalise my experience..... I felt reassured by what the [staff] said ... basically said it's understandable and it's a huge step to take.

The ex-patient group recognised that involvement of family was welcome and that Day Hospital endorsed collaborative working relationships in which family could take the initiative to present issues and speak for the patient.

Because I couldn’t and my aunty was telling them everything I couldn’t tell them.

At the time of initial assessment most patients did not have family involved.

The initial assessment didn’t involve my family really.

The social context of the illness was acknowledged, as were the personal and family impacts of the unwellness. This occurred as part of continuing assessment in which there was dialogue that compared the views of staff, patient and family.

With just .. staff and family present .... facilitated discussion was actually good. I’d actually recommend that almost as a standard sort of thing to do on the basis that most of things happening with people certainly aren’t isolated from what is happening in their family situation.

Family contact
Family contact differed according to the ex-patient’s capacity to articulate his or her needs and issues. The only person to have family present at the initial assessment was the person who could not communicate issues other than her deep distress and desire not to be a patient. This person’s family took the initiative to be involved, as they knew of her incapacity and resistance. The other two people who were more able to represent themselves began family contact in response to a problem or as part of the review of progress. The staff suggested these contacts.
I reached a crisis point and that’s when the circle was enlarged. [Spouse] was included and so were you [interviewer]……

Organised and structured family meetings were the most frequent form of family contact.

[Spouse’s] mother came to one of those meetings because it was really important for her to be able to know what was happening, what was going on. To have her say how she thought I was doing.

Family members who were socially confident were also able to have informal phone contacts or spontaneous one to one contacts.

Reasons for family involvement and influence
The ex-patients acknowledged that their family was involved because the family wanted to improve the patient’s well-being and help their recovery. The family gave information about the patient’s history as well as current needs, issues and functioning. This happened especially at times of review of progress and discharge.

When I first came here [spouse] was the one who informed on ..... what really mattered. [Spouse] was really worried about me being at home with the (children) and could I cope if [spouse] went back to work and could I manage to keep myself safe.

The family was involved as a way of demonstrating support.

They were a huge part of getting to go home …. and starting all over again.

The family set limits to ensure its survival and to protect what it considered was in the interest of the patient. An ex-patient described her spouse as advocating discharge rather than supporting an extended period of care and treatment.
He didn’t think it was doing me any good especially after the horrible thing that happened with the suicide. That’s enough, you need to get out of there.

The families were involved so that their needs and issues were appreciated and responded to. The families received support, reassurance and feedback on care, treatment and progress. It was eventually a safe place to communicate and work with personal and sensitive concerns.

Well the safety was covered as far as reassurance for my [spouse] … [Spouse] was more worried about it than (spouse) had been letting on at home. … [Spouse] was prepared to talk about it here.

Critical aspects for an active partnership relationship
The ex-patients described four dimensions as critical to creating a relationship of active partnership.

- That family contact was an essential source of information and a resource for care and recovery.
- That the experience of the patient and family provided valid knowledge that was used as part of the intervention plan.
- That staff facilitated communication so that the patient, family and staff collaborated in the provision of care and recovery.
- That family contact was based on a common and agreed purpose to which each person contributed.

The response of the ex-patient who initially excluded herself from working together with her family and the staff, illustrated that a shared commitment to a common and agreed focus was necessary for the development of an active partnership relationship. The staff facilitation of communication was an essential element that enabled the resources of the family, patient and staff to work together for recovery.
You want to talk to my [spouse] you talk to [spouse] but don’t expect me to be there. Because I also thought [spouse] was telling staff .. at those meetings stuff that would put me back in hospital again. Looking back now yeah I think staff did the right thing but at the time I didn’t.

The same person acknowledged that her family’s commitment to a common purpose made a significant difference to the course of her recovery.

My whole family, everyone just wanted me to get well and go back to the person I used to be. ... They were a huge part of the getting to go home – getting to go home and starting over again.

It was through family contact that the context of the illness was understood and an active partnership relationship developed. This provided a wider perspective that included the knowledge and the needs of both the patient and the family.

I think this was where the useful part with [spouse] coming in and having those sessions was. Because anything else would be limited by my ability to recognise them. .... I’m thinking both of us [patient and spouse] had been trying to shield each other from things and not communicating very effectively.

Expertise
The ex-patients acknowledged that one of the consequences of their illness was diminished capacity to articulate. An important issue was that the needs and concerns of the patient were incorporated in the intervention plan. The ideal was for the patient to be an active contributor to the knowledge that directed the plans for care and treatment.

I certainly had the feeling that it was very flexible and open to my input. Which was really good, I really liked that because I think that one of the worst things about being ill is that you’re not really taking part in your own care. ... this is where Day Hospital just seemed to get the balance
right for me because I also like that the fact that staff stepped in and said this is what we need to do with you now when things got really bad.

All the ex-patients recognised that their well-being and recovery were strengthened by the contribution of others even though the knowledge of others had the potential to put at risk the hopes and the participation of the patient. This potential threat led to one ex-patient choosing not to initially participate in family meetings. This threat has been discussed in the previous section.

The expertise of others was recognised as occurring through the processes of support and specific problem solving.

O.K. there was something quite specific because I reached a crisis point and that's when the circle was enlarged ... a couple of meetings relating to exactly how we were going to cope with [spouse] going away for three months.

All the ex-patients acknowledged that the source of expertise varied. When the person was advanced in their recovery the expertise lay more in the interaction of the patient, family and staff. At the time of initial assessment and treatment the staff were the dominant experts and interaction was focussed on a dialogue between the patient and the staff. One of the ex-patients recognised that specific meetings were needed so that family could be part of collaborative dialogue.

I think other than the family sessions we had, I don't think she [spouse] felt particularly well included. That's why she was keen to have that type of session, which worked well.

The dialogue that came from participation in the formal programme was recognised as a source of expertise.

The things that did help I suppose were the opportunities to talk about things ... around and within the broad sort of community setting. Sort of
support was good. .... The topic in a lot of the sessions was quite useful with looking at problems and issues that were sort of affecting people.

Partnership and Decision-Making
The ex-patients were not unanimous in their experience of decision-making. The more actively the person was involved in his or her intervention, the greater the degree of full consultation and full agreement. The participant who was unable to collaborate in her care and treatment was the only person to experience that decisions were implemented without her agreement. However the decisions that were implemented without agreement were discussed with her beforehand and were subject to review.

Issues of safety and crisis and the needs of all parties influenced partnership relationships and processes of decision-making. The ex-patients acknowledged that staff exercised judgements based on professional best practice. Staff were perceived as giving opportunity to make decisions based on dialogue and agreement.

The fact that he [staff] had stepped in and assessed where I was ... it was a very appropriate call. I knew that ... I couldn’t quite .... fit the bill. But the fact that he had stepped in and acknowledged where I was at and reflected the acuteness of my state very appropriately was enormously empowering in some paradoxical way.

This dialogue was about a patient deciding against in-patient admission.

The ex-patients recognised that the source of power for decision-making was flexible and varied. The group acknowledged that there was equity in that there were times when the patient and the family dominated decision-making. However the staff retained overall dominance in shaping the partnership and process of decision-making.

You want to talk with my husband, you talk with him but don’t expect me to be there.
This patient exercised her resistance to the staff. At a later stage in the interview she accepted that collaboration was desirable.

Looking back now .... I think that they [staff] did the right thing but at the time I didn’t.

Staff Provided
The ex-patients recognised that the staff provided the framework for interaction. The staff facilitated participation and maintained the intervention focus. The initial focus was centred on the needs and functioning of the patient.

I remember the focus being really just on me and my health. And how I was functioning, how I was not functioning and how I was feeling at that particular time.

Family participated usually because staff invited them to attend a formal meeting. These meetings involved elaborating an intervention plan and facilitating communication.

The whole act of engaging [spouse] first of all in the process of review was incredibly powerful as far as feeling supported. And feeling on the road that was going to be constructive and helpful for rehabilitation and for health.

The engagement of family with staff occurred through staff acknowledging and validating the experience of family. They provided support and reassurance particularly through the process of reflective listening that gave family the experience of being understood.

[S]afety was covered as far as re-assurance for my wife. That there weren’t safety issues. [These issues were] part of the discussions when she was here for some of those sessions because she was more worried about that than she had been letting on at home.
The needs and issues of all parties were established and clarified. This involved identifying the capacity, strengths and resources of members of the intervention partnership. These formed the basis of the intervention plan. This involved the staff contributing their specialist input based on their clinical role, and information on how the care and treatment system operated. The focus was on providing an understanding of illness and giving specific advice about the management of signs of unwellness.

At the time of the discharge meeting, the staff focussed on the issues of functioning and management.

How safe I thought I would be at home with [spouse] being away at work. Did I know what to do if anything went wrong? Did I know whom to contact. .......... Talk about my medication and how to keep myself safe.

Staff were active in facilitating communication and collaboration. The focus of this work was on problem solving and decision-making.

[Spouse] and I found those [family meetings] were useful. In fact I think setting up something in those sort of family orientated small groups with just ... staff and the family present was actually – facilitated discussions was actually good. ...... I think that some of the sort of things that came up in the family meetings was how much stress my wife was under at home and sort of made people aware of that. It assisted in getting those [home supports] set up.

Information Exchange Process
The needs of the patient and the impact on family formed the content for the exchange of information. The contexts for information exchange were the less formal one to one contacts of the patient and staff as well as the structured family meetings. The participation of the family was usually associated with the incapacity of the patient and was a problem solving response.

[A family member was] important to me anyway. Very important too because staff would ask me questions that I just couldn’t think about
answering because I was so tearful and nothing would come out but she was able to tell them what she thought I wanted to tell them I think. She was pretty good, she still is.

When the agenda was clear and the meeting had a defined purpose, knowledge was built and decisions made through a fully collaborative dialogue process.

O.K. there was something quite specific because I reached a crisis point … relating to exactly how we were going to cope with [spouse] going away for three months. So that was something quite specific that we were focussing on

The participant who experienced not being listened to and understood was unable to be involved in dialogue and collaboration.

Trying to get me in - running back into mixing in with my family through help from a counsellor and I think there was mentioned parenting classes, which I no way was I going to do. I wanted to do this on my own.

The majority of ex-patients experienced that they were listened to and through dialogue were able to exert influence over what was accepted as the knowledge on which decisions were made.

Oh definitely, definitely I mean to me that always has been the central part of my whole experience with P.D.H. was the compassion of the staff every one of them and their ability to listen and empathise appropriately... I certainly had the feeling that it [dialogue] was very flexible and very open to my input.

The more actively involved the participant was in interventions, the less likely the participant was to experience that information exchange was in the hands of others such as family and staff. The patient who was unable to be involved in dialogue demonstrated her resistance to the perceived sources of power by limiting her
involvement. This person did not perceive that the exchange of information was relevant or responsive to her needs.

I can't remember I just—no body's [needs]. I think—every body was telling me all these things that would just go in one ear and out the other. The needs were for probably [spouse] and the boys.

Everybody acknowledged that safety issues, a mutual commitment to problem solving and the development of resources for the recovery of the patient were factors controlling information exchange.

Family Meetings

Family meetings were the primary way of enacting the partnership. All patients recognised that family meetings were the sites where the social context of the illness was acknowledged. The meetings were forums that acknowledged and responded to the patient's needs and the issues and impacts for the family.

