NARRATIVE SELF-INQUIRY TO CAPTURE TRANSFORMATION IN MENTAL HEALTH NURSING PRACTICE

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Narrative self-inquiry to capture transformation in mental health nursing practice

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ABSTRACT

The aim of the study is to identify and map the process of transformation of the practice of a mental health nurse from everyday practice to desirable practice (that is, the realisation of mental health Recovery) through self-inquiry into a series of narratives derived from that practice. Recovery is desirable in terms of clinical governance and is also desirable practice for mental health nurses as a standard to which they should practice. A series of reflexive narratives signposted the transformative journey and also captured the lived experience of transformation.

Experiences from practice were captured as spontaneous stories. Guided reflection obtained insights from these stories, and the insights derived from the stories were subsequently reflexively deepened by inquiring into them. In time the cues in the model of guided reflection became internalized to the extent that practitioner narratives arose that already embedded insights. Self-inquiry into these practitioner narratives indicated the nature and the felt affect of constraints met within practice. The affect of these constraints upon the individual practitioner and upon the ability of the individual practitioner to achieve desirable practice is indicated by self-inquiry into them.

The result of the study was the realisation that transformation is unable to take place without the individual practitioner being fully aware of who one is, in order that s/he may effect transformation and change. Whilst self-inquiry into the narratives indicated the constraints upon the individual practitioner, the psychological unpreparedness also indicated by that self-inquiry indicated why that the tension between the reality of practice and desirable practice could not be adequately explored.

The thesis takes the form of a narrative about writing narratives. The narratives illustrate the norms and values that affect individual practice both vertically (that is, from the organisation and the government), and horizontally (that is, from colleagues and managers), and how an individual practitioner experiences these as obstructive to delivering the service they desire. There have been no narratives written by practitioners about the journey to realise Recovery in their practice; and the structure of the narratives as performances is unique to this subject of thesis by a mental health nurse.

In memory of Alex

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And I have something to expiate:
A pettiness.

- D.H. Lawrence, *Snake*

CHAPTER ONE

BACKGROUND

This thesis is about a journey; but it is itself also a journey. The dictionary definition of a journey is a travelling from one place to another, usually taking a long time; a period of travel; or passage or progress from one stage to another (Chambers Dictionary, 2011).

The Ancient Chinese philosopher Lao Tzu declared that, “Even the longest journey must begin where you stand.”[1] I like this quotation because it implies that the origin of the journey is in stillness, and requires the will to begin the travel, and the desire[2] to undertake it.

My own journey started from the place of my everyday practice of being a registered mental health nurse; it was the place where I was standing when I decided to begin my journey. In that sense I found myself suddenly 'thrown' into the journey, into being, into desire. Heidegger calls this particular quality of human existence *Geworfenheit o*r 'thrown-ness' (Sembera, 2007). My desire was to achieve a certain set of skills and knowledge in my practice as a registered mental health nurse and it was this desire that propelled me on the journey.

My thesis is that this journey is possible, and that this very act of achieving the practice I desire implies a personal and professional 'transformation'. At the commencement of my journey I stand as a mental health nurse who practices an everyday set of knowledge and skills called 'mental health nursing'. My will (or 'desire') was to practise a more advanced set of mental health nursing knowledge and skills.

The way that I would achieve this transformation was through reflection; more particularly going back on my reflections of my practice as a mental health

[1] This is a less well-known but more accurate translation of the oft-quoted proverb, “A journey of a thousand miles begins with a single step” (Benner, 2012: 222)
[2] A desire is a longing or a wish (Chambers Dictionary, 2011)

nurse in order to deepen insights I had gained by this process. Johns (2010: 35) describes reflection as a process of learning, and equates it to

> a window through which the practitioner can view and focus self within the context of her own lived experience in ways that enable her to confront, understand and work towards resolving the contradictions within her practice between what is desirable and actual practice.

Reflection is the means to achieve desirable practice from a position of everyday practice (Fig 1.1).

