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'Talk about Trouble': Practitioner Discourses on Service Users Who Are Judged to Be Resisting, Contesting, or Evading Treatment

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Introduction

> *Where the environment is stupid or prejudiced or cruel, it is a sign of merit to be out of harmony with it.*
>
> (Russell, 1930, p. 105)

In this chapter, we report research investigating interactions of practitioners and adults with mental health conditions where the latter are judged to be resisting, contesting, or evading treatment. During the last 15 years, we have conducted various studies examining the discursive practices through which practitioners make sense of and respond to those with whom they work, focusing especially on situations in which individuals are considered difficult to manage. Our main purpose has been to better understand the practices by which the mental health disciplines seek to regulate service user expectations and behaviours in light of the discourses that inform them, especially those arising from the social justice and human rights concerns evident in recent mental health policy both in Australia (Australian Parliament Senate Select Committee on Mental Health, 2006) and internationally (UN, 2006). Much of our work in this area has involved practitioner interactions with people living with borderline personality disorder (BPD). In what follows, we begin by outlining the current policy and practice context in Australia. The remainder of the chapter discusses a number of studies in which we have investigated interactions between health practitioners and people living with BPD or other forms of severe prolonged mental illness.

Mental health policy and practice in Australia

Despite having a modern comprehensive mental health system, there is a high unmet need for psychiatric treatment in Australia (Hazelton, 2005). Since the

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early 1990s, a range of mental health-related issues and service shortcomings have been addressed through a national mental health strategy, implemented through successive five-year plans (Commonwealth of Australia, 2009). A number of policy expectations have evolved including: services ought to be responsive to the needs of users and located close to where people live; care ought to be delivered continuously across both inpatient and ambulatory services; and the citizenship entitlements and human rights of persons living with mental illness must be safeguarded. By the fourth plan (2009–2014), social inclusion and recovery, prevention and early intervention, quality improvement and innovation, and accountability were being emphasised (Commonwealth of Australia, 2009).

While the reforms have brought increased resources and some service improvements (Whiteford, Buckingham, & Manderscheid, 2002), there has been little evidence of beneficial impacts on citizenship participation and human rights protections for those living with mental illness and their families (Hazelton, 2005). Indeed, the findings of recent studies such as the Survey of High Impact Psychosis (SHIP) in Australia indicate that people living with severe prolonged mental illness experience educational and employment disadvantage and are heavy users of alcohol and illicit drugs (Morgan et al., 2012). When asked to identify immediate challenges, participants in the SHIP study indicated those listed in descending rank order in Table 21.1. It is not clear that the policy aspirations can be realised, especially if responsibility for claiming rights falls on the vulnerable individuals concerned and their families (Johnstone, 2001; Watchirs, 2000). While people living with severe mental illness identify financial concerns, loneliness, and insecure accommodation as pressing challenges, progress has been slow in developing the rehabilitation, housing, and support services necessary for life in the community (Carr, Whiteford, Groves, McGorry, & Shepherd, 2012).

Table 21.1 Challenges over the next year as identified by people living with psychotic disorders

Challenges
Financial matters
Loneliness/Social isolation
Lack of employment
Poor physical health/physical health issues
Uncontrolled symptoms of mental illness
Lack of stable/suitable housing
Other
Stigma/discrimination
No family or carer
Inability to access specialised mental health services
Difficulty getting a medical appointment

Source: Carr et al. (2012).

In recent decades, underdeveloped services and human rights violations have been recurrent themes in numerous reports addressing deficiencies in mental health services in Australia (Australian Parliament Senate Select Committee on Mental Health, 2006; Human Rights and Equal Opportunity Commission, 1993; National Mental Health Commission, 2014). It is ironic that in an era in which the policy aim is to humanise mental health services, the experience of 'being in care' may have become more restrictive than in the past. Mental health facilities have become more risk averse (Clancy, Happell, & Moxham, 2014; Hazelton, Rossiter, Sinclair, & Morrall, 2011). Risk management regularly supplants therapeutic concerns, often on the basis of 'health and safety requirements'. Despite a policy focus on reducing restraint and seclusion (National Mental Health Working Group, 2005) and evidence that such reductions are possible (Gaskin, Elsom, & Happell, 2007), a range of security and surveillance techniques and devices (e.g. duress alarms, closed circuit television monitoring) are in routine use in Australian mental health facilities. There has also been heavy reliance on 'zero tolerance' polices in dealing with patient aggression and violence.

Mental health consumers or citizens recovering from mental illness?