Later there were sessions set up between [staff] [spouse] and myself. I found those were useful. .... I think setting up ..... facilitated discussions was actually good.

Family meetings were more likely to happen when the staff invited contact. The usual impetus for contact and the focus for meetings were the needs of the patient. However the complementary needs of all parties were discussed.

Well definitely when (spouse) became involved ... [staff] suggested that he come in and we have a meeting with him and .... definitely his needs were focussed on. And there was a great effort made on behalf of the staff to discover what could be done to help [spouse] continue to support me.

The level of family contact was shaped by the amount of involvement the patients had in their care and treatment. If this was low then the level of family contact was dependent on the skill and initiative of the family and there was greater focus of
concern on family needs. When the patient avoided dialogue about his/her care and treatment he/she experienced relationships as conflictual and unsafe. Therefore he/she did not get involved in personal and sensitive work. This was most evident in the circumstances of the patient who feared that family contact would realise her fear of hospitalisation.

You want to talk to my husband you talk to him but don’t expect me to be there. Because I also thought [spouse] was telling staff here at those meetings stuff that would put me back in the hospital again.

This patient perceived that family contact was not about meeting her needs but the needs of others.

Yeah and the family’s, my boys’ and [spouse].

All the ex-patient participants, regardless of their level of involvement, agreed that a reason for family meetings was to give a means of integrating the views of family, staff and patient. In this forum, issues were assessed and reviewed, people were supported and knowledge and capacity were built for the purposes of understanding and managing illness. The patients acknowledged that the quality of the relationship between family and staff was enhanced when staff validated and responded to the issues of the family.

I think other than the family sessions we had I don’t think she felt particularly well included. That’s why she was keen to have that type of session, which worked well.

**Family Group**

**Initial Assessment**

All the participants who were involved in the initial assessment recognised that this was focussed on understanding the specific and unique issues for the patient and their family. The staff took initiative to create and implement an intervention plan and provide information about the operation of the mental health service.
I think that for us the opportunity to sit in and highlight what we felt were the important things. And how we had seen things was - very helpful. And right from the start we felt it was going to be a good shared caring for [patient].

One of the family participants did not take part in the initial assessment. This person thought that assessment and treatment belonged with the staff and the patient.

I’m not the expert in this area and to me treatment was totally an issue for the hospital.

The other two participants who experienced collaborative partnerships were able to be active in presenting the needs of the patient and family. They participated in developing an agreement about the content and processes of the intervention plan. These participants recognised that their lived experience was acknowledged and responded to. There was acknowledgement that the intervention plans were shaped by family knowledge, relationship commitments and the positive contribution family made to recovery.

I think that was done sort of gradually .... was sort of a learning process for us all. … We had to be able to say well this is [patient’s] life, this is normal life, this is who [partner] is in her life, this is who I am, her mother. And for [patient’s child] to be part of that too because [child] …. is a very vital part of [patient’s] life so anything that included her or was to do with (patient) we wanted to make sure [child] was there as well.

The two families who were present at the initial assessment had prior contact with the mental health service and were able to engage in a stronger collaborative relationship. They were successful in asserting the needs of the family and the patient. The family participant who did not have previous contact with the mental health service and did not participate in the initial assessment was unsuccessful in asserting his need to have separate consultation.
One or two things .... made me suggest that to staff .... that maybe we should have a one to one chat sometime but it seemed to fall on deaf ears. Which probably frustrated me a wee bit at the time but I didn’t push it any more.

Family contact
All participants recognised that family contact enabled an understanding of issues and participation in providing care and support. Contact enabled involvement in therapeutic interventions and problem solving and was dependent on the agreement of the patient. Contact was usually initiated by an invitation from staff and or was the expectation of an assertive family member.

Oh! By actually speaking up and making requests or demands .. to speak, ....... and not being afraid of being bullied. .... but knowing that our viewpoint was valid and demanding to be heard really.

The person who perceived the staff as experts was the exception in that he alone did not have contact with staff at the initial assessment. This person experienced that all contact was mediated through a process of family counselling and that he was an associate client rather than a partner throughout the intervention.

My understanding would be that they were not a review meeting, they were just part of the counselling process. In terms of trying to address possibly more the family issues that had come up as part of the ongoing treatment. ..... The reality the only involvement that I had or anybody else in the family appeared to be getting was through those lunch-time counselling sessions.

This family member also acknowledged that limiting contact enabled him to retain functionality.

I just had to turn off to [patient’s] situation and just not think about it. As it would have interfered with work a lot. Well it did. .... I probably did
tell quite a number of people that the only way that I really coped was by turning off.

The other two family participants had extensive contact and considered that they were an integral partner in the processes of care, treatment and recovery.

Both [staff – key workers] were very good at including me in everything really and explain what was going on and if we did like the craft afternoon I was just like another person in the group, which I found very helpful.

Reasons for Family Involvement and Influence

The reasons for family involvement were based on the understanding that family contact would enhance the recovery of the patient and provide a means by which the concerns of the family would be made known and responded to.

I think that everybody just got in and did what they could and talked about what they needed to. And it was just all worked together was how I feel it was.

Families involved from the beginning of the intervention were able to be more specific about their reasons for involvement and the scope of their involvement was more comprehensive. The reasons included:

- To contribute to the patient’s intervention plan based on recognition of family as having valid knowledge
- To access help for the patient and to enable engagement of the patient in care and treatment
- To make known the needs and issues of the family, in particular the need to know about progress, to access support and reassurance and to share responsibility for care and treatment.
- To influence decision making
- To support and protect the patient
To reinforce family connection and sense of belonging

The family participant who was not involved at the initial assessment expressed the view that his participation was influenced by his assumptions about the expectations of staff. When given the opportunity to reflect on consultation with staff he stated:

I suppose when I think about it – it probably would be useful because in terms of Day Hospital’s treatment of [patient]... the issues were in relation to her and how she saw life and her own views on herself and her relationship with other family members. So I suppose I could assume that basically Day Hospital would want to see how her other family members were coping.

Critical Aspects of an Active Partnership

The belief about who holds the expertise and responsibility for the intervention shapes attitudes towards the partnership relationship. This was shown by differences in the level of interaction within the active partnership. All family participants recognised that there were four critical aspects for an active partnership.

- That family contact generated valid information and access to resources for the care and recovery of the patient.
- That staff acknowledgement of the experience of the patient and family shaped the attitude towards partnership.
- That the level of collaboration as shown by the patterns of communication is indicative of the level of the partnership.
- That the roles and responsibilities of the parties contribute to an agreed and common focus.

The family was recognised as possessing valid knowledge and relevant resources for the patient’s recovery.

We were taking part right from the start. And it was just all through out that it was us, all of us and that is how it is. When you are looking after
someone like [patient] who is so unwell I mean it is all of you who are living through it. ….. Because she wasn’t able to explain it or you know to be able to say things. So it was just the knowledge that we could fill in bits and [patient] could say bits and we could all say bits together.

The understanding of the family and its context was critical in enabling some patients to engage in the intervention process. These understandings shaped the partnership and the course of care and treatment.

There were such a lot of hurdles and we were so nervous about her coming and her agreeing to come – because we have had bad past experiences with it. So it was a real relief to see that it was done well we thought quite thoroughly and gradually really. And that she was assessed from what she – how it would be for her really. ….. We had already made that known that [patient] wouldn’t come willingly unless it was done like that. Unless it was done as an encouraging and gentle, unless she could relate to the people that were doing the assessment and the family interview and everything there was no way that she would be a willing participant in that way.

The pattern of communication was illustrative of the level of partnership. The person who limited his communication in terms of the specific concerns of the patient did so as a means of preventing himself from being overwhelmed.

I turned myself off to it [patient’s concerns]. I know yeah I probably did tell quite a number of people that the only way that I really coped was by turning off.

Staff facilitation of communication aided the level of collaboration within the partnership.

I suppose knowing that in the meetings that if you said something that wasn’t right or worded rightly it was actually normally you guys would sort of help to re-word things and get things on a good plane of things
again. Because sometimes you don't say things right and it's good to know that you can say things without it being taken wrong. So that was good.

The family participants were clear that the purpose of the partnership was to respond to the needs of the patient. They recognised that this was a priority but also that the needs of others were considered.

I actually think [patient] was number one, her needs and her issues were number one – rightly so I think. But I think that they considered the family in altering what they would normally do .... They considered all of us in the fact that you know what we could manage really.

This person recognised that family was a critical component in the partnership that contributed to the recovery and well-being of the patient.

Oh yeah I did experience that I was a vital part really of [patient’s] helping I know that to be true. So I think I was in partnership yeah. I think they [staff] put that across to me.

Expertise
The standout difference in the family participant group was between the participant who thought that expertise lay with the staff and those who considered that knowledge and wisdom were shared phenomena.

The participant who viewed the staff as the expert in treatment was the only family participant who was absent from the initial assessment. This person suggested an individual consultation with staff. This request was not implemented and his involvement in dialogue was restricted.

I have to say that basically on – probably on a couple of occasions I did suggest that maybe - there should have been maybe one to one meetings, maybe with staff of Day Hospital and myself just to talk maybe talk through on more one to one basis how I felt and maybe some of the
issues as I saw them. That didn’t happen and I was surprised that it didn’t happen. ..... I thought that maybe it would have been part of the ongoing process that I would have been asked to express my views in a private capacity.

In contrast, the other family participants experienced flexibility of interaction that led to dialogue that recognised that expertise was shared and varied according to the issue.

I think that for us the opportunity to sit in and highlight what we felt were the important things. And how we had seen things, that was very helpful.

These two participants were able to meet staff on an individual basis as well as be part of a family meeting.

I know that if we had asked for a meeting it would have taken place. I know I specifically wanted (patient) to go onto a medication .... which I felt was helpful and suggested that. And we did have a meeting to discuss that. And that was really good that I was listened to and followed up. It was just the knowledge that you could ask and that you were heard.

Partnership and Decision-Making

The family participants were not unanimous in their experience of the process of decision-making. The two participants who attended the initial assessment and maintained active dialogue throughout the intervention, acknowledged that full consultation and agreement occurred when decisions were made except when the issue challenged the fundamental knowledge and responsibility of the staff.

Well there was information about the medication and what we believed was the alternatives to the medication ....... We involved the pharmacist who also did some research for us. .... And discussing
whether we could integrate the whole thing into her health plan. That was really well handled. The staff and the doctors and that listened to our alternative viewpoint. .... But I don’t think it was really considered in the whole kind of therapeutic plan of things. .... They tolerated [family] viewpoints on medication and things but it wasn’t considered.

When the issues were focussed on the social context of the patient and family, the decisions were directed by the needs and capacities of those involved.

The fact that we live at a distance that was talked about and included in the plan. The fact that we can’t give [patient] more than three days in town because of our circumstances and that was considered.

The person who was the exception in that he had more limited participation and dialogue, looked to the staff as the experts to guide and direct the intervention plan.

Well I think the staff here gave me confidence. They certainly knew no matter what the situation was they knew how to address it.

This person felt that the partnership and decision-making were based on the needs of the patient and the staff and did not actively include his needs.

I think the issues talked about were probably issues that the staff of the Day Hospital had realised had come up. Issues that they had identified with (patient) that were issues for her.

The other two participants acknowledged that the partnership and decision-making were based on the needs of the patient and incorporated the needs of the family in a complementary manner.