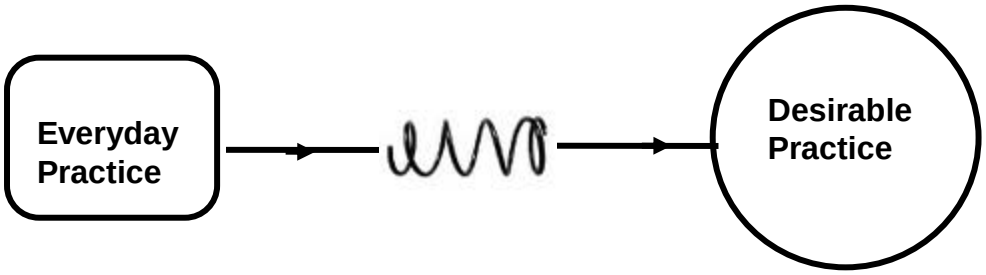

Figure 1.1: Achieving Desirable Practice

(In the above diagram reflection is represented as a coil because achieving desirable practice through reflection is not straightforward.)

Such transformation is built on the foundations of self-inquiry (that is, my reflections on my own practice); and the insights derived from that self-inquiry would influence the process of transformation. Reflection is fired by the desire to achieve the practice I wish for.

In order for me to discuss the context in which my study took place I will borrow terms from the Twentieth Century philosopher Martin Heidegger, who offered a structure for *Dasein* – or 'Being-in-the-World – to comprehend the world in which *Dasein* finds itself (Dreyfus, 1991). Such an understanding however can move in two directions: towards the world or towards the self. In moving towards the self, *Dasein* seeks to understand itself (for it must do this before understanding the world), and refers to itself; a reflexive action which Heidegger terms 'interpretation' (Dreyfus, 1991). This is the general working out by *Dasein* of the possibilities before it. Understanding projects itself by use of a fore-structure - that is, a framework that *Dasein* uses in order to couch its understanding. This fore-structure can be understood as (i) Fore-having (or

'where I am coming from') (because *Dasein* already moves in a 'world' and not a void) (ii) Fore-sight (or 'where I am') (that is, the particular aspect that *Dasein* is dealing with; or what is before it) and (iii) fore-grasp (or ' where I want to get to') (as *Dasein* must have a concept of the particular object or direction in which it is moving within the 'world').

(i) Fore-having

Je suis un Marxiste, tendence Groucho

- *Room C205. University of Nanterre, Paris, 1968*

This well-known quotation, found during the time of the Paris student riots in the late 1960s, relates to the canon of Groucho Marx, head of the comedy troupe The Marx Brothers which enjoyed considerable success in early twentieth-century North America. The quotation is no doubt intended to satirise the earnestness and fervour with which followers of the Nineteenth Century economic philosopher Karl Marx regard the world.

I use this quotation because since an adolescent Marxism has been the primary lens through which I see the world. Simply put, Marx viewed industrial society as the conflict of one class (the bourgeoisie, who own the means of production) against another class (the proletariat, who have only their labour to sell). For Marx the inevitable logic of this struggle was that the proletariat will realise they are oppressed and that a much fairer and more moral society will arise after they (the proletariat) seize the means of production for themselves. One of the greatest assets of Marxism is that it questions commonly-held assumptions – that is, it is critical. Marxism does not seek to reinforce and maintain apparent truths, but because it is mainly concerned only with the phenomena and interrelations of historical and social life it seeks to establish an objective reality by critiquing those truths (Korsch, 1971).

Ostensibly Marxism appears to correspond to notions of morality and fairness (Churchich, 1994). For this reason perhaps I am attracted to the ethics of Marxism because they resonate with my own desire for morality and fairness.

This is because I speak with a stammer, and have done so for all my life. A stammer is a type of speech disfluency characterized by repeated or prolonged sounds or syllables within a word or a sentence (Linn and Caruso, 1998). Often I feel angry and frustrated at my lack of disfluency when it happens, and at the negative reactions to my stammer that I can perceive from other people.

Adults such as me who stammer encounter particular social pressures and demands resulting in stigmatization, negative stereotypes, discrimination and sometimes social withdrawal or avoidance (Hunsaker, 2011). This is because talking is an important form of communication in any human society (Hunsaker, 2011). Having a stammer is described as being a struggle by those who live with one (Riddell and Prince, 2010). Having a stammer involves a social and a personal struggle to overthrow stigma, negative stereotypes and the circumstances of one's perceived difficulty (Hunsaker, 2011). On the face of it this struggle against perceived injustice bears a resemblance to some general principles of Marxism; and it also echoes the social experiences of many people who meet with mental health difficulties (Time to change, 2008; Green, 2009; Thornicroft *et. al.*, 2010; Rose *et. al.*, 2011).