A key aspect of current mental health reform globally has been attempts to transform the mental health patient into the mental health consumer. While the aim has been to elevate the status of those living with mental illness to citizens and shift therapeutic discourse towards a focus on recovery, such reforms have not gone unchallenged. For instance, it has been suggested that if (mental health) 'consumerism' implies choice, there are many circumstances in which the choices available to users of mental health services are severely curtailed (Hazelton, 2005). The experience of living with mental illness is difficult to reconcile with 'consumer choice'; we need only to think of involuntary admission to a mental health facility; being placed on a community treatment order requiring treatment with powerful psychiatric drugs; or being denied access to a mental health treatment when in a distressed state.

Similarly, it has been suggested that while the recovery movement was instigated by the actions of service users and their advocates, it has long since been co-opted by policymakers, managers, and practitioners and that the progressive potential in recovery has largely been neutralised through processes of professionalisation and bureaucratisation (Hamer, Finlayson, & Warren, 2014). Undoubtedly, notions of recovery and consumerism have come to feature heavily in the professional discourse of policymakers, managers, and practitioners. However, in countries such as Australia, many people treated for psychosis meet criteria for metabolic syndrome, which in part reflects the iatrogenic effects of psychiatric pharmacotherapy (Morgan et al., 2012); improvements in Indigenous mental health remain elusive (Parker, 2010); the physical health of people living with mental illness is poor (Carr et al., 2012); and controversy surrounds the influence of the pharmaceutical industry on medical science and health professional practice (Boyce & Malhi, 2012). It seems important to ask how such concerns might be reconciled with a notion of recovery (e.g. Mancini, Chapter 18, this volume).

People diagnosed with BPD have consistently been marginalised and discriminated against, often by the very services and practitioners who should be providing help:

> A diagnosis of BPD closes the door to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as 'attention seekers' and 'trouble makers'. BPD is the diagnosis every patient wants to avoid.
>
> (Senate Community Affairs Committee Secretariat, 2008, p. 168)

Concerns such as these align with our own experiences of working in and conducting research with mental health services. While our clinical practice and research interests have involved working with a range of service user groups and healthcare practitioners, a central focus has been on practitioner discourses surrounding the management (or non-management) of people living with BPD and other forms of severe prolonged mental illness (see also Bone & Marchant, Chapter 23, this volume for discourse work on personality disorders).

Project overview

While there are various forms of discourse analysis, all share a concern with exploring the political dimensions of language and the ways in which organised sets of discourses are connected to particular social interests. The approach to discourse analysis used in most of our research operates at two levels – text and context. Textually, we are concerned with the structural aspects of a discourse – how grammar and syntax are used, rhetorical devices are employed, and preferred meanings are constructed. Contextually, the focus is on the social-political function supported by a discourse (Chapman & Lupton, 1994; Hall, 1996; Lupton, 1992).

We have also been influenced by Foucault's (2007, 2008) notion of 'governmentality'. Foucault sought to downplay the importance of the state in processes of political subjectification, pointing instead to the role of practices operating both within and beyond the state – a kind of 'government at a distance'. He construed political subjectification in various practices located both within and beyond the state. For mental health, this might involve practitioners working in hospitals and other organisations, self-help groups, and the families of services users (Dean, 2010; Miller & Rose, 1988;

Rose & Miller, 1992). Foucault (2007, 2008) considered political action and personal conduct to be interlinked and suggested that the successful government of others depends heavily on the capacity to govern oneself (Dean, 2010).

An important but often overlooked consideration in studying interactions between practitioners and service users is power. Psychiatric power has typically been linked to social control, implying restrictive understandings of the activities of practitioners. We would argue that such an approach risks missing a range of mental healthcare activities that might be understood in more positive, productive power-analytic terms (e.g. talking therapies, counselling, group work, and emotional work). Here again Foucault's work is instructive, drawing attention to the 'productive' aspects of power implicit in much of mental health work. Following Foucault, power can be approached in relational terms as seeking to affect the actions of individuals by working on the ways in which behaviour is largely self-regulatory; and the extent to which the exercise of power is always accompanied by possibilities for resistance, contestation, and evasion (Hindess, 1996). Such an approach suggests the need to reconsider the nature of interactions between practitioners and service users, understanding the therapeutic enterprise more in terms of the promotion of subjectivity and the forging of alignments between the personal projects of citizens and the prevailing social order (Dean, 2010).

Following the approach outlined above, much of our work has involved analysing the mindsets, techniques, and practices routinely employed by mental health practitioners in monitoring, directing, and shaping the conduct of those under psychiatric 'care'. Procedurally, we follow an approach suggested by Dean's (2010) elaboration of Foucault's (2007, 2008) work on governmentality: we question practitioners about what they are *seeking to achieve through the interventions* being used; the *nature of the interventions* being used to target mental health problems and disorders; the various *identities* (or subject positions) assigned to people living with mental illness; and finally, what are considered to be the *ideal outcomes* for those receiving such help.