Very much [patient’s needs] but also very much ours which we really appreciated as well.
When there were issues of safety, consultation occurred but the decision-making was in the hands of the staff.

I know safety was the issue but in terms of us influencing any decisions about her ongoing treatment I don't know whether we did really have influence, …

The family participants recognised that the intervention plan and relationships were flexible, responsive and accommodating to the particular issues and needs of the patient and the family.

She [patient] was being recognized as somebody who was uniquely her own unique self. And in a small way we were as well I guess, as family.

Staff provided
All the family participants acknowledged that the staff provided the framework for the patient and family to interact with them. The flexibility of the framework contributed to participation. This flexibility enabled one family to initially accompany the patient in every aspect of the intervention.

Well … it was explained to us what would happen at Day Hospital …. We just felt really fortunate with the type of people they were and could understand and talk (patient's) language. …. And they were very good at sharing with the family too and including the family. [Patient] wouldn’t come on her own right from the beginning so I came with her…. I came in for the three days and we would bring [child] up to see where mum was settling in… I would sit with her. She couldn’t she just couldn’t relate to anybody and would not have lunch on her own or participate in anything unless there was somebody sitting right next to her – like which was me really. I tried not to interfere but both [staff] were very good at including me in everything really and explain what was going on.
The family participant whose request for one to one contact was not accepted did not experience a flexible framework for contact and did not know what was acceptable.

I'm not sure what the hospital's staff's general direction is in terms of involvement of other family in discussions and in their counselling service.

This person recognised that family contact was welcome but was unaware of the specific expectations.

I certainly had the impression that the hospital staff were very happy to have the family involved in the treatment plan. Our involvement was probably to the extent that basically we were asked by the hospital staff.

The other two family participants acknowledged that staff provided support, reassurance and validation of the experience and knowledge of the family.

But there was a concern by staff to include the family and how we were all doing and I know there were quite a few times when I was really finding it difficult and both [staff] and [staff] were concerned about my well-being and how was I doing and if I needed any help or to talk to anybody. So I thought that was pretty special.

The staff provided the focus for intervention that was inclusive of the needs of all parties. They facilitated communication and an integrated intervention plan that came from the collaborative dialogue of those whose lives where impacted by the illness.

It was just knowing that we were helping her. .... Yes but then again you have got to go through things like that (facing the suicidality of the patient) to actually get things out in the open and to talk about things. .... And it is just knowing that you people were there to pull it all together. And ask questions you know and just get things talking and moving on.
The staff provided the framework and facilitated processes of dialogue that produced knowledge and decisions that shaped the intervention plan. This began with the identification of needs and capacities. Staff created a collaborative partnership in which the experience of others was valued, strengths and resources developed, problems solved and decisions made. When the role of any party was confined, the range of knowledge and resources available for the intervention became restricted.

Yeah I think with the help of the staff here I think the issues particularly the family relationship issues were probably fairly well defined. I know that the anxiety issue for her was well addressed.

Information Exchange Process
The contexts in which information was exchanged differed according to the level of collaboration. The more limited the collaborative dialogue, the more likely that contexts were crisis and therapy focussed. The person who viewed staff as the expert was restricted in his dialogue with the patient and staff. He experienced family counselling sessions as limiting communication and as the only way that issues of assessment of needs, review of progress and planning for discharge were presented to him.

In reality the only involvement that I had or anybody else in the family appeared to be getting was through those lunch-time counselling sessions.

The other two family participants acknowledged the value of formal family meetings as well as informal individual contacts.

It was helpful to all sit down as a family and to discuss what we were seeing and what staff were seeing. .... And for me to be able to ring up and talk to [staff] and without having [patient] there as well just for me to be able to sort of check things myself was really good.

These two participants were involved throughout the intervention and were prepared to question, challenge and articulate their issues. They experienced that they were
influential in the knowledge that was accepted as relevant and used in decision-making. They recognised that knowledge was built and decisions made through collaborative dialogue in formal meetings where the agenda was explicit and focussed on the intervention plan.

We had discussions about how a normal week would be. ... It was a case of being able to afford and to plan our trips to town and things like this and .... we all decided including [patient] ..... we had to make that clear and try to work out something do-able from both sides.

All the participants acknowledged that knowledge was built when information was exchanged and people collaborated to develop a collective response to an issue. This was most likely to occur in the context of problem solving and defining the critical elements of the experience of the patient and the family. Listening, clarifying, dialogue and debate were helpful processes.

[Partner] had looked into the information about using Omega 3 to treat Bi-Polar. ..... And discussing whether we could integrate that whole thing into her [patient’s] health plan. That was really well handled, the staff and the doctors and .... our viewpoint as to alternatives in treatment that was well listened to and considered even though it wasn’t part of the usual kind of. .... sort of realm she [doctor] hadn’t got into that – the benefits of Omega 3. ... But I can remember some good discussions with everybody being heard.

This person found that the process of being instructed was not helpful in the building of knowledge.

Yeah .... we did talk about recognising the signs of [patient] got high. ..... [partner] and I were set this sort of homework that we have done so many times in the past about what happens .... how would you recognise that [patient] is going high again and we did that and we brought that we wrote it down and by that time I was pretty fed up with actually having to do it at all really.
Participants who were more active in defining the critical elements experienced a greater degree of control in the exchange of information and a capacity to positively influence the partnership. Safety concerns were an overriding issue that exerted control of the exchange of information. An illustration of a helpful process was the assessment of a patient who was initially unwilling to engage in any intervention. This was discussed in this chapter under the section of critical aspects of an active partnership.

Family Meetings

Family meetings were the main forum for collaboration and dialogue. They were an important and safe way of bringing out the social context and needs of the patient and family. The endorsement of family meetings was stronger amongst those families that maintained collaboration.

Yes everything was taken in as a big picture and identified and to be worked on slowly as [patient] could cope. I needed to be able to talk about that because ... I mean it is so different.

This participant recognised that family meetings were strengthened by the facilitation of the staff.

I could talk about anything in the meetings and really I suppose knowing that in the meetings that if you said something that wasn’t right or worded rightly it was actually normally you guys would sort of help to re-word things and get things on a good plane of things again.

All the participants acknowledged that the priority for family meetings was a focus on the needs of the patient. The person who limited his collaboration was the only one to experience family meetings as not meeting the needs of family in a complementary manner. He was unable to recall that his specific issues were identified and responded to.
I'm not too sure whether there was a lot of inquiry into our specific needs. Maybe because we had possibly given the impression that we were coping well enough.

In comparison the other family participants were clear that the intervention responded to comprehensive needs.

We were contacting each other and talking things through and that was really good. But I suppose it was .... all getting together. .... And that is a good way instead of just being [patient’s] decision or our decision it was just everybody working together.

This person spoke about the family meetings as a place where her concerns were responded to.

I know that if we had asked for a meeting it would have taken place. ... I was listened to and followed up.

The family meeting was a place where collaborative dialogue occurred so that assessment, review, decision-making and problem solving issues could be brought together in an integrated way.

I suppose meeting people everybody here from the start when [patient] first came in, it felt as if it was us as well. .... And it was just all through out that it was us all of us and that is how it is. .... So it was just the knowledge that we could fill in bits and [patient] could say bits and we could all say bits together.

The same person recognised that meetings were a significant way to influence the intervention plan.

Well we did influence decisions because obviously if we weren’t happy about things we would have said so. And that would have been through the meetings and telephone calls.
The participants recognised that the staff facilitated communication on difficult issues associated with strong feelings. The family meetings were experienced as a safe place in which sensitive concerns could be processed.

I could understand - the way some issues were addressed, brought up .... it was the way staff approached these matters in their discussions in terms of making it as easy as possible for the patient to or their family to actually sit down and talk about things in a … very calm situation and be able to address the serious issues without getting up tight or in an angry sort of state.
Chapter Five

CROSS COMPARISON OF THE THREE GROUPS

Introduction
This chapter compares the findings of the three groups on the issues that contributed to active partnerships. The responses were categorised into four dimensions which generated findings that developed an understanding of the components of best practice for collaborative interaction between family, patient and staff. The focus was on processes involved in the exchange of information.

The four dimensions were:

- Creating the relationship - the process of engagement and the framework for interaction.
- Strengthening the relationship – the critical relational aspects and reasons for maintaining contact.
- Experiencing the relationship – the building of knowledge and capacity, and the exercise of power through the process of decision-making.
- Foundational contributions to the relationship. The currency of the relationship was the exchange of information, particularly in the context of family meetings which were shaped by staff who were the dominant source of power.

Creating the relationship
Engagement
Similarities
All members of the three groups viewed the creation of a collaborative working partnership as based on dialogue about care and treatment. This dialogue began by identifying the needs and issues of the participants. The staff initiated a process that resulted in an agreed intervention plan and facilitated communication by listening actively and validating the unique circumstances, knowledge and capacities of the patient and family. Where the families were strongly involved they contributed to the partnership by speaking for the patient.
Differences
There were differences at individual and sub group levels with all but one participant acknowledging that staff explained their role and made an agreement about the intervention's content and process. This person was the family participant who was refused separate communication. His relationship with staff was based around family therapy sessions. He and the ex-patient who was fearful of interactions restricted the creation of working relationships.

The sub groups saw differences in the issue of the staff informing participants about the purpose and process of collaboration:

- All the staff stated that they gave this information.
- The family participants who were actively involved agreed
- The ex-patients and the family participant who was not actively involved did not agree.

Differences were seen about whether it was standard practice for the family to take initiative in communicating issues about assessment and care:

- The staff group and the two family participants who were assertive said that it was standard practice.
- The family, the ex-patient participants who were focussed on self-protection and the ex-patient whose family began involvement only in response to a problem did not recognise that it was standard practice.

Acknowledgement

Similarities
All the participants recognised that it was essential to acknowledge the social context of the patient and family which enabled the person rather than the illness to be the focus. It was important that needs and impacts were acknowledged and that experience and knowledge were validated.
Differences
Two participants found that collaborative partnerships were inhibited by the focus on the patient’s needs. These participants were the staff member who was least committed to involving families and the family participant who was refused separate communication.

Two staff and two family participants doubted that the service would meet the reasonable needs of the patient and family. This was based on a history of the services failing to deliver their expectations.

Process of assessment

Similarities
Participants acknowledged:

- Collaborative assessment contributed to partnerships
- Review meetings were part of continuing assessment
- Dialogue that shared and compared different perspectives influenced the intervention plan

Difference
A major difference was that staff believed that collaboration for assessment began at the time of the initial assessment whereas the majority of ex-patients and one family participant experienced that this began at review meetings or for specific problem solving.

Contact between family and staff

Similarities
All participants agreed that contacts that established the relationships were based around formal events such as assessment, review, discharge or problem solving meetings which were facilitated by staff.
Differences

The one staff participant who recognised that family initiated contact was very active in cultivating a relationship with the family. All the staff acknowledged that contact with family involved giving information about safety and crisis, as well as enabling the family to be involved in care and treatment. The contact based on safety concerns did not occur for two ex-patients and one family participant.

The family participant who protected himself from being engaged in the details of his spouse’s care and treatment perceived that his contact was based on an undefined need to be part of family counselling.