Marxism as a vehicle of resistance may also be attractive to me because as an infant my primary carer (my mother) suffered regular bouts of serious depression which necessitated in-patient admissions to what were termed at the time ‘mental hospitals’. According to child development theory, the inconsistent parenting that can result from such a major variable can lead to self-defeating behaviour and social masochism in later life, most clearly expressed in the form of resistance-rebellion between the adult (libidinal object) and the desire (or ideal) (the anti libidinal object) (Johnson, 2004). Throughout my adult life I have myself experienced regular episodes of depression. Indeed, during the writing-up phase of this study I took the decision to enter privately-funded psychotherapy[3] during a spell of depression that for the first time in my nursing

[3] I remain in psychotherapy at the current time

career adversely affected my practice as a mental health nurse.

This particular psychological development may also account for my personal struggle throughout my adult life with Protestant Evangelical Christianity, which I adopted in my adolescence perhaps because of its psychopathological components. These offer psychological advantages such as

• the redefining of one's personal life situation or circumstances
• the alleviation of stress
• the development of improved coping mechanisms (Grzymala-Moszczynska and Beit-Hallahmi, 1996).

As a result I have often felt a tension in my life between my personal religious faith and my political belief in Marxism. Whilst religious belief can have benefits for mental health, by assembling a unified world-view, Marxism offers resistance in the form of critical theory, and rebellion in the form of the revolutionary overthrow of existing conditions (including of religion). Marx and Engels in *The Communist Manifesto*, famously described religion as "the opium of the masses" (Finger, 2007). Similarly the Marxist philosopher Georgy Lukacs stated that religion was the class structure divinely inverted, in the sense that the poor would meet justice in the next life rather than in the present one (Lukacs, 1975).

Marxist academics very heavily influenced my degree studies in higher education, because the BA Media Studies degree that I studied for was heavily weighted towards Marxism as a critical method of analysis of the UK mass media. Marxism is an ideal framework within which to couch any qualitative research study (such as this one), because both qualitative study (Hall, 2007) and Marxism (Korsch, 1971) seek to accurately describe and interpret the meanings of phenomena[4] occurring in a normal social context. Subsequently I view the 'world' of nursing that I inhabit as a Marxist would – that is, as the conflict of two classes: for me the Department of Health (more specifically the

[4] A phenomenon is any state or process that can be known through the senses rather than by intuition or reasoning (Honderich, 1995)

health care organisation) represent the bourgeoisie, the owners of the means of the processes of production in healthcare (such as the machines that nurses use for example; or the equipment used in surgery); and nurses represent the proletariat, who have only their labour to sell. I am also heavily influenced by Louis Althusser, who suggested that the bourgeoisie also own the means of ideological production (Althusser, 2008). Similarly I hold with Antonio Gramsci's concept of the hegemony, which is a system of relations of domination based upon consent rather than coercion (Chouliaraki and Fairclough, 1999: 24). In this sense, then, the Department of Health has a hegemonic power over nurses.

Nurses are like many other social groups in that they find themselves constrained by the factors of force, tradition and embodiment (Fay, 1987). Force may exist overtly in the form of legal codes (such as nursing regulation) or in more subtle (less overt) forms of discipline such as social scripts. Tradition exists in the very practices and norms that infuse the social world of nurses. Such beliefs and practices are communicated between registered nurses and their students (Myrick and Billay, 2010); who will in turn communicate those same practices and beliefs after they themselves have become registered practitioners. This influence is recognised by the nurses' registration authority, the Nursing and Midwifery Council [NMC] in its documentation on mentorship, preceptorship and practice teaching (NMC, 2008b). Nurses' oppression is embodied by their very identities in the face of dominant hierarchies such as masculinity and Medicine (Johns, 2009: 16). The notion of the doctor (representative of the dominant hierarchy) has been internalized by nurses, and the medical model has been uncritically accepted by nurses as being normative (Roberts, 1983).

Indeed the nursing literature is replete with the observation that nurses view themselves as an oppressed group, to the extent that it is now generally accepted (Szutenbach, 2008; Kavanagh, 2003; Vessey *et. al.*, 2011). Much of this understanding arose from the work of Roberts (1983), who identified patterns of behaviour amongst nurses that led her to the conclusion that

because nurses view themselves as being oppressed they behave in a particular way as a result. Nursing exhibits many of the symptoms of being oppressed – such as bullying, scapegoating, elitism, criticism and a sense of unfairness. However the oppression is not imagined, for historically nursing – a traditionally female occupation - has indeed been subjugated by the dominant – and primarily masculine - hierarchy of Medicine (Forman, 2010). For nurses, to be resigned to this condition is a survival strategy, because by accepting this state they can manage emotions in difficult and oppressive circumstances (Roberts, 1996, 2006; Traynor, 2002). Feeling oppressed is also a way of nurses identifying with peers as part of a social group (Szutenbach, 2008).