The initial use of this approach was in a study of the discourse employed by mental health personnel in making sense of concerns surrounding safety and risk management in everyday psychiatric work (Hazelton, 1999). That study set the scene for subsequent work by exploring how discourses deployed around the themes of safety and risk management were displacing therapeutic themes in the everyday work of practitioners, undermining the social justice aspirations of mental health policy and shifting the ethos of mental health work away from the provision of *care* and towards *control*.

The studies reported in what follows received ethics approval from the respective university and health service human research ethics committees. More detailed methodological discussions can be found in Hazelton (1999), Hazelton, Rossiter, and Milner (2006) and Hazelton et al. (2011).

Talk about trouble

'Managing' to manage

Among people who present regularly to emergency departments and mental health services are a deeply stigmatised group of individuals who have been given a diagnosis of BPD (Cleary, Siegfried, & Walter, 2002; Deans & Meocevic, 2006; Fraser & Gallop, 1993; Hazelton et al., 2006; Nehls, 1998). This disorder involves significant emotional distress and impaired interpersonal and emotional functioning, has an early onset (18 to 25 years of age), and is more likely to be diagnosed in females (about 75%) (Hazelton et al., 2006). Gunderson (2001) has suggested that the severity of disability associated with BPD 'involves a terrible way to experience life' (p. 13).

In 2004–2005, we conducted a series of practice-based workshops in a semi-rural health service in Australia, to support clinicians to develop compassion and skills in dialectical behaviour therapy (DBT) that would enable a more positive response to people living with BPD. Survey results and transcripts from focus groups conducted prior to the DBT workshops found overarching themes of 'difficult consumers' and 'ineffective treatments' (Hazelton et al., 2006). Each workshop commenced with a small group activity in which participants were asked to identify 'messages and myths' regarding BPD. Butcher's paper notes collected from such activities provided a rich tapestry of phrases that further illuminated the pre-workshop findings. Regardless of the profession (nurses, allied health professionals, and psychiatry registrars), workplace (emergency departments, mental health services, or generalist services) or experience of the participants, the messages were consistent. Derisive phrases such as 'manipulative', 'impossible', and 'undeserving of services' arose in each workshop. A belief that difficult behaviours were deliberately designed to cause trouble was apparent in comments such as 'they're there to make your life a misery', 'they don't want to change', and 'no matter what you give them they want more'. That self-harm and suicide attempts were considered attention-seeking gestures was apparent in comments such as 'they don't really want to kill themselves'. Questions such as 'why do we have to see them, they're bad not mad' and comments such as 'they belong in jail' suggested that some practitioners found it difficult to contemplate that people living with BPD were deserving of help.

When asked to identify issues and challenges experienced while working with people living with BPD, the frustration and difficulties were obvious. Some practitioners identified the BPD behaviours as the cause of the challenges. These were often phrased in generalities such as 'never keep appointments', 'they sabotage attempts to help', 'loud and can be obnoxious', and 'they consume more attention and believe they are more special than others'. Others identified practitioner-related factors that contributed to the challenges experienced. These included, 'staff attitudes', 'a need to distance oneself from one's own reactive responses', 'countertransference', and 'limited training in working effectively with this client group'. Service-related problems were also identified including 'siloed services', time and resource limitations and service-related stigmatisation of the people with BPD.

Practitioners were then asked to consider the impact of these messages and challenges on the care provided for people with BPD. Repeatedly, participants identified a sense of 'hopelessness', 'a lack of consistency within and between services', 'disorganised responses', people 'miss out on services', and efforts are made to 'avoid' contact with people put in the 'too-hard basket'. Frequently, responses were described as 'crisis-driven' and reactive. The extent of the impact could be viewed as indicative of a misuse of practitioner power where people with BPD are marginalised, labelled, and stigmatised as being 'untreatable', unworthy of treatment, and likely to cause trouble. These beliefs were then used to rationalise behaviours that are rejecting and invalidating of the person living with BPD (Hazelton et al., 2006).

While it is perhaps tempting to vilify practitioners who struggle to respond therapeutically to people living with BPD, it is important to acknowledge the impact of attempting to work with behaviours that at times can be confronting, challenging, and frightening. Wright, Haigh, and McKeown (2007) have made the point that '(however) we care to define or make sense of it, the particular behaviour that typically leads to a personality disorder diagnosis is likely to challenge and frustrate care staff engaged in attempts at therapy' (p. 244). Participants in our study spoke of treatment interactions with people living with BPD as 'making us feel like we don't care', while others admitted that these interactions 'bring out our own worst features' (Hazelton, Milner, & Rossiter, 2003). Added to these challenges, practitioners' comments suggested a service culture in which people living with BPD were discursively constructed as 'trouble', and that 'more worthy' people were missing out on care. Some participants disclosed that they had not previously had training they felt equipped them with the skills required to work effectively with 'these people'.