Strengthening the relationship

Reasons for family and staff contact

Similarities

It was universally acknowledged that family contact was a positive resource and strengthened the relationship by contributing to the intervention plan and exerting influence on decisions. This widened dialogue including advocating for the patient and the family and demonstrated support for and recognition of capacities and limitations.

Differences

The most significant differences were at an individual level. The family participant whose relationship with the patient was restricted had the narrowest range of contacts between himself and staff. He alone did not acknowledge that staff provided support, reassurance and feedback. He did not give information about the patient’s history and functioning nor did he acknowledge receipt of information about the patient’s illness or the mental health services. His partnership relationships were weakened because his request for individual contact was refused.

Critical aspects for an active partnership

The participants recognised that there were four elements critical to the strengthening of an active partnership.

- Family was recognised as contributing real and relevant knowledge
- Staff validated the experience of the family
- Interaction between the participants was based on a common focus and agreed purpose
- Knowledge was developed and decisions were made through a process of collaboration

Family contributed to knowledge

*Similarities*
All participants recognised that the exchange of information was based around the needs of the patient and family. This was especially important when there were issues of risk and safety.

*Differences*
The family participant who severely limited his involvement and sharing of information did this to protect himself from being overwhelmed. He perceived staff was focussed on the patient because of the lack of specific and separate acknowledgement and response to his issues. He alone did not acknowledge that the quality of the family relationship was relevant to recovery.

Validation of the family experience

*Similarities*
All participants acknowledged that the social context and social roles of the participants were relevant. The validating of the knowledge and experience of the family influenced decision-making and strengthened the partnership.

*Difference*
The ex-patient who was suspicious of others’ motives experienced lack of validation of her experiences. She felt the relationship was not safe enough to allow for personal and sensitive work. The family participant who was refused separate consultation agreed with this.
Common focus and agreed purpose

*Similarities*

All participants accepted that the recovery of the patient was the common focus. All participants acknowledged that they had roles and responsibilities that contributed to the agreed purpose of supporting recovery.

*Differences*

The family participant who was self-protective and considered the staff to be the expert was the only person to reject the idea that it was the right and the responsibility of the family to exercise influence and take part in decision-making.

The majority of staff and family and the ex-patient who was minimally involved acknowledged that the family acted as an advocate by speaking for the patient who was unable to voice his or her own issues.

Collaboration

*Similarities*

Most participants acknowledged that collaboration was the central feature that strengthened relationships. Collaboration supported the building of knowledge and enabled the development of resilience and recovery.

*Differences*

The two participants who limited their involvement viewed collaboration as not always creating a safe relationship because it would put at risk trust, support and participation.

The ex-patient participant who was suspicious of the motives of others considered that collaboration meant that the strengths and resources of the family were exploited.

**Experiencing the relationship**

This section compares and contrasts the experience of the sub groups about where expertise is located. It reviews the processes of decision-making and partnerships.
Sources of expertise

Similarities

All participants involved in the initial assessment recognised that expertise lay in their dialogues. At later stages of intervention the relational group providing expertise widened, especially when consultations were flexible and responsive so that the voices and the needs of all parties were acknowledged and responded to. Interaction developed the strengths and resources of all participants, especially the patient and family.

Differences

When the family was included at the initial assessment, expertise was recognised as developing from the collaboration of the patient, family and staff. This was not the situation for two ex-patients and one family participant who experienced an initial assessment without family participation. The participants who had family involvement at the initial assessment also recognised that dialogue between the patient and family was a resource for recovery.

All family participants valued medication as a critical resource but only a minority of ex-patients and staff agreed. All the ex-patients valued the group treatment programme, dialogue between themselves and family and the wider mental health service as sources of expertise. However the majority of staff and family participants did not acknowledge this view.

The ex-patient who was suspicious of others identified that a source of expertise developed from her abandoning the ‘sick role’. Others did not voice this view.

The relevance of appropriate information as a resource for recovery was recognised by all participants except the self-protecting family participant.

Partnership relationships and decision-making

This section considers the characteristics of the partnership relationship and decision-making in terms of:

- the communication and consultation processes in decision-making
• the factors that directed decision-making
• where power was located in the partnership and decision-making
• the membership of the partnership and decision-making dialogue groups

Processes of communication and consultation

Similarities
Eight of the nine participants acknowledged that support and persuasion occurred before they consented to decisions, apart from when there was a significant safety issue. Then decisions could be made without agreement but the decision could be reviewed.

Differences
Only one participant recognised that some decisions were made without agreement, apart from when there was a significant safety risk. This person was a determined advocate and described herself as having alternative views and lifestyle.

Some participants recognised that decisions were made through indirect processes that involved discussion and information sharing and that decisions were implemented provided no objection was raised.

The two participants who protected themselves by limiting their involvement were exceptions to the process of full consultation, agreement and organised implementation of decisions.

Factors that directed the decision-making process

Similarities
All participants acknowledged that the following factors drove the decision making process:

• safety concerns and the management of crises
• needs of the patient and family
• principles of best practice
• common goal of recovery of the patient
Differences
The two participants who limited their involvement to protect themselves did not accept that decisions were directed by dialogue with all the stakeholders. These two participants recognised that some decisions were influenced by their non-involvement. The process of decisions being influenced by non-involvement was also recognised by another family participant.

The location of power within the relationship and in decision-making

Similarities
Most participants recognised equity of power in decision-making and variety in the sources of dominant power. The family participant who was refused separate consultation with the staff did not support these views. Most participants acknowledged that there were times when decision-making was dominated by staff.

Differences
A staff participant recognised that some families did not perceive equity of power in relationships. He focussed on a history of being verbally abused by families who held grievances.

All family participants recognised that the patient had some dominance in the decision-making process. The staff participant who was a doctor and the ex-patient who described himself as having diminished capacity did not recognise this dominance of the patient.

Membership of the dialogue groups

Similarities
Most participants acknowledged that the dialogue groupings were flexible and varied. The most influential groupings in shaping knowledge and decision-making were the patient and staff; and the patient, family and staff. The only participant who did not recognise the family and staff grouping was the excluded and self-protecting family participant.
**Differences**

All the family participants, two ex-patients and one staff participant recognised that patients formed influential dialogue groupings as a result of the group programme.

Two family, two staff and one ex-patient participant recognised that the staff were a separate dialogue group that had influence on decision-making.

**Foundational contributions to the relationship**

The sub-groups identified three foundations for an active partnership

The contribution of staff

- The exchange of information
- The family meeting

The contribution of staff

Two aspects will be examined:

- The framework for the relationship and the staff role in facilitation
- The information and advice given about the illness, the intervention plan and the patient

Relationship framework and staff facilitation

**Similarities**

All participants acknowledged that staff

- valued the expertise and wisdom of others
- listened to the patient and family and validated their experience
- sought to provide understanding
- encouraged the family to participate in the intervention
- initially focussed on deficits and on identifying patient needs

As the intervention developed, the participants’ strengths and resources were identified. Staff harnessed the resources of all parties and facilitated communication and collaboration especially for problem solving and decision-making.
Differences
The only participant who did not acknowledge that staff identified their philosophy of collaboration and recovery was the family participant who was refused separate consultation.

The staff participant who was cautious about the strong feelings of family and the potential for conflict, stood apart from the others in that he did not actively validate and encourage family participation.

Information and advice
Similarities
Staff provided advice and information on the intervention plan, especially care and management strategies.

Differences
The family participant who was refused separate consultation was the only person who did not acknowledge that staff provided information on the mental health service and on an understanding of the patient’s symptoms, diagnosis and management.

The ex-patient who had limited involvement recognised that staff provided advocacy and advice on the care and protection of herself and her children.

One staff participant did not give information on diagnosis as she preferred to focus on strengths and capacity building rather than on diagnosis and deficits.

The exchange of information
The exchange of information was the currency for interaction.

Similarities
Most participants acknowledged that staff facilitated the exchange of information in the contexts of acute problem solving and formal meetings. The processes of decision-making were varied. Listening, clarifying and exchanging information built knowledge, so that problem solving occurred and the critical elements of the intervention plan were developed. Safety issues controlled information exchange and
only the two participants who felt excluded did not agree that mutual concern was the basis for developing knowledge and decision-making.

Differences

For one family participant the only context for information exchange was the family counselling sessions. All family and the two actively involved ex-patients acknowledged that the group treatment programme was a context for information exchange but this was not acknowledged by any staff.

The two participants who protected themselves did not experience collaborative dialogue and collective decision-making. They experienced that knowledge was built by instruction.

The staff were recognised by most participants as being the most dominant group, the participants who did not described their interactions and relationships as ideal. Each group perceived other groups as being more dominant than themselves. Only the participant who was suspicious of others was given an explanation of meeting processes.

Family meetings

The family meeting was the main site for interaction and foundational for active partnerships. All participants recognised that the level of involvement was dependent on the initiative and skill of staff.

Similarities

All participants acknowledged that family meetings:

- were the forum where the social context was recognised and where the impact of unwellness was acknowledged
- were the sites of collaboration and support for the patient and family

The primary focus of meetings was on the patient’s needs. Meeting dialogue contributed to the assessment of needs of the patient and family, evaluation and
review, problem solving, capacity building and decision-making. All participants recognised that the level of involvement in the family meetings was dependent on the initiative and skill of the staff to facilitate and invite participation. Family meetings enabled the intervention plan to be integrated and holistic and through support and reassurance relationships were sustained. Most participants recognised that family meetings were a place of safe and non-blaming communication.

Differences
The participant involved in family counselling was the only participant who did not recognise that family meetings had a complementary focus on the needs of all parties. Two ex-patients considered that the meetings gave priority to family needs. The two participants who limited their involvement did not recognise that illness education and strategies for managing behaviours and symptoms were learnt at the meetings. Most participants viewed that the family meetings were the result of family expectations or requirements. This view was not shared by those who did not have family at the initial assessment. Staff and the two actively involved family participants recognised family meetings as an environment where perspectives were shared and differences tolerated.

Conclusions
The conclusions that come from comparing and contrasting the experiences of the sub-groups of participants are:

- There was consensus that involvement of family in the intervention plan was a positive resource for the recovery of the patient.
- Family meetings were the principal forums for collaborative dialogue.
- Staff members were influential in setting a framework for inclusion.
- Staff facilitation enabled and strengthened collaboration.
- Participation in initial assessments strengthened continuing collaboration.
- Family involvement in the intervention plan helped the family to manage the issues that came from the patient’s unwellness.
- Making meeting agendas explicit and providing formal events for assessment, review, problem solving and discharge enhanced collaboration.
• When specific attention was paid to the issues which hindered some participants from full involvement there was wider involvement and greater satisfaction.
• Information exchange was foundational for building team knowledge.
• A safe environment enabled the participant to be included in dialogue, negotiation and problem solving which built knowledge and led to decisions that met the needs of all parties.
• Collaborative working relationships were more likely when the participants shared dominance in power relations.
• Staff use of flexible and responsive processes of interaction helped inclusion of the family.
• Managing risk was the overriding variable in all interactions.