Therefore mental health nurses as an oppressed group are in a unique position to identify with service users who are themselves also an oppressed social group (Office of the Deputy Prime minister, 2004; Dong and Temple, 2011). This might suggest that nurses and service users can become empowered together (Dong and Temple, 2011). However I believe that it is more likely that nurses will experience Recovery by service users as a sort of *vicarious* emancipation, because nurses' experiences of their practice and of the healthcare structures within which they give care are organised such that those are accepted as being natural and therefore unchangeable (Powers, 2001; Turkovic, 2005). This maintains oppression and precludes empowerment. The nursing literature indicates a more circumspect means of emancipation and empowerment as being available to nurses, such as reflection and qualitative research methods (Munhall, 2007). However such methods are presented as a means of reconciliation to oppression (Kavanagh, 2003), rather than as tools of outright liberation.

My own Marxist leanings framed a belief that mental health Recovery is revolutionary in nature. It appeared to me to represent something that could change not only my own practice as a registered mental health nurse, but more particularly could change the lives of people who use mental health services.

Therefore my ambition in this thesis was to inquire into the narratives derived from my practice as a critical tool whereby I could uncover nursing reality and establish new knowledge about and awareness of what I considered to be the harsh objective conditions in which mental health nurses must practice. Such an aim is consistent with that of Marxism (Korsch, 1971). It is a notion also consistent with Marxism that such transformation takes place with the attainment of knowledge about objective reality (Lukacs, 1975).[5] For example, it was my desire that if true nursing reality can be regarded as being something that is hidden but which can be appraised, then once nurses have achieved knowledge of this true nature they can overthrow the conditions that preclude their empowerment and liberation. Such conditions of constraint would not only include oppressive social conditions (Roberts, 1983, 2006) but also the economic conditions that complicate nursing practice, such as low staffing (White *et. al.*, 2010). I wanted my narratives, based on my practice, to reveal such existing conditions.

Another important effect of my mother's serious mental illness[6] was that I was instructed from a comparatively young age in her belief that some forms of intervention used in her psychiatric care were in fact destructive. For example, she believed that the Electro-Convulsive Therapy [ECT] she had been treated with on several occasions as a psychiatric in-patient had impaired her cognitive functions, in particular her memory. An examination of the research indicates that this may or may not be the case (Ottosson and Fink, 2004). However the repetition from a young age of the message that ECT is physically and psychologically harmful was bound to influence my own perception of at least some forms of intervention in mental health care, not simply ECT. Such suspicion of some psychiatric interventions is reinforced by media images, such

[5] This however is a form of positivist trap in that at the same time as I might assert that the only thing that is true is that which can be positively known (or is factual; i.e., objective), the way the knowledge was gathered upon which to base that deduction (i.e., my interpretation of my experience of practice) are not factual because they are at my own admission my personal interpretations of real events and *ipso facto* objectively untrue.

[6] My mother has since recovered from mental ill-health having derived support from psychotherapy.

as the infamous and harrowing ECT scene in the Holywood movie *One Flew Over the Cuckoo's Nest* (Warner Home Video, 1975).

In my adulthood I found employment as an Orderly in the Operating Theatre of a large general hospital. I enjoyed communicating with patients when I accompanied them to and from the Theatre before and after their operations, and many patients told me that they appreciated my interaction. After several years in this employment in 1994 I decided to train as a mental health nurse, qualifying in 1997. I did not know immediately why this choice (or why this specialism) seemed such a natural one for me, but I later noted Dartington's (1993: 32) "general observation" that:

> many people are drawn to the "caring professions" because they have both a wish and a need to put something right, to make reparation....It rises from guilt or concern, and its aim is to heal emotional wounds - one's own and those of the damaged figures of one's imagination.

This prompted me to realise that my choosing to train as a mental health nurse was a projection of my own desire to care for my mother in a way that I was not able to do when I was a child. I became aware of this desire towards the end of my nursing studies when I conducted a small and local research project for my Nursing Studies Diploma. As a part of the project I interviewed registered mental health nurses. One such registered mental health nurse, who was in training to be a psychoanalyst, told me of her belief that nurses enter the profession for their own psychological reasons. The nurse challenged me by asking me why I wanted to train as a mental health nurse. Awkwardly I confessed to her that I was unaware of any reason; but the longer that I dwelt upon the matter, the more I realised what my motivation really was.