A substantial literature describes the effect on therapist psychological well-being of working with people such as those living with BPD who have experienced a range of traumatic events in their lives (Kottler, 2008; Sprang, Clark, & Whitt-Woosley, 2007; Todd, 2007). Participants in our study identified issues associated with working in settings where people living with BPD are regularly encountered as contributors to 'higher stress and burn-out', reductions in empathy, a sense of hopelessness, avoidance and disputes between staff members. Also identified were increases in sick leave and acknowledgement that some staff members were left carrying a heavy clinical load as others avoided contact. Wright, Lavoie-Tremblay, Drevniok, Racine, and Savignac (2011) argue that it is important not to minimise the challenges of providing help for this group of people. However, the 'unhelpful polarization of viewpoints' reflected in practitioner comments about BPD may result in 'the diagnosed' becoming 'divorced from the rest of humanity' (p. 241).

Given the negative and stigmatising attitudes expressed by many participants, attempts to teach skills and therapeutic interventions needed to be preceded by strategies designed to challenge such attitudes and elicit capacity for empathy and compassion for people living with BPD. Without the ability to recognise a shared humanness or 'a re-engagement with common humanity', training is likely to be unsuccessful (Wright et al., 2007, p. 236). The training provided initially focused on this issue and analysis of focus group transcripts conducted post-training in DBT found a positive change in practitioners' views of people living with BPD. Therapeutic pessimism had been replaced by optimism, compassion and humane understanding, and a more hopeful outlook regarding the outcomes of treatment (Hazelton et al., 2006).

The impact of the DBT training was such that the health service supported the development of a DBT treatment team. An unexpected finding was accounts of personal benefits experienced by practitioners as a result of undertaking the DBT training. In particular, a comment by a clinician that 'this therapy has changed my life' prompted further reflection. It would be reasonable to anticipate that the person receiving therapy might describe positive changes occurring as a result of treatment. However, it was unforeseen that practitioners/therapists might attribute positive personal benefits from learning and delivering a particular therapy. Comments such as this led to follow-up research to explore, interpret, and understand the experience of clinicians training and practising as DBT therapists (Rossiter, 2008, 2009).

Practising and preaching

The follow-up study referred to above employed phenomenological methods, utilising three distinct, yet interrelated steps or 'rules', that is the rules of epoché, of description and of horizontalisation (or equalisation) (Spinelli, 1989). Data collection involved both in-depth and semi-structured interviews. A purposeful sample sought medical, allied health, and nursing practitioners who were trained and actively involved in practising as DBT therapists within a public mental health service. Participants were aged between 27 and 55, with five male and eight female clinicians representing a range of mental health professionals. One psychiatrist, four psychologists, three occupational therapists, three social workers, and two nurses were interviewed. Six participants were employed in a multi-disciplinary, tertiary-level team providing specialist services for people with BPD. Six worked in a semi-rural mental health service comprising an acute inpatient psychiatric ward and a community team with a small therapy team. This service provided generalist services with treatment for people with BPD comprising a component of the work only. The final participant worked across an acute inpatient service and the tertiary-level team. Experience working in mental health services varied widely as did experience practising as a DBT therapist. The least experienced participant had six months active involvement with over three years familiarity with DBT while the most experienced had six years of practice as a DBT therapist.

Each person reflected on 'pre-DBT' experiences, with some presenting their personal experiences while others highlighted their observations of the challenges and difficulties associated with people living with BPD. Views consistent with a discourse situating the problem within 'this group' were expressed:

> But oftentimes it's just too hard and you can think I don't want to work with this group (Extract *R6*).

> I was working very much on the frontline...seeing the culture of a hospital setting, and seeing how people treated this group...It was really very tough...This is a very hard, awful group. We don't want to work with them...very stigmatizing (Extract *R3*).

This suggestion that association with people with BPD tainted anyone associated with them was expressed much more strongly by another participant:

> This is a population that is still effectively being told to go away and get lost...People with borderline personality disorder are the stigmatized of the stigmatized, and I mean there's secondary stigmatization that occurs for the staff that have worked with them (Extract *R7*).

Another participant flagged the emotional intensity of the interactions between staff and people with BPD:

> Looking at the angst in the staff...and the conflict that arose between the clients and staff,...staff seemed to be so sensitized to anything that they did, and very reactive in nature (Extract *R2*).