**Issues for analysis and development**
• The role of staff in creating conditions favourable to a collaborative partnership
• The role of the patient in creating conditions favourable to a collaborative partnership
• The role of the family in creating conditions favourable to a collaborative partnership
• Pathways to a collaborative partnership – structural and informal
• Setting, implementing and auditing standards for collaborative partnership
• Training to identify and work with the key factors that establish and maintain active partnerships
• Providing outcome evidence from collaborative partnership work
• Strategies for working with people who are the exceptions to inclusion
• Identifying and promoting at the macro, meso and micro levels the foundations for active partnerships
• Issues of safety that are relevant in collaboration
Chapter Six

ANALYSIS

Introduction
This chapter analyses the theory of relationships as family, patient and staff respond to episodes of mental illness. It looks at the formation of best practice, linking theory to the findings derived from the discourses of participants. The accounts from the study participants are linked with the truths, of the grand theories and the models of mental health intervention as discussed in chapter two.

The account of the participant is the truth for that participant. In this study the researcher uses Foucault's view that truth is not an absolute position but that what is accepted as the truth is a response that reflects power relationships (Walker, 1997).

There is a battle 'for truth' or at least 'around truth' ...... it being understood also that it's not a matter of battle 'on behalf' of the truth, but a battle about the status of truth and the economic and political role it plays (Foucault, 1980: 132).

Walker links the production of truth to power.

It is power that supports or enforces discourses as truths; the battle for power is inextricably linked with the battle for truth. ........Therefore a discourse from a powerful body sets in place what is true (Walker, 1997: 85).

The focus of analysis is the power relationships that occur in partnerships. Attention is paid to the phenomena of dominance and exclusion.

The study participants' truths are shaped by power relations at macro, meso and micro levels. The study focuses on the micro level of clinical practice and analyses interactions for evidence of relationships of dominance, exclusion and marginalisation. The aim of the study is to generate best practice strategies that
manage the risks of exclusion and marginalisation. The work of the interacting parties is to build knowledge and make decisions. The aim of the partnerships is to create and sustain relationships that contribute to teamwork.

At the macro level, the state exercises its influence through the setting of overall policy and the provision of funding through the Ministry of Health. At the meso level, the service delivery organisations exert their influence through the creation of policies, facilities and programmes. The micro level influence comes from the provision of interventions with specific service users.

It is through the relationships at the micro level that the needs and issues of individuals and families are met. Therefore the prime focus for the analysis is the relationships at the micro level.

Foucault considers that the analysis of power is achieved through the study of the ways that people are viewed (Faubion, 2000). Therefore a focus of this study is on how participants view each other as they work to respond to the issues raised by the mental and functional disorder of the identified patient.

According to the theory of Foucault, it is through the interaction of people that power relations are expressed or produced.

Power exists only as exercised by some on others, only when it is put into action, even though, of course, it is inscribed in a field of sparse available possibilities underpinned by permanent structures (Faubion, 2000: 340).

A study of power relationships in action examines where expertise lies. Such an analysis leads to an understanding of the factors that contribute to collaboration and to exclusion in the working partnerships.

This analysis examines the choices that are made about what is the truth that informs decision-making. Choice requires freedom of action amongst a range of possibilities
even though constraints and privilege occur. The effects of the power relations are shown by actions of acquiescence and resistance.

**Relationships for analysis**

The relationships that impinge on the clinical responses of the mental health service occur at multiple levels. Therefore the analysis of power relationships considers the factors of influence that come from multiple levels. The power relationships between the immediate players in a mental health service can be diagrammatically shown as:

![Figure 6.1 Relationships for analysis](image)

**Analytical tools**

The analysis aims to generate theoretical understandings of best practice working relationships.

The work of Kelly, (2001) is a tool for analysis of power relations and uses trialectic logic to examine the tension between three or more sources of power within a field of inquiry. Trialectic logic develops an understanding of the whole field of inquiry rather than creating a view that supports one discourse as being the truth.

Bunch, (1983) uses radical feminist theory to develop a theory that examines the experience of power relationships. This theory examines the experience in four stages from the description of the experience to constructing strategy for change. Chapter two has a discussion of these two analytical tools.
Matrix of influences

The data for analysis was collected from micro or clinical level relationships. This data which has been described in chapter four and five has been influenced by sources of power at the meso level of organisations and at the macro level of the state.

The trialectic logic of Kelly and Sewell (1983) analysed the power relations experienced by participants. A diagrammatic representation of these power relations shows the dominance of the staff – patient relationship. This dominance was made evident in that family was not an automatic and integral part of intervention plans. The principal focus of interactions was on the patient’s needs and no decisions were made without the consent of the staff. The relationship of patient and family and the relationship of staff and family were dominated by the knowledge that focussed on the patient’s issues and the staff status as the expert with responsibility for the well-being of the patient.

![Diagram of Dominance of the staff – patient relationship]

Figure 6.2   Dominance of the staff – patient relationship

Analysis

The analysis of the experience of the study participants focuses on why the relationships exist. Analysis according to Bunch, (1983) is concerned with determining the factors that explain the origins of forces that enable continuation of dominant relationships.
Establishing the relationship

The partnership relationships exist as a result of the belief that negotiated relationships make a positive contribution to patient recovery and family resilience. The belief is that relationships access knowledge and resources that enable the patient to participate in their community. These resources are critical components that enhance the recovery and resilience of the patient and family.

This belief in negotiation and collaboration shapes the current mental health service. The underlying theory is based on the Recovery Approach which is consistent with the value positions of both the Liberal and Third Way grand theories. Liberal theory informed the Mason Report which was critical of the mental health services that were shaped by the ideology of Institutional theory.

The rhetoric of professional experts, government policy makers and advocacy groups supports the concept of full partnership between patient, family and staff. This partnership is acknowledged as the means of accessing comprehensive knowledge and competent decision-making that give the best outcomes for efficient use of resources, least risk exposure and effectiveness of clinical interventions.

The ideal of full collaboration was not the reality experienced by all participants. Most patient participants identified that family was not always included in the partnership, particularly at initial assessment or time of first contact. The force that constrained family from involvement was that family involvement was not an automatic process. Staff traditionally held the role of directing processes of care, treatment and communication and some family and patients did not challenge this traditional view. Family involvement only occurred at the time of first contact if family members were assertive and declared that they expected to be included or if staff found that working only with the patient was so problematic that family resources were critical to the intervention plan.

Even when staff invited the patient and the family to work as a collaborating team some patient and family participants limited their involvement because they perceived that closer involvement would threaten the participants’ independent knowledge and
decision-making and put at risk their functioning and/or the relationship between family and patient.

Strengthening the Relationship

Relationships were strengthened by continuation of the factors that helped to establish active working partnerships. These factors included acknowledgement of needs and issues of the patient and family and valuing their knowledge and experience. All participants confirmed that being part of a collaborating team was useful for patient recovery and family resilience even though some participants experienced that there were times when they felt uninvolved or marginalised. Staff endorsed the concept that strengthened relationships widened the resources of knowledge, increased practical and relational support, made interventions more comprehensive and increased hope and the likelihood that interventions would assist the recovery of the patient.

The working relationships that began at the time of the patient's initial contact were the most comprehensive in terms of knowledge building, shared decisions and access to a wider range of material, social and relational resources.

Recognition of the social context strengthened the relationship enabling the impact and consequences of the mental disorder to be understood. The participants who limited their involvement did so to preserve their functional capacity and reduce the possibility of being overwhelmed.

The relationship was strengthened when staff emphasised relational issues rather than the illness.

Involvement provided opportunities and positive experiences which reinforced the value of working collaboratively. Families found that their knowledge was accepted as relevant and they influenced care, treatment and management. The experience that contributing made a difference was rewarding and helped to sustain involvement and strengthen collaborative working relationships.

The staff strengthened relationships by inviting participation, facilitating communication and modelling processes of problem solving and conflict resolution.
The staff facilitation role was consistent with their traditional role of expert, having authority and responsibility to initiate interventions. Patient and family supported these roles as they experienced staff facilitation as helping them meet their needs.

Staff facilitation was constrained when interactions were perceived as a source of conflict and as exposing participants to greater negative consequences. Participants who had a history of unresolved conflict were often reluctant to risk participating in a rerun of issues and interactions.

The risk of being overwhelmed by interaction was intensified when the person experienced that his/her needs and issues were not acknowledged and supported, especially by staff. Therefore staff had a powerful influence in the marginalisation of the patient or family member. This power was based on the belief that staff were the experts and held dominance in knowledge and decision-making. This perception meant that staff were the critical people to associate with or avoid, according to whether the person felt supported or challenged. The degree of support and positive acknowledgement experienced played a central role in strengthening the working partnership between patient, family and staff.

Experiencing the relationship
Staff perceived a different relationship than that experienced by the patient and the family. This difference was manifested in terms of when contact first occurred. Staff believed that family were full partners from the time the patient first had contact with the Psychiatric Day Hospital. This was not the experience of most patients. The families that were present at the initial assessment were there because the patient was unable or unwilling to articulate his/her needs and issues. The families that were present at initial assessments were strongly committed advocates.

Family and patient participants who were not at initial assessments experienced that they were recruited as a supplementary resource. Family became involved in response to a problem that was initially present or arose during the course of care and treatment. The difference between the view of staff and the experience of the patient and the family can be accounted for by the traditional role of staff as the expert who thereby dominated control of communication and interaction. Countering this
traditional position of staff as the expert is the consumer and family rights movement which is a feature of Neo-Liberal theory.

The dominant role of staff continued in the decision-making process. The staff participants believed that decision-making occurred with full consultation. However the study participants who experienced exclusion and marginalisation did not experience full consultation. These participants believed that they had no option but to limit their contact with others. The participants who experienced that their needs were supported and satisfactorily responded to were able to maintain the relationship and have full consultation even though they did not agree with every decision.

All parties acknowledged that staff had dominance in decisions about safety. The tradition of the staff being ultimately responsible for safety assessments and risk management affected the power relations. The formal authority and responsibility of the staff carried over into all areas of decision-making. The experience was that the staff had the power of veto and no decisions were made without staff consent. The role and responsibility of the staff is reinforced by the judgements of the Health and Disability Commissioner in the Burton Inquiry (Paterson, 2002). However as the rights and responsibilities of consumers are strengthened, the role of staff to have sole responsibility for risk management is challenged and changed. A recent example where the responsibility for managing risk was found not to lie solely with staff was the case of the midwife found not guilty of professional negligence following the death of a newborn (Sinclair, 2006).

Relationship factors were the most powerful influences in the recovery of the patient and the resilience of the family. The primary relationships were those of the family, staff and patient and the clinical relationship of the patient and staff. Through these relationships, needs and issues were articulated and responded to. These relationships formed the basis for hope of recovery and sustained the patient and the family even for those who limited their involvement. The relationships provided meaning and satisfaction and allowed for engagement in the processes of intervention. They persisted in adversity because they were the basis for survival and resilience.
People who were fully involved in collaborative relationships experienced flexibility and variety in these relationships. The staff’s role of facilitation gave the staff dominant power in creating relationships that enabled some participants to be fully involved while some participants experienced exclusion and marginalisation.

The skill of the staff member in managing conflict and the underlying philosophy of his/her professional training influenced the degree of flexibility in relationships. The staff member with recent training was well focussed on the strengths perspective. She automatically assumed that the family, patient and staff would work in partnership. The staff member who did his basic training in the era of Institutional theory relied more heavily on his role as the expert. He viewed family as more likely to be conflictual and resistant. In comparison the staff member who trained during the Neo-Liberal era had a focus on the rights and responsibilities of all parties.

Relationship foundations
There were three dimensions of interaction that were foundational for an active collaborative partnership.