(ii) Fore-sight

To continue to follow the broad Heideggarian structure of this chapter is to consider the part of the (existential) totality that I am faced with – that is, mental health nursing.

Nursing

A nurse is a professional giver of care; one who has graduated from an

approved training programme with a diploma or a degree (Quan: 2006: 2). Nursing is:

> The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death. (Royal College of Nursing, 2003b)[7]

In the UK general (that is, physical health) nursing, mental health nursing and learning disability nursing (as well as midwifery itself) is regulated by the Nursing and Midwifery Council [NMC] under different parts of the Register. A nurse, midwife or specialist community health nurse must be registered with the NMC in order to be able to practice in the UK. Registrants are required to pay an annual registration fee, subject to meeting certain professional standards such as continuing professional development, if they wish to continue to practice.

The NMC was set up by the UK Parliament in 2002 following the Nursing and Midwifery Order of 2001. The NMC superseded the UKCC [United Kingdom Central Council for Nursing, Midwifery and Health Visiting]. The NMC, like the UKCC before it, asserts that its aim is to protect the health and well-being of the public. The NMC produces regulatory standards and guidance to which all nurses, midwives and specialist community public health nurses must practice. The most pertinent regulatory document to my practice is *The Code* (NMC, 2008a), which provides registrants with standards of conduct to which they must adhere. The NMC has recently received public criticism for its poor accountability and corporate governance (Council for Healthcare Regulatory Excellence, 2012). It is therefore unsurprising that the NMC is not generally trusted by its registrants (Middleton, 2012).

The origins of mental health nursing

The general origins of nursing can be traced back to Holy Orders, in particular the work of nuns caring for the sick and infirm (Salvage, 1991). Psychiatry as a

[7] The concept 'health' is problematical. The concept, 'health' is not just a physical thing – it also depends on our relations with other people. It is therefore not a static concept, but a dynamic one (Blaxter, 2010). For example, health can mean the absence of illness, or it can indicate personal and social functioning (Larkin, 2011)

body of expert knowledge arose from the practices of ancient human tribes (Shrives, 2008: 14) when psychological conditions were believed to have a supernatural cause, and witch doctors and shamans were held to be the only members of the tribe who had privileged knowledge of the supernatural. If one substitutes the term "shamans and witch doctors' with the contemporary term "psychiatrist" then one can see that psychiatry is already potentially a controversial area. The psychiatrist and writer Thomas Szasz remarked that psychiatry arose along with the rise in secularism, so that the control of social conduct and morality changed from being within the purview of priests to being by physicians (Szasz, 1970: 160). This is why Szasz referred to psychiatry as the new priesthood (Barker and Buchanan-Barker, 2010).

In fact psychiatry was only formally recognised as a legitimate profession in 1808 (Porter, 1990). For many years prior to this psychiatric nursing was considered merely an accessory of general nursing (Nolan, 1993). Care for the mentally ill was first extant in Celtic Christianity, when there was a tradition of itinerant monks known as ‘soul friends’, who specifically worked with the mentally ill (Nolan, 1993). Their spiritual role was to befriend the mentally unwell and guide them back into the community (Nolan, 1993). Similarly some monasteries permitted the mentally unwell – or ‘penitents’ as they were described – to reside with the monks. It is not fanciful to imagine that this is an early precursor to institutional care of the mentally unwell (Nolan, 2008).

Until the Industrial revolution, and the advent of workhouses and lunatic asylums, successive generations placed a moral expectation upon the Established Church to care for the mentally ill (Nolan, 2008). During the Industrial Revolution there were a few notable exceptions to the warehousing and marginalization of the mentally unwell; yet this inexorable course continued unabated until the end of the Nineteenth Century, as did the requirement for lowly-paid and poorly-educated attendants of these institutions (Nolan, 2008). Nursing care of the mentally ill can be first identified as being significant in 1885 when the *Handbook for Attendants on the Insane* was published (Stockwell,

2010). The handbook advised attendants to bestow kindness upon their charges and to encourage activities, as these were perceived to be of therapeutic benefit. After this time lunatic attendants gradually began to receive some training and instruction; however the ethos remained one of benevolent constraint (Stockwell, 2010).