Observations such as this suggest a limited capacity among some practitioners to respond therapeutically to people who have been admitted under the diagnostic label of BPD. This is consistent with strongly held beliefs that such people are not deserving of care, are irritating, and do not have a 'legitimate' mental illness.

The interview data provided insights into how engagement with DBT as a therapist impacted both personally and professionally on each person's sense of self and other. Participants spoke of the ways in which the process of learning

DBT, the philosophical principles underpinning the therapy, the assumptions that guide therapist–client interactions, and the skills taught had shifted their view of people living with the disorder:

> By actually doing the training...you're almost forced to become more mindful and go through some of the process itself, so I think it really helps in...understanding what's actually happening, right here right now with...the client (Extract *R8*).

> Taking a much more non-judgmental stance towards the client...rather than just kind of getting angry and pissed off at the client for doing that...It helps you to understand how they've come to be that they were behaving in such a way (Extract *R6*).

This contrasts starkly with pre-DBT discourse with participants acknowledging the shift that has occurred in their responses. They were able to discriminate between previously non-empathic stances to a newly adopted non-judgmental stance and mindfulness. To what did these participants attribute this shift towards more compassionate and effective care? Just as mindfulness is described in DBT as a 'core skill', for many participants their practice of mindfulness was described as central to personal changes and an enhanced capacity as a therapist. The impact was often seen as pervasive:

> I think the biggest one for me is...the whole idea of mindfulness and how useful it can be in everyday life (Extract *R8*).

> ...mindfulness and that's something that I'm just continually aware of in my life...it helped me to actually have more of a sense of being alive by using mindfulness...to actually notice kind of each moment (Extract *R6*).

For some, an enhanced capacity for emotion regulation was noted:

> I don't take things so personally anymore...it just gives me...the capacity to engage my wise mind regularly...it's just with me all the time (Extract *R1*)

For others, the mindfulness-related concept of radical acceptance was paramount:

> The radical acceptance idea has been really big. That this just is how it is. It's a big thing...and once you can stop focussing energy on battling that because many of us do, it's amazing how much energy you've got to do other things (Extract *R3*).

> I think that practice of mindfulness and... acceptance, has just made it easier to work what at times is a really difficult job...but not let that have an impact in other parts of my life. But most probably easier on myself and others outside of work (Extract *R7*).

The discourse related to participants' practice of mindfulness was linked to an enhanced level of self-awareness:

> A greater awareness of myself...also those around me and my interactions with them,...a greater awareness around notions of self...When things are okay, when things are not quite so okay. Do I need to work on them, or do I need to just...let it go (Extract *R3*).

Specific DBT skills, in particular, interpersonal effectiveness skills, were attributed with an enriched capacity to more effectively negotiate encounters in relationships outside of work:

> I was not always cognisant of the whole describing what I want and expressing my emotions and asserting myself and reinforcement...it's helped me at times to think about...how to communicate what I want...and thinking about other people and the way I word things ...I'm a bit more aware of how I do that (Extract *R10*).

Participants provided insights into the ways in which training and practice in DBT had challenged their attitudes, beliefs, and behaviours both in their professional and personal lives. With increasing self-awareness came an awareness of potential hypocrisy or 'incongruence' between what they espoused and how they lived:

> I'm asking my patients to do this, well bugger it, I've got to do it too...but I think it's important for me to practice what I preach, and to have an actual experience of what I'm teaching people (Extract *R10*).

> ...we make it very, very clear you know that to clients we're in no way perfect and that when we're teaching skills, my God there's lots of stuff that we should be doing. You know that practising and preaching thing (Extract *R3*).

In contrast to attitudes indicative of a level of arrogance or of being the 'one who knows' and judges harshly, participants demonstrated awareness of their own humanity and recognition that they too have much to learn. Some participants discussed ways in which aspects of DBT now informed and guided their lives, leading to enhanced capacity to 'live life to the full':

> I think some of the fundamentals that this practice has really given me, like a model to work with that's very manageable and I've embraced in all areas of my life...I find it comforting to know that I've got a way of understanding things (Extract *R1*).

> ...we've had discussions ourselves around the way in which DBT becomes part and parcel of your life...we talk at length about the way in which we've grown from it...I think it's really important...that we recognize and we reflect on the way in which it impacts on us, because...as a service, DBT has become a whole service approach...to acknowledge that it's done more than just affect the service (Extract *R3*).