- The staff provision of a framework for interaction and staff facilitation of communication.
- The processes for information exchange which built knowledge and influenced decision-making.
- The characteristics of family meetings which were the principal means of enabling collaborative exchange of information.

Framework
Staff provided the framework that focussed on the issues of patient recovery and family resilience. This framework enabled dialogue and collaboration so that all parties could contribute to the formal events of assessment, review and discharge. The framework provided opportunity to develop understanding of illness and strategies for managing the consequences of illness.
The participants who were exceptions to the ideal of full collaboration found that the staff created a framework which did not meet their needs. These participants did not feel safe enough to have open dialogue. They did not experience that their needs were identified, accepted and supported. Their need was for a framework that was flexible and provided alternative ways of contributing to knowledge building and decision making. The study participants, especially those who limited their participation, were not invited to describe, define and negotiate the framework for relationships which would have enabled sufficient trust and safety for them to fully collaborate.

**Information exchange**

The ideal process of information exchange would result in discourses of multiple experts rather than dialogue dominated by one party. The most powerful contents were dialogue about issues of safety, problem solving and defining the critical elements of an intervention plan. These issues favoured the power of staff who traditionally had role authority and institutionally confirmed expertise and responsibility.

**Family meetings**

Family meetings were the main forum for sharing of information and developing collaborative partnerships. The main focus was on the patient's needs. Family meetings enabled the integration of the concerns and efforts of all parties. The effectiveness of family meetings depended on the level of skill and initiative of staff and the circumstances that first brought the family, patient and staff into contact. Not all patient and family participants found the family meetings a safe environment. If conflict and resistance were not resolved then a degree of alienation and limited trust became established.

Family meetings were not an automatic part of the Psychiatric Day Hospital service. They were driven by the expectation of the family and patient or were a response to a concern that could not be resolved without family input. The way family were engaged in partnership was dependent on the initiative of one or more of the parties. The policies at macro and meso levels had rhetoric that supports the use of the family meeting but do not require them or specifically resource the service delivery.
organisations and staff to facilitate family meetings as the vehicles through which collaborative partnerships flourish.

Vision

The Blueprint describes the principles on which services are to be based. It sets out a vision of collaborative working partnerships. The Blueprint defines how the Government's national mental health strategy is to be made real. The central theme is that services are responsive to needs by the use of the Recovery Approach.

There are significant advantages when support for families is provided as part of a continuing care programme. Services are most likely to be effective when they utilise the knowledge and experience of the people closest to the person who is ill (Commission, 1998: viii).

The Mental Health Commission considers that the Recovery Approach needs to be embedded in all aspects of the mental health service.

Historically, mental health services have failed to use a Recovery Approach. Recovery could never take place in an environment where people were isolated from their communities, where power is used to coerce people and deny them choices, and where people with mental illness are expected to never get better (Commission, 1998: 1).

The Blueprint has a comprehensive view of what constitutes a successful mental health service. It places importance on recognising the social and personal context of illness and accepts that illness has impact for families.

Their families... cannot escape being affected by it (mental illness of the patient). ... Interventions that only include the individual with mental illness are making only a partial response and therefore can only ever be partially effective. Fully effective interventions acknowledge and access the needs of everyone affected by the illness (Commission, 1998: 9).

The Blueprint states that the working relationships of interventions should aim for:
• Exchanges of information, and having a process by which family members, the person with the mental illness, mental health workers and clinicians learn from each other.

• Early development of an open and co-operative relationship between the family, the person with the mental illness. To achieve this, it is essential that these key people communicate and meet regularly (Commission, 1998: 10)

The family are to be full members of the recovery team. This involves making decisions as well as exchanging information.

It is essential that families and whanau participate in the planning of services at all levels. … Identification and response to whanau needs will lessen the impact of whanau disturbance on Tangata Whaiora, and lessen the need for services. Whanau strengths can buffer the impact of illness on Tangata Whaiora, and thus lessen the need for services (Commission, 1998: 10).

The National Mental Health policy documents are committed to the ideal of relationships that are flexible, collaborative and responsive to needs. The policy documents leave open the details on how the collaborative relationships can be achieved. The only directions given are that people affected by the mental illness should hold regular meetings which begin at an early stage and that communication be an open process in which information can be exchanged and that all people are involved at all levels of service planning (Commission, 1998).

The study participants shared the vision of the Mental Health Commission and the Blueprint. However the experience of the study participants was not uniform. The reality for some was that they needed to constrain their participation to prevent being overwhelmed. Power was heavily weighted in favour of staff because of their roles and responsibilities. This meant that the vision of full co-operation was limited because staff had veto power about what knowledge and decisions were acceptable.
The vision of working partnerships that the Blueprint describes would be fulfilled by the inclusion of family and others affected by the patient’s mental illness. This would need to be an automatic process just as assessment, review and discharge are. The vision would be more complete if collaboration began at the point of the patient’s initial contact with the mental health service. Communication needs to be flexible and responsive to needs while retaining an agreed focus on recovery.

Figure 6.3  Ideal working relationship

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Staff

+       +

Patient       Family

+       +
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The trialectic logic of Kelly and Sewell (1983) illustrates the power relationships that the vision advocates. Dominance is shared between the three sites of power unlike that shown in figure two. Trialectic logic illustrates that for the vision to be fulfilled all the relationships are sites for change.

**Strategy**

Strategy developed in this part of chapter six is concerned with hypothesizing how to change working partnerships as described by the study participants, to working partnerships that match the Blueprint vision. The strategy involves judging what will lead to change in the working practices of partnerships. The strategy will consider changes at all levels - macro, meso and micro.

The strategies for ideal working partnerships involve examining the four stages of partnership relations.
Establishing the relationship
The Blueprint values collaborative relationships as the means of enhancing recovery, resilience, knowledge building, resource efficiency and ultimately reducing the demand for repeated use of the mental health service (Commission, 1998).

Enhancing collaboration would involve change in clinical practice such as making involvement of family an automatic process. Instead of the family having to opt into involvement, the standard practice would be for family to be part of the collaborating team.

The study found that partnership relationships were established by identifying, acknowledging and responding to needs and issues. Therefore a structured event at the earliest possible time with the agenda of assessing the needs and issues of all parties would help establish the ideal working relationship. This structured event would bring the team together to engage in collaborative teamwork. An automatic process of all the parties focussing on comprehensive and collective concerns would establish the platform for an active working partnership. This would not depend on the assertiveness of the patient or family or the presence of a problem that can be managed only by including family into the working team.

Strengthening the relationship
The relationship is strengthened when the prime focus is on the person and his/her social context rather than on the illness. Therefore assessments are helpful when focussed on issues of impact for the person and his/her relationships. A shift of thinking is required of staff who initiate the formal tasks of assessment, review and discharge. This would align practice with the paradigm shift of the Blueprint so that services are based on the Recovery Approach.

Staff would need training in working collaboratively and facilitating communication. Training provided for Restorative Justice facilitators teaches skills in collaborative communication\(^8\) (Justice, 2003).

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\(^8\) The Restorative Justice pilot programme was introduced into three New Zealand courts in 2001. The training programme covers issues of roles and responsibilities, the nature, history and purpose of
Relationships were strengthened when all parties were involved in talking, listening, discussing and negotiating. The staff role was to initiate the working relationship. For several participants an explicit invitation was required to enable family involvement. Competent practice of staff would include formal invitation to family to participate. At present the staff are permitted to involve the family, subject to the approval of the patient, but are not required to automatically initiate such family collaboration.

The same factors that helped to establish the working partnership were important to strengthening the partnership. A necessary change is that there is flexibility in collaboration and partnership. Some study participants experienced that involvement could occur only on terms suitable to staff members.

Experiencing the relationship
The Blueprint advocates that the family should be involved at the earliest possible opportunity (Commission, 1998). The participants experienced that family were involved at different points of the intervention. Families involved at the time of the patient’s first contact became natural partners in the processes of assessment, evaluation and planning. The families that became involved specifically in response to a problem had a less comprehensive involvement. An automatic invitation to family to participate in collaboration would normalise involvement. This would require a change at the micro level of clinical practice and at the meso level of organisational policy.

A strategy for change at the meso level would be for service delivery organisations such as the Otago District Health Board to update their policy on family contact. For example the Otago District Health Board’s principal policy that supports the vision of collaboration is entitled ‘Enabling and Empowering Families to Receive Support, Information and Education - Mental Health and Intellectual Disability’. The approach to partnership is one where the expertise lies with the staff. It states:

restorative justice and skill training in facilitation and collaborative processes. The Department for Courts manages this programme for the Ministry of Justice (Ministry of Justice, 2003).
In order that family/whanau are able to be involved in the care and support, if appropriate, of the family/whanau member they require support and education. (Board 2005: 1)

The emphasis of this policy is on educating the family to assist in the care and support of the patient. No mention is made of the needs and issues of the family nor the possibility that the needs and issues of the patient, the family and the staff are complementary.

Another example is the Otago District Health Board’s policy ‘Family Advice to the Mental Health and Intellectual Disability Service’ (Board, 2004) which facilitates family involvement in issues of planning, implementation and evaluation of services. The policy applies only to members of the Family Council and is concerned with input into issues at the service development level but not concerned with the activities of individual clinical work. The family council has a proposal for recognition and response to family issues. This proposal is for the development of a family recovery action plan that aims to make family issues an integral part of micro level interventions. This project is acknowledged in footnote 13.

The study participants agreed that hope was the greatest resource for recovery. The relationships between people provided hope. Recognition of the critical importance of relationships would be a strategy for change. This recognition needs to be reflected in the training focus for staff in the mental health services.

The sub groups had different expectations and experiences of the processes of communication and decision-making. When critical issues such as safety arose all sub groups shared a common concern and decision-making was uncontested. Study participants tolerated differences more easily when they experienced that their issues were explored and considered as part of the intervention plan. Clarification of roles, responsibilities and processes of partnership is a strategy for change. This would be best done at the time of first contact when ground rules, the agenda and processes for working together in partnership are defined.
Study participants found that recovery and resilience were enhanced when staff had the role of creating the framework for interaction, setting the ground rules and sustaining a culture that focussed on the recovery needs of the patient and the reliance of the family. A strategy for change is to make explicit in the job description of staff their role and responsibility for initiating and maintaining the collaborative working partnership.

Foundations of the relationship
Relationships are the basis of the Recovery Approach and strategies for change need to be centred on enhancing the capacity of staff to facilitate relationships. The study participants found that they were generally well supported and respected in the working relationships with staff. Change is not about a radical departure from the processes of intervention used but about reducing the risks of exclusion from full participation in the collaborating team. The study identified three aspects of the relationship that were foundational for achieving inclusive working partnerships.

Framework
Foundational to partnership relationships is the framework for interaction which staff provide. The ideal framework accords with the Blueprint and is based on the Recovery Approach. The framework that a staff member uses is associated with the era in which he/she received professional training. Therefore a strategy is needed to provide staff with explicit learning about the theory and practice of the Recovery Approach.

Training in facilitation of family meetings, teamwork, conflict resolution and flexible ways of communicating would increase the likelihood of participation and inclusion of the people who felt the need to limit their involvement.

Exchange of information
The processes for the exchange of information need to be functional and validating of the contribution of all parties. Study participants who were marginalized and restricted in their participation were not clear about the processes of communication and the intentions of others. Making the roles and responsibilities explicit could reduce uncertainty. In this way the purpose and agenda of contacts could be
negotiated and compromise achieved so that interaction was a partnership not dominated by any one party.