In the UK successive legislation, starting with the Mental Treatment Act 1930, has required a gradual change in approaches of care offered to people who are mentally unwell (Stockwell, 2010). In turn this required the historical role of psychiatric nurses as custodians to also develop. At the time of writing the current legislation affecting the role of mental health nurses is the Mental Health Act 1983 (amended 2007). This Act provides for the detention under certain circumstances of a person if it is perceived that they are a danger to themselves or to others by reason of mental illness. This includes recall to a mental health unit if the person concerned is living in the wider community at the time.

Under Section 5 (4) of the 1983 Mental Health Act a registered mental health nurse (subject to the policy of the employer) is required to detain a person in a psychiatric facility (pending review within six hours by a psychiatrist) if a person has already agreed to be admitted on a voluntary basis. An example of when this may happen is if the person wishes to leave the unit in which they have agreed to reside and in the clinical judgement of the registered mental health nurse for the service user to do so may place the service user or others at risk of harm. Mental health nurses as individual practitioners and also as part of a multi disciplinary team may detain service users. However, by whichever method a mental health nurse by nature of their role is complicit in the detention of another human being to receive treatment against their will.

Such requirements of the role of mental health nurse may appear to be at odds with the ethics of giving care, which include a displacement of ordinary self-interest into unselfish concern for another person (Slote, 2007: 12). Care is not only a concern for the welfare of the individual but also consideration of a good

relationship with them (Slote, 2007: 12). This ethic is compromised by certain elements of mental health nursing, such as in terms of legal duties.

One way in which I rationalise this tension is to assert that the minimizing of harm to the individual or to others is also an exercise of 'care' (Sadoff, 2011). The notion of care is open to interpretation. It is an often used term but can mean many things. For example it may be considered within a family or social or institutionalised context. It may mean affection, duty, reciprocity and well-being. In some circumstances care can be considered a commodity that is delivered as part of a service, such as in large organisations like the National Health Service or in private healthcare companies (Phillips, 2007). The definition of care that most resonates with my own values is that of Brechin (1998: 1) who asserts that care is “to accept a host of moral responsibilities for your own and others' well-being...to accept that people matter.”

As a mental health practitioner I embody the tension between beneficence and maleficence that is for ever present within the role of mental health nurse. For example in my mental health nursing career I have been occasioned to force service users to be subjected to humiliating treatment against their will, such as the administration of an injection to their naked buttocks while they are under restraint and after forcibly moving their underwear in order to gain clear access to the injection site. Similarly many people reasonably feel extremely angry and disorientated to be detained against their will when they believe this is without cause (Campbell, 2006; Roberts *et. al.*, 2008; Copeland and Mead, 2008). During the course of my career as a registered mental health nurse I have observed such anger and distress many times, especially in acute settings. Yet this coerciveness is what the Mental Health Act 1983 (2007) compels registered mental health nurses to be part of as a condition of registration. It can be seen then that the role of the mental health nurse is one of continuous ethical struggle. It is also evident that the custodial significance of a mental health nurse's role is still relevant today.

The National Health Service

During my study I was employed as a mental health nurse by the National Health Service. The National Health Service [NHS] is the biggest employer in Europe, employing more than 1.3 million people (NHS Jobs, 2012).

The NHS arose in 1948 out of an ideal held by the UK socialist Labour party of the time that health care should be available to everybody regardless of wealth. For the first time some previously diverse services as hospitals, pharmacies, opticians and dentists were brought together under one umbrella organisation; and these services all became free for people to use them when they needed to (NHS, 2011). The NHS was to be funded through national taxation, which implied that people would only pay for the service according to their means (NHS, 2011).

Unarguably the NHS has met with many challenges over time (Pollock, 2005; Klein, 2006, 2010); not least of these is continuing to fund the service as the pressures upon it have increased (Pollock, 2005). Such pressures include

- financial pressures (Smith, 2012)
- poor staffing (Rathfelder, 2013)
- ever-expanding services (Ham, 2006)
- an increasing elderly population (Baggot, 2012)
- increased public health expectations (White, 2010).

This is notwithstanding general pressures on the national economy (such as on local government and defence). Inevitably the NHS is something of a political football (Klein, 2006). It has moral significance in the national psyche, because it is held to be fair by the British public in that it offers free health care at the point of need (Bruner, 2013: 146). In other words, public health care is seen as a form of distributive justice (Carrick, 2007).

The first major assault on such pressures on the NHS took place during the Conservative government 1979-1993 under Prime Minister Margaret Thatcher. The Thatcher government sought to excise waste from existing NHS processes,

in the first instance by replacing the system of consensus management that had existed with a system of general management in which responsibility for services lay with individual managers. In 1988 the Thatcher government announced a review of the NHS, and two white papers, *Working for Patients* and *Caring for People* were published, which sought to establish the so-called 'internal market.' This concept was further refined two years later with the introduction in England of the National Health Service and Community Care Act (Klein, 2006).