These examples can be understood as expressions of a theory and therapy embodied within the lives of the participants; of fundamental changes that have occurred at both a personal and professional level from immersion in a therapy that provides both a set of assumptions that challenge the prevailing discourse and a tightly held structure and supportive framework that enables therapists to stay in relationship throughout the most demanding encounters (Spinelli & Marshall, 2001).

When addressing attempts at engaging therapeutically with people living with BPD, the discourse shifted markedly from one replete with expressions of frustration, blame, futility, and hopelessness to one suggesting a heightened capacity for collaborative relationships:

> ...people are doing the best they can...remembering that is one of the key things (Extract *R10*).

> ...a really big focus on...acceptance...in the validation of that relationship (Extract *R5*).

An even greater shift was evident as participants described with enthusiasm and admiration their responses to the progress made by people with whom they had worked closely:

> It takes a lot of courage and commitment to do that,
> ...you're very humbled often by their stories and what
> they've done and...you share in their joy when they ...get
> it you know...you kind of get excited about how they go
> off into life with a whole bag of skills that means
> they'll enjoy their life, and have control and be in
> charge of their life (Extract *R1*).

> We were seeing people's lives change radically...seeing
> them challenged within their lives but their skills
> allowing them to keep moving forward (Extract *R7*).

These changes indicate that participants' professional development and their sense of self had matured in such a way that they could now develop therapeutic relationships with people for whom intimate relationships had previously been damaging. This maturity included an enhanced moral sensibility – behaving in a 'just and moral' manner towards people who had previously been seen as 'unworthy of care' and 'untreatable' (Rossiter, 2008, p. 139).

People with BPD are at high risk of suicide and may present frequently with self-harm such that many health professionals struggle with strong emotional reactions and are reluctant to become involved in working with this group (Commons Treloar & Lewis, 2007). Participants demonstrated an ability to override this antipathy and engage in accepting and caring therapeutic relationships. This shift involved a more humanistic attunement to the other with a capacity to care for and rejoice with the person at signs of progress even in the midst of the distress related to living with BPD. 'The capacity . . . to deconstruct the damaging attitudes and beliefs about people with BPD and replace these with an empathic stance and enhanced self-awareness is integral to enabling therapeutic engagement and effective treatment outcomes' (Rossiter, 2008, p. 141).

The trouble with new graduates

> It is the ultimate hypocrisy of our profession that we do not or cannot do the same things we ask of our students and clients.
>
> (Kottler, 2003, p. 57)

As part of a wider study addressing the experiences of new graduate nurses commencing employment as registered nurses in a public mental health service, our attention was drawn to the ways in which mental health services may impede rather than facilitate recovery from mental illness. That study was conducted in 2005 and 2006 and involved the evaluation of a group mentorship programme for new graduate nurses working in an Australian public mental health service. The mentorship programme was one year in duration, comprised three, four-month rotations through different clinical services, involved shift work, and commenced with a one-week orientation. Participants were new graduate registered nurses (n = 18) commencing full-time employment in mental health and clinical nurse consultants (n = 5) – advanced practitioners, with postgraduate qualifications and extensive experience in mental health. The mentorship groups met fortnightly, and comprised six new graduates and two clinical nurse consultant mentors. Data collection involved audiotaping mentorship group discussions, participatory observation by research team members, and brief participant-completed summaries of the key points of discussions. Data were analysed using the approach described in the methodological description provided above.

While the main focus of the study was on the needs of the new graduates for structured support and guidance as they commenced employment as registered nurses, the discussions frequently addressed problems such as the arduous nature of mental health work; the uncaring attitudes of and practices of many of the veteran nursing staff; and the maltreatment and neglect of service users. In general, the new graduate nurse participants characterised the public mental health facilities as tough security-minded places, where staff act more as risk-managers rather than therapists, and all service users are treated as if they might be dangerous. The following extracts are examples of the issues frequently raised by the new graduates within the mentorship discussions.

New graduates being put in their place by veteran staff:

1 You go on the ward and a simple thing like
2 transferring a [phone] call...'You don't know how to
3 transfer a call'? And [I] said, 'no, but if show me
4 [I will] know'...in the end you don't want to ask
5 questions (Extract *female new graduate*).

The maltreatment and neglect of people living with mental illness:

1 There was an incident last week...the client actually
2 said: 'well we can do this the easy way or we can do
3 this the hard way'. [A staff member] said 'f...it,
4 let's do it the hard way'; they weren't prepared to
5 wait around...I would have explored the other option
6 first (Extract *male new graduate).*

1 We had a girl [admitted]...She was absolutely paranoid...
2 but I made a connection with her...and she told me all

> this stuff and I am new. I went back to the staff... and they said, 'off you go [home]'. [I said] 'I have just spoken to this girl...I want to tell you...what she told me [because] that is going to affect her treatment'...That is how they related to her...nobody is interested (Extract *female new graduate*).