Communication processes that focus on participants' strengths and needs would identify their expertise so that all can contribute to the collaborative work of the team. This requires variety and flexibility, resulting in a process where there would be multiple experts with shifting levels of dominance in the work of building knowledge and decision-making. This way of exchanging information differs from the medical model where the emphasis is on identifying deficits.

**Family Meeting**

Family meetings were the primary structural vehicle for partnership dialogue. It was through dialogue at family meetings that the experience and expertise of each participant was acknowledged and valued. The dialogue built knowledge and exercised influence.

Sharing and comparing information helped strengthen relationships. These relationships were the critical resource that reinforced hope for recovery and strengthened resilience for coping with the impacts of illness. Successful conduct of a family meeting depended on the skill of the staff. The skills that made family meetings satisfactory were the ability to clarify and negotiate the purpose of family meetings and facilitate each person’s contribution.

Competent meeting management involved facilitating communication, reinforcing the agreed boundaries for safe interactions, conflict resolution skills and maintaining the focus of the meeting. A strategy for change would be to strengthening the effectiveness of the family meeting and recognise them as the foundational vehicle for teamwork. This requires all staff to have training in the theory and practice of managing family meetings. The skill training does not exist as a separate component in the professional training of any one discipline. However large service organisations such as District Health Boards are likely to have some staff members who are competent and practised in small group work. These staff could model and teach others how to develop and sustain effective facilitation and management of family meetings.
Strategy of continuing what is helpful

In analysing what is needed to achieve the vision of collaborative working partnerships it is important to acknowledge the fundamental principles currently in use at the Psychiatric Day Hospital. The strategy for achieving the vision involves continuing to:

- Identify, acknowledge and respond to the needs and issues of the patient and the family.
- Maintain a focus on the issues of the patient while also incorporating the issues of family in the intervention plan.
- Initiate structured events to which family and patient are invited whereby staff facilitate communication between the parties.
- Recognise the social context of the patient and the family and that this context influences the intervention plan.
- Value the person more than the illness and recognise that relational resources are the most important resource for recovery.
- Take the knowledge and experience of the patient and family seriously and use these to influence decisions of the intervention plan.
- Have staff take primary responsibility for oversight of significant issues of safety.
- Have family meetings as the central vehicle for teamwork, information exchange and decision-making.
- Maintain family advisor input into service development and evaluation at a senior management level.

Changes recommended at macro level

- That the business plan that is the basis of contract between the Ministry of Health and the District Health Board specifies a service target that family meetings occur with a nominated percentage of service users.
- That the statistics used by the Ministry of Health to monitor service delivery performance include the regular reporting of the number of family meetings and the number of patients involved.
• That the Ministry of Health funds the provision of training in the theory and practice of the Recovery Approach. That components of this training cover conflict resolution skills, facilitation of collaborative communication and decision-making, and skills in managing family meetings.
• That funding of this training is part of the government commitment to workforce development.
• That training in the Recovery Approach is required for all staff. That certification of current competence is required of registered health professional staff.
• That formal auditing of mental health interventions is conducted by the Mental Health Commission and that these audits influence the contracts between funders and providers of services.

Changes recommended at meso level
• That policies of service providers reflect the Blueprint ideal that families are involved in shaping the clinical intervention plan. This change to be consistent with macro level contractual requirements to make collaboration with family at clinical level standard practice.
• That service organisations resource families with skills and strategies required to cope with the illness so that recovery and resilience are enhanced.
• That staff are provided with education and practice skills so that the service delivers interventions that comply with the Recovery Approach.  
• That the service information package for families and patients provides a checklist of the standard practices that demonstrate the Recovery Approach.
• That service audits survey family involvement and the use of collaborative processes that demonstrate the Recovery Approach.
• That job descriptions identify that clinical staff have knowledge and practice skills in the use of the Recovery Approach, including skills in facilitation and management of collaborative meetings.
• That staff performance appraisals include demonstration of the use of the Recovery Approach.

9 An example is the mandatory in-service education workshop for all clinical staff of the O.D.H.B. The workshop ‘Involving Families’ could be a forum for presenting the findings of this study (Dent and Marks, 2006).
• That use of Family Recovery Action Plans is standard practice. (See footnote 12.)

• That innovation and achievements of merit in family inclusion in clinical practice are recognised by the presentation of Recovery Approach awards. (See footnote 13.)

Changes recommended at micro level

• That there is skills training of staff in facilitation and management of family meetings.

• That family inclusion in assessment, review and discharge is the norm, that invitation of family to participate is standard practice and that family opt out of inclusion rather than opt into inclusion and participation.

• That it is protocol for staff to automatically invite and facilitate family involvement at the time of initial assessment.

• That there is flexibility of interaction, not a one size fits all approach.

• That barriers to inclusion are identified and responded to thus minimising the risk of exclusion and non-participation.

• That the intervention plan is relevant to the emotional, educational, social and clinical needs of the whole family.

• That the intervention plan formally assesses and documents the strengths, problems and goals of the patient and key family members where these are relevant to the mental illness.

• That the recovery plan is focussed on assessment and development of strengths rather than focussed on deficits.

Conclusion

This chapter analyses the participants’ discourses, comparing them with those of the grand theories. The analysis focuses on examining power relations that shape the discourses. The purpose is to further develop theory on what constitutes best practice for an intervention team of patient, family and staff.

The tools for analysis were the trialectic logic of Kelly and Sewell (2001) and the theory of strategy for change of Bunch (1983). These analytical tools were used to
examine the experience of the study participants and to create a vision of what would be best practice.

In the development of best practice it has been necessary to examine policies and practices at macro, meso and micro levels to analyse how these contribute to inclusive partnerships.

The practices at the macro level that would strengthen family inclusion are business plans or contracts that require services to be family inclusive and subject to routine reporting.  

Training programmes could be required to provide education in recovery competencies and skills in facilitating family meetings and collaborative partnerships. This could be included for example in the Ministry of Health funded postgraduate training course for new graduates in allied health professions.

Meso level changes are concerned with policy and training developments. It could be policy for the Otago District Health Board to develop the work of the family council project of Family Recovery Action Plan. In this way there would be family input into clinical work as well as family input into issues of service development. A strategy for change would be to reform policy to ensure collaborative working partnerships with the family at the clinical level. This would mean that family meetings were an automatic response to a mental health intervention unless the patient and the family choose to opt out.

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10 The Ministry of Health requires that the Otago District Health Board reports monthly the number of times and amount of time clinicians spend in contact with family/whanau. The report records the time and number of active contacts focussed on active treatment/care management issues but excludes passive support or crisis contacts (Bayne, 2006).

11 The Wellington Polytechnic School of Nursing is the contracted agency for the post graduate training of allied health professionals who have commenced work in the mental health field and have less than two years of clinical experience.

12 The Otago District Health Board Mental Health and Intellectual Disability Services business plan/services 2006/07 has ongoing goals of staff training, family satisfaction surveys and audits of family participation as measures of family participation and collaboration. There is reference to the development of Family Recovery Action Plans being included in the notes of the patient. There is a time frame for the achievement of the first three goals but no time frame for the Family Recovery Action Plan (Coop, 2006).
The Otago District Health Board has a compulsory in-service training programme which requires all clinical staff to take part in a workshop on working with families. The present focus of this workshop is on psychoeducation issues of support and education of the family, with staff holding the position of expert. A recommendation for change is that staff are educated in the Recovery Approach and the processes for facilitating family meetings and collaborative partnerships. Another strategy for change would be the revision of job descriptions to include the facilitation of working partnerships with families as a key performance indicator.

The development of the Family Recovery Action Plan is a meso level strategy that aims to further the goal of family participation and collaboration. This strategy which is the responsibility of the Family Council is at the embryonic stage of development. It is an example of how family input can shape meso level policy and micro level practice.
Chapter Seven

CONCLUSION

Introduction
The goal of the study was to add to theory that describes and explains the nature of a best practice working partnership. The research questions sought to elucidate strategies that will reduce the exclusion of the family and the patient from full collaborative partnerships with staff as they work at building knowledge and making decisions.

This thesis explored discourses about power relations between the patient, family and staff. The site of investigation was the Psychiatric Day Hospital in Dunedin. The study viewed the historical and current place of family in the formal mental health services of New Zealand. The analysis of the discourses explored the dominance in relationships. Strategies that altered dominance were identified so that interactions would reflect the Recovery Approach and the goals of the Blueprint.

The study identifies strategies at the macro, meso and micro levels that maintain and strengthen the goals of the Blueprint.

At the macro level these strategies are the provision of policy, funding and service contracts that set the framework and resources for service delivery that are responsive to political, professional, community and consumer needs.

The meso level strategies are the setting of policies and standards for clinical practice and the provision of staff training which requires accountability to the principles of the Recovery Approach. This requires services to adopt a suite of strategies that enable negotiation between stakeholders so that they work in collaborative ways that respond to the general as well as the particular issues generated by mental illness.

At the micro level the strategies are concerned with how clinical interventions occur. Paradoxically it is the staff who are most likely to be able to alter the balance of power relations so that they no longer dominate the processes that generate
knowledge and influence the decisions of the intervention plan. The study found that staff have a central role in facilitating inclusion, communication, participation and problem solving so that interventions are tailored to the context of those affected.

The strategies for change would prompt a shift of dominance in power relations. Instead of dominance from one source, parties would work interactively. This would be consistent with the policies of the Blueprint and its principles of inclusion, participation, collaborative partnerships and community living.

**Background and history**

Chapter one discussed the development of the formal mental health services of New Zealand. A feature was that the state and staff held the position of dominant experts.

The foundational policies of New Zealand's mental health service were institutional care, state funding and separate management (Brunton, 2001). Changes to these policies began with the process of de-institutionalisation. A turning point was the Mason Report. The report reviewed services and highlighted the shortcomings of a service that did not emphasise the rights and needs of the patient and the family.

The Mason Report initiated a shift in focus that resulted in the Blueprint policy document and adoption of the Recovery Approach. The Blueprint aimed to empower the patient so he/she would be included as a participant in his/her community rather than be subjected to power relations dominated by staff and by organisations that provided care and containment.

**Creating a best practice model**

This study used a grounded theory approach so that the socially constructed views of the patient, family and staff contributed to the development of theory about what is best practice interaction for working partnerships.

**Voice of participants**

The voice of participants was grouped into three units according to their roles of patient, family or staff.
All in-depth interviews covered the same eleven questions. These centred on the
topics of information sharing, interactions between the family and staff and the
processes of decision-making. Particular attention was paid to the times of
assessment, review, problem solving and discharge.

The nine topics of interest that evolved from the discourses were discussed in chapter
three. From these nine topics, the empirical data was analysed into four dimensions
that described the nature of best practice relationships. These four dimensions were
how the relationships were established, strengthened and experienced and what were
the foundational dimensions of partnership relationships.

The findings were derived from the experience of the case study groups. The
discourses were compared and contrasted and used to inform an analysis of what best
practice theory would look like.

Analysis
Best practice was based on the relational processes that enable parties to sustain active
engagement and to collaborate in response to the needs of those affected by an
episode of acute mental unwellness.

The trialectic logic of Kelly, (2001) and the theory development and change strategy
of Bunch, (1983) were the tools used to analyse the transcripts and develop the theory.