Under this Act, Health Authorities no longer ran hospitals but instead "purchased" care from their own hospitals or from other hospitals belonging to other health authorities. Some General Practitioners were designated as fund holders and 'purchased' care for their patients. The ‘providers’ of purchased services were called NHS Trusts. This strategy was designed to encourage competition, thereby streamlining resources and minimizing waste. If a particular resource or service was not competitively priced, then there would be no need for it in the internal market place (Pollock, 2005).

Whilst in opposition to the Thatcher government, the Labour Party condemned these changes, accusing the government of seeking to privatise the NHS, and pledged to remove the 'internal market' and to abolish fund-holding. After New Labour won the General Election in 1997 the promised policy of overturning the internal market was initially pursued; however following re-election in 2001 Prime Minister Tony Blair changed the Labour Party’s direction and embraced the principles of the internal market as a means to 'modernise' the NHS.

Somewhat predictably the term ‘modernisation’ came to be a euphemism for more rigorous and leaner management, such as in the form of providing targets for services to meet, rigorous financial budgeting, the commissioning of services (remarkably similar to the principles of the internal market), revised job specifications, the closure of facilities that were deemed superfluous, and a rigid emphasis on clinical and corporate governance (Pollock, 2005). Whilst the NHS

remained free at the point of need, the Government encouraged medical services, and support for those services, to be outsourced to the private sector. Some of these strategies, such as the Private Finance Initiative[8], have been immensely controversial (Pollock, 2005; Greener, 2008), and have led to further claims that the UK Government seeks to privatise the NHS in an underhand and surreptitious manner. Another such strategy was the upscaling of NHS Trusts into NHS 'Foundation' Trusts. These were intended to operate more like a private company and were therefore, at least in theory, less of a drain on the public purse (Pollock, 2005; Greener, 2008).

This brief overview of contemporary NHS history is relevant to my study, not only because this is the context in which much nursing takes place in the UK (Fatchett, 1998); but also because part way through my study the NHS Mental Health Trust for which I worked was subsumed by a larger and much more successful NHS Foundation Trust, apparently at the behest of the Strategic Health Authority.[9] My subsequent practice as a mental health nurse took place within the context of my employment by the new Trust. Whilst the NHS Trust for which I originally worked was patently failing, the effectiveness of the NHS Foundation Trust which subsumed it seemed to rest on the basis of meeting service targets, operating an intimidatory management style, and enforcing financial stringency. This is not to say that such organizational deportment is amiss (as it was extremely successful in the economic sense); but such a business philosophy in health care presents many challenges to both clinicians and managers of what is ethical for health care and what is good for the business (Lachman, 2009).

This shows the political and economic context in which all staff employed by the NHS work, and suggests that the constraints placed upon NHS staff (which include nurses) in fact vary over time and according to political conditions. The

[8] The private finance initiative (PFI) is a way of public building projects (such as hospitals and schools) being funded by private capital. Briefly put, after the building is completed the public body agrees to lease it back for a fixed period of time, usually thirty years (Pollock, 2005)
[9] A regional body responsible for enacting national health policy at a regional level.

reality is that these constraints can vary within a comparatively short time, as can be witnessed from the frequent peppering of the NHS by political rhetoric (Klein, 2010).

Mental health Recovery

I began my journey wanting to achieve mental health Recovery[10] in my practice as a mental health nurse. This was my desire as a practitioner.

Recovery was desirable to me because:

• it is central to the Clinical Governance[11] of health care in the UK (Department of Health, 2001a, 2004b, 2009, 2011; Roberts and Wolfson, 2004, 2006)

• it is central to the practice of registered mental health nurses (Chief Nursing Officer, 2006).

• it is *ethical.* The roots of Recovery are firmly located in those principles of individual rights and social welfare that derived from the Enlightenment (Charland, 2007). These were related to specific beliefs of the time including benevolence (Charland, 2007) and religious function (Davidson *et. al.*, 2010). Recovery remains ethical today because it is a mental health service user movement (Turner, 1991), and shares aspirations of freedom, choice, autonomy and empowerment (Davidson *et. al.*, 2010) consistent with current western beliefs on ethics (Arrington, 1998).