While the participants' discussions ranged over many issues in mental healthcare, a particular area of concern was how to help a person who had been vilified by staff. In one discussion, a participant discussed her recent experience of working with a person who has been admitted with a diagnosis of BPD:

> We had a [person with] borderline [personality disorder] on the ward and I spent some time [with her]...So I am writing up her notes and three people said: 'waste of space, you are wasting your time writing it up' (Extract *female new graduate*).

A number of the new graduates also perceived a connection between the dismissive ways in which they were often treated by veteran colleagues and the widespread mistreatment of service users:

> I still find at handover there will be three people...and they will talk as if I am not in the room; am I not working on the shift? Do I not need to know about the client...I don't know if it is a conscious thing, or maybe it is because people have worked here for so long (Extract *female new graduate*).

> The people who intimidate me,...intimidate...patients on a worse level (Extract *female new graduate*).

Clinical relevance

Effective mental health work requires self-regulation in balancing the degree of liberty one extends to service users with the need for providing help and managing risk. Getting the balance right is especially demanding when working with people at risk of harming themselves or others. The risk-bound nature of mental health work is evident to practitioners regardless of health professional background and experience; is raised in undergraduate health professional education in Australia (and comparable countries); and is reinforced from the moment a new graduate enters the mental health work force. At the same time, university studies also emphasise the human rights and citizenship entitlements of persons living with mental illness. Concepts such as 'mental health consumer', 'least restrictive environment', and 'recovery-oriented practice' imply the need to exercise a kind of 'soft' power to regulate the behaviours of vulnerable and distressed individuals. However, coming to terms with the power-relations inherent in mental health work poses a challenge for new graduates, and it should be said, many 'old hands'. While new graduates and more experienced health practitioners may be confronted by the uncaring and coercive ways in which some professional colleagues deal with service users, lack of experience and/or prevailing (formal and informal) workplace authority structures may contribute to a (perceived) lack of professional power to change things. Such lessons are not readily covered in formal university studies, and the informal lessons of the workplace often seem more concerned with maintaining 'how things are done around here'.

In the studies referred to above, participants indicated a desire to become more effective practitioners/therapists; many also acknowledged the need for confidence to deal ethically with what were considered to be poor standards of practice encountered on an almost daily basis. What ought to be done if ethical issues were encountered was a frequently discussed topic and might range from how to manage in situations in which service users had been demonised by staff (e.g. working with a person with a history of child abuse, or working with a person diagnosed with BPD) to instances in which an individual's rights are being violated. The following extract from the new graduate mentorship project illustrates the type of narrative likely to leave participants ill at ease and unsure of how to respond:

> [This service user] thought she was going to get out [of hospital], we weren't allowed to say that we were going in for a two-month order to keep her here. [The nurse unit manager said] we weren't allowed to say you are going to be here for two months. I wished her luck and hoped she got what she wanted all the time knowing that she was going to have a two-month stay. That's really hard, but I wasn't in a position to [tell her the truth] (Extract *female new graduate).*

The participants in the studies referred to in this chapter were involved in mental health work a decade or more following the implementation of the National Mental Health Strategy in Australia. Given the reform directions set down in policy, the principles learned at university, and the standards of practice advocated by the health professions, the participants might have expected to find a service culture in which genuine care and concern were shown for service users;

where staff and service users collaborated in treatment decision-making; where policies and procedures were non-discriminatory and sensitive to human rights; and staff expected service users to recover even in cases of severe mental disorder. However, the findings of the studies reported in this chapter suggest that the work environment in mental health services may fall short of the stated ideals of policymakers, consumer spokespersons, and health professionals. Similar findings in other parts of the country would imply a wide gap between ideals and practices in many mental health services throughout Australia.

Clearly, mental health work is demanding. While participants could identify strong role models and supportive colleagues, they also disclosed numerous instances of having to work alongside staff they considered to be indifferent or even hostile towards services users and also in some instances towards themselves and other staff; this was certainly the case for new graduates, but was not restricted to this group alone. Participants discussed many instances of a lack of concern and defensiveness shown by colleagues towards people living with mental illness, and frequently such staff reactions involved diagnostic groups assumed to be 'troubling' and 'troublesome'. The maxim that relationships 'are the heart and soul of mental health care' (Wright et al., 2011) seems to have had little sway over such uncaring staff.