Discourses and dominance
The views of staff dominated the relationships of intervention because historically the
staff voice was given expert status by the state and the community. The voice of staff
was dominant by reason of their holding responsibility for managing the conditions of
care and containment.

In comparison the discourses of the patient and the family emphasised needs and help
seeking due to the incapacity of the patient and the adverse impact on the family of
mental illness. An underlying theme was that the resources of the patient and the
family were supplements that could be accessed.
The ideologies of the grand theories altered the patterns of dominance in the working relationship between the patient, family and staff. For example Neo-Liberal theory advocated for the rights and responsibilities of the patient and the family. The Third Way theory advocated the Recovery Approach which is based on a model of empowerment and partnership that result in the patient’s inclusion in the community.

Changes in dominance at the macro level had a flow on effect at the meso level of policies and practices. These in turn impacted on micro level practices of clinical relationships.

The study was done in the Third Way period. The theory of this period is compatible with the Recovery Approach as it balances the tensions of competing sources of power. At the macro level the tensions include restrained public spending, reduced incidence of mental illness, enhanced recovery from illness, reduction of family burden and minimised risk and community concern associated with mental illness. At the meso level the Third Way theory shapes the planning and provision of services to reflect local strengths, resources and needs. At the micro level the Recovery Approach provides the framework for clinical interventions which focus on processes of collaboration. The competing sources of tension are balanced by active inclusion of the patient and family in interactive dialogues.

Elements of control
The elements of control that shape the provision of services and the interaction between patient, family and staff exist at the macro, meso and micro levels.

At the macro level there is control over funding and purchase of specific services. For example the Ministry of Health negotiates the annual business plans of the District Health Boards which then sub-contract for services within their local districts (Coop, 2006).

At the meso level control occurs through the development of policy and the processes of employment contracts. The service delivery organisations exercise control and influence through the strategies used to manage services and resources. The culture of
the organisation is demonstrated in documents such as job descriptions and practice and service standards, service provision policy and the provision of staff training.

At the micro level the skills and attitudes of the participants affect the degree of control each holds. Usually the staff hold greater dominance because of their role of employed expert with professional status, education and training. A patient or family member who asserted his or her rights to be a full team member could alter this dominance. This was not easily attained as the patient and family member were in a disadvantaged position because they came to the interaction seeking help. The patient and the family were dependent on the staff to legitimise their becoming full members of the intervention team. This required the work of the team to be based on a culture where dominance could shift between members and where the processes of building knowledge and making decisions were ongoing and focussed on a common understanding about the work of the team. If the interaction and teamwork were based on a pattern of fixed dominance then relationships of resistance, conflict and exclusion were likely.

Opportunities to change the balance of dominance
The findings of the study showed that some participants, especially patients and family members, experienced active exclusion, resistance to inclusion or inclusion only as a secondary consideration.

The study findings identified principles and practices that would enhance service delivery in order to meet the ideals of the Blueprint. These principles aim for a service without fixed dominance in working partnerships. Specific recommendations for change were discussed in chapter six.

Macro and meso level policies make it possible for staff to practise the Recovery Approach. Clinical practitioners have opportunity for recognition of their initiative and efforts in promoting recovery and partnership. However there are mixed messages to staff about where dominance in relationships is to lie. To change the historical pattern of dominance takes extra effort and enterprise. The complex interactions of control and influence predispose the family and patient to the dominance of the established sources of power. The staff are paid to be the experts
and their role and responsibility establish them as the source of dominance. They are required to work within the constraints of the policies and contracts of the Ministry of Health and the protocols and practices of the service delivery organisations. Paradoxically however it is the staff that can most directly alter the balance of dominance in clinical work.

**Summary**

Essentially the findings of this study, which contribute to best practice principles, are refinements of the Blueprint.

There are opportunities to modify the balance of power in relationships towards the ideal pattern advocated by Recovery Approach principles of inclusion and participation for all whose lives are affected by mental illness. These opportunities readily occur at the meso and the micro level.

At the macro level, the policy framework has been defined, and provided resources and contracts remain aligned with the Blueprint reformation of traditional dominance will occur.

At the meso level, policy directs clinical practice. Therefore the way that services are configured and managed influences the expectations and opportunities for staff to interact with the patient and family. The study participants identified that if family was involved from the time of the patient's initial contact with the service then an active partnership responsive to the needs of all parties is likely. A meso level policy can make a difference to when, how and why the family, patient and staff interact. Meso level decisions are required for the endorsement of special projects that enhance collaborative interaction, such as the proposal for Family Recovery Action Plans. Meso level recognition can be given to innovative projects that model the Recovery Approach.  

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13 The Mental Health Consumer Council of the Otago District Health Board makes annual awards to staff or service projects that recognise the Recovery Approach as a central part of the service that they deliver (Roper, 2006).
The study participants identified that at the micro level the relational skills of the staff enabled interactions to be inclusive and participatory. These facilitation skills reduced the dominance of the staff and engendered a culture where it was safe to exchange information and make decisions that were responsive to the needs of all parties. Study participants highlighted that the principles of the Recovery Approach required staff to be proactive in setting out a framework for interaction which took into account the social context. Skills in conflict resolution enabled the intervention to focus on the common ground of recovery for the patient. These skills assisted in the management of adversity for those whose lives were affected by mental illness.

This study has sought to describe and explain the experience of three small groups, family members, ex-patients and staff, as they interacted in response to an episode of acute mental illness. The experience of the participants has been analysed in terms of power relations that are sourced from the macro, meso and micro levels. Power relations at these levels impacted on the working relationships within a mental health service. The aim of the analysis was to add to the theoretical knowledge of what is best practice in the field of inquiry of working with families and patients. The analysis was grounded in the experience of the participants. It illustrated what was common ground and what were barriers to inclusive and participatory working relationships.
Appendix 1

Research questions

Family version

Knowledge:

1. What kinds of information were shared between the family, patient and staff at the particular times of the initial assessment, review meetings, and discharge from the Day Hospital?

2. Apart from the three times already mentioned were there any other times when information was shared?

3. Throughout the times of the various contacts when information was shared whose needs and issues were being attended to?

Interactions:

4. Were the strengths and resources of the family identified, supported and developed? If so how was this done and by whom?

5. Were the needs and issues of your family member (patient) specifically identified and by whom, and were these needs and issues included in the care and treatment plan?

6. Were the needs and issues of your family, that is all the factors that impacted on the family, specially identified and by whom, and were these needs and issues included in the care and treatment plan? [If necessary ask ‘How were the needs and issues of family identified? Were they asked about explicitly or did they emerge from other parts of the contact?”]

7. Tell me about your experience of being in contact with the staff of the Day Hospital – please consider issues such as how comfortable you were, your level of confidence in the staff and the degree to which you were a partner in the care and treatment?

Decision making:

8. Were the family included or excluded in the decision making of the care and treatment plan?

9. Were the family involved in defining the issues at the time of the initial assessment, the redefining of issues at review meetings and the defining of issues at the time of discharge? What specific decisions were family involved in making?

10. Do you consider the family influenced the decisions about care and treatment? If so why did family exercise their influence and how was this done?

11. Tell me how much you feel that family were part of the care, treatment and decision making team?
Research questions

Staff version

Knowledge:
1. What kinds of information are shared between the family, patient and staff at the particular times of the initial assessment, review meetings, and discharge from the Day Hospital?
2. Apart from the three times already mentioned are there any other times when information is shared?
3. Throughout the times of the various contacts when information is shared whose needs and issues are being attended to?

Interactions:
4. Are the strengths and resources of the family identified, supported and developed? If so how is that done and by whom?
5. Are the needs and issues of the patient specially identified and by whom, and are these needs and issues included in the care and treatment plan?
6. Are the needs and issues of the family, that is all the factors that impact on the family identified and by whom, and are these needs and issues included in the care and treatment plan? [If necessary ask ‘How are the needs and issues of the family identified? Are they asked about explicitly or do they emerge from other parts of the contact?’]
7. Tell me about your experience of being in contact with families at the Day Hospital – please consider issues such as how comfortable you are, your level of confidence in the families and the degree to which families are partners in the care and treatment?

Decision making:
8. Are the family included or excluded from decision making of the care and treatment plan?
9. Are the family involved in defining the issues at the time of the initial assessment, the redefining of issues at review meetings and the defining of issues at the time of discharge? What specific decisions are family involved in making?
10. Do you consider that family influence the decisions about care and treatment? If family do so why do you think they exercise this influence and how is that done?
11. Tell me about how much you feel that family are part of the care, treatment and decision making team?
Research questions

Patient version

Knowledge:

1. What kinds of information were shared between the family, yourself and staff at the particular times of the initial assessment, review meetings, and discharge from the Day Hospital?
2. Apart from the three times already mentioned were there any other times when information was shared? If so what information was shared?
3. Through out the times of the various contacts when information was shared whose needs and issues were being attended to?

Interactions:

4. Were the strengths and resources of the family identified, supported and developed? If so how was this done and by whom?
5. Were your needs as a patient and family member specially identified and by whom, and were these needs and issues included in the care and treatment plan?
6. Were the needs and issues the family that is, all the factors that impacted on the family, identified and by whom, and were these needs and issues included in the care and treatment plan? [If necessary ask ‘How were the needs and issues of the family identified? Were they asked about explicitly or did they emerge from other parts of the contact?’]
7. Tell me about how you think your family experienced being in contact with the staff of the Day Hospital – please consider issues such as how comfortable they were, their level of confidence in the staff and the degree to which you think they were a partner in the care and treatment?

Decision making:

8. Were your family included or excluded in the decision making of the care and treatment plan?
9. Were the family involved in defining the issues at the time of the initial assessment, the redefining of issues at review meetings and the defining of issues at the time of discharge? What specific decisions were family involved in making?
10. Do you consider that the family influenced the decisions about care and treatment? If so why did the family exercise their influence and how was this done?
11. Tell me how much you consider that your family feel that they were part of the care, treatment and decision making team?
Appendix 2

Research participation consent form

Research into the interaction between family and staff at the Psychiatric Day Hospital.

I have read the Information Sheet and I have had time to consider whether I will take part in this study. I understand what the study is about. All my questions have been answered to my satisfaction. I understand that I am free to ask for further information.

I know that:
1. Participation in the study is entirely voluntary.
2. Withdrawal from the study can occur at any time without any disadvantage.
3. The audiotapes of the interview and the personal details used to identify the interview record will be destroyed at the end of the study. The interview records and raw data from the study will be kept in safe storage for five years at the Community and Family Department. Then they will be destroyed.
4. The interview and the write-up may cause discomfort by recalling the issues and events connected with care and treatment at the Psychiatric Day Hospital. Support and counselling associated with this study is available through Donna Tunnicliff and I have her contact details.
5. The findings of this study may be published in journals and presented to people who have an interest in mental health. The thesis will be available in the University of Otago Library. Taking part in this study is confidential and neither I, nor my experience will be identified by name. Every attempt will be made to preserve my anonymity.
6. My participation is dependent on consent from both ex-patient and family.

I agree to participation in this study.

(Signature of ex-patient) 
(Signature of family)

Study explained by:

Researcher Ivan Criglington Phone 474 7007 ext 7351

This study has been reviewed and approved by the Otago Ethics Committee.
Bibliography