According to the Care Services Improvement Partnership *et.al*. (2007), and as reiterated by the mental health advocacy group Rethink (Slade, 2009a), mental health Recovery is a way of somebody managing his or her life following a period of mental ill-health. Recovery is:

• a process which is active, ongoing and centred upon the person

• requires an individual to negotiate the way that a mental illness may affect a person personally and socially

• to regain a feeling of control in one's life

[10] Throughout the text I will use mental health Recovery with a capital 'R', to distinguish it from both the noun and from other forms of recovery, such as recovery from addiction.

[11] An umbrella term that seeks to integrate all the activities that affect care into one coherent and coordinated strategy (Royal College of Nursing, 2003).

• finding personal meaning through one's own experiences and through the shared experiences of others
• the creation of social networks of support with valued people and through valued activities (Slade, 2009a).

As a registered mental health nurse it is my obligation to facilitate through my practice the Recovery of people who use mental health services (Chief Nursing Officer, 2006). However it is not possible to focus upon any one definition of Recovery and say that one thing is Recovery (National Institute for Mental Health in England, 2005; Bonney and Stickley, 2008; Slade, 2009a; Stickley and Wright, 2011a, 2011b). Rather, any definition of Recovery contains elements of lots of different components. For example, Recovery includes the cultivation of hope, and the access and utilization of support from others (such as friends and family), and requires close work between service users and their carers, workers and professionals (Lieberman, 2008). Support such as this enables somebody who experiences mental illness to live in a way that is meaningful and fulfilling to them (Lieberman, 2008).

In this way Recovery is intended to challenge traditional approaches to mental health services which assert that somebody experiencing mental health difficulties will never recover from them (Roberts and Wolfson, 2004; Slade, 2009a) and will never live a 'normal' life (Deegan, 1996). Mental health Recovery is a change in thinking that radically departs from previous advances in the treatment of psychiatric care which tend to be seen in terms of improved medication and better service delivery (Roberts and Wolfson, 2004). Some academics assert that Recovery necessarily implies (or requires) a paradigm shift for it to fully alter existing mental health service provision (Stickley and Wright, 2011a). However others argue that such an assertion is perhaps optimistic by pointing out that the process of Recovery merely reclaims practices of mental health care that were first initiated in some post-Enlightenment practices of the Eighteenth Century (Roberts and Wolfson, 2006).

Most importantly Recovery does not mean 'cure' or returning to a previous state (which, as Ralph and Muskie (2000) observed, may in fact be the very state that precipitated illness). Until a person experiencing mental health difficulties is able to accept that they are responsible for their own recovery, and they can decide what it will be (and what form it will take), they will not feel motivated to be involved in it (Rethink, 2005). This is because Recovery requires commitment from service users (Hauser *et. al.*, 2006) and the mental health workers who are to support them (Watkins, 2007). It is an accepted practice in Recovery for people experiencing mental health difficulties to use a self-management plan called a Wellness Recovery Action Plan (Copeland and Allott, 2010).

In fact there are a plethora of definitions of mental health Recovery (Amering and Schmolke, 2009). The Recovery writer Piers Allott (Mind, 2008) reported his disappointment that Recovery is treated much like a newly-discovered land that is contested by a number of different interests; and that this discordance is antithetical to the notion that Recovery is a partnership between all relevant parties. (To be sure, Recovery is not 'owned' by anybody.) Repper (2006) argued that mental health practitioners must resist making definitions of Recovery, for such definitions are unlikely to echo the subjective experiences of service users, because many practitioners will not have had the same or similar – defining – experiences. I find this to be a presumptuous claim however, for in my own experience of working alongside other mental health practitioners many have (or do) – as do I - experience difficulties from time to time with their own mental health. However a culture persists in mental health care that practitioners do not admit to such experiences (Joyce *et. al.*, 2009). It is as though such self-disclosure may suddenly render the practitioner without the authority to magically 'heal' others. Sometimes I also wonder whether users of mental health services might themselves require a practitioner to be mentally and emotionally 'stronger' than them somehow; certainly research indicates that this may be the case (Gaillard *et. al.*, 2009). Of course it may be the case that users of mental health services ‘expect’ such psychological strength from

practitioners because this is required of the traditional medical model of treatment, and is the assumed means of professional behaviour (Clarke, 2008).

Towards a definition of Recovery

I believe that the most apposite descriptions of Recovery are those put forward by the very people who experience mental health difficulties. William Anthony's definition of Recovery (Anthony, 1993) - that it describes the personal growth derived from the experience of mental illness, and engenders new meaning and purpose