Todres, Galvin, and Holloway (2009) have argued that when health professionals offer care that supports the autonomy, dignity, and complexity of individuals, they bolster opportunities for humanisation. Such caring values were little evident in participants' descriptions of how many staff interacted with those for whom they provided 'care'. Historically, attempts at humanistic care have often been shadowed by punitive and constraining treatments to achieve broader social aims for the control of madness and 'crazy' individuals. In this sense, we might say there has always been a 'dark side' to mental health work which is sustained by the social role of the mental health professions in maintaining social order and intermittent moral panics surrounding mental illness and dangerousness (Beresford, Nettle, & Perring, 2010; Morris, 2006).

The findings of the studies reported in this chapter indicate the ways in which policy and practice improvement initiatives may be modified, undermined, or simply ignored by staff. Unfortunately, such policy-resistive practices align with the increasingly risk-averse and defensive nature of mental healthcare in Australia and internationally (Hazelton, 2005; Hazelton et al., 2011); high security design and defensive practice have become standard in many services. One especially worrying recent development is the increasing use of electronic stun (Taser) devices by police in the course of intervening in mental health emergencies in the community (O'Brien & Thom, 2014); might this be extended to clinical settings in the future? 'Zero tolerance' polices have also been introduced to deal with patient aggression and violence with 'mentally ill being seen as especially threatening in busy acute care services such as emergency departments and psychiatric assessment units' (Pich, Hazelton, Sundin, & Kable, 2010). Zero tolerance has also been criticised for taking the therapeutic initiative away from healthcare practitioners, thus removing opportunities for building service user engagement with care (Stone & Hazelton, 2008; Wand & Coulson, 2006).

Bringing about change in any area of public policy requires that consideration be given to stake-holder engagement. If the process of professional identity formation influences workforce development and retention (Morrissette, 2010), new graduates' workforce transition experiences are likely to shape their developing understanding of mental health work. Regular exposure to senior colleagues displaying cynical, uncaring, and hostile attitudes and behaviours to service users and professional peers could influence whether new graduates build a professional ethos primarily in terms of duty of care or duty of control (Bertram & Stickley, 2005). For participants in the new graduate project, the mentors provided a model of how to build a therapeutic skill set within an ethics of caring. The participants in the DBT studies also faced demanding work circumstances in which the practices of some colleagues might be damaging to service users and staff. For these more experienced staff, training in and then working with a focused psychological intervention seemed to play much the same role as the mentors in the new graduate project – providing structure and support.

Other studies have used different approaches to analyse situations in which the understandings and expectations of practitioners and patients and different groups of practitioners do not align. Crepeau's (2000) narrative analysis of clinical team meetings considered similar issues to those addressed in this chapter, but in the context of an inpatient geropsychiatric service in the United States. That study explored how patient refusal to comply with sick role expectations might undermine the professional composure and therapeutic confidence of some treating staff and the ways in which persistent negative staff images of a patient might be changed .

There are important implications here for the prospect that key mental health policy reforms might be realised in practice. In each of these studies reported in this chapter, participants were offered and usually took up opportunities of accessing structured in-service education and ongoing support. Such involvement included techniques for recognising and subverting damaging discourses; shifting work-related conduct in more positive directions; building the capacity for moral behaviour; and becoming more effective in dealing with people and situations. To put it another way, participants were asked and supported to practice what they preach; to do many of the same things they ask of the

Table 21.2 Clinical practice highlights

1. Evidence-based therapeutic practices implemented with careful attention to challenging prevailing stigma-laden discourse can positively influence both service user outcomes and practitioner well-being.
2. The risk averse nature of the current environment in which mental health services are delivered requires practitioners who have the opportunity to regularly engage in debate focused on the moral and ethical implications of practice.
3. Practitioners who actively engage in practices focusing on enhancing self-awareness and mindfulness will be better equipped to resist urges to misuse the power inherent in their role.
4. Adopting DBT or similar therapeutic assumptions such as 'the person is doing the best that they can' supports a focus on working with people living with mental illness in a person-centred manner.
5. Abiding by the golden rule to 'treat others as you would wish to be treated' and 'practicing what you preach' are essential if practitioners are to see the person living with mental illness as a 'fellow human'.

service users with whom they work. For a simple summary of the practical implications, please see Table 21.2.

Summary

This chapter has reported research investigating interactions between practitioners and people living with mental illness who are considered to be resisting treatment. The main purpose has been to better understand the discursive practices by which 'troubling' and 'troublesome' service users are constructed and managed, within the context of policy and practice tensions in which practitioners often seem caught between providing care and managing risk. In the various ways in which they sought to resolve these tensions, participants in the studies reported took up opportunities for structured in-service education and ongoing support. Through involvement in techniques designed to enhance self-awareness, increase mindfulness, build compassion, and challenge stigmatising attitudes, participants came to realise that they were practising what they preach.

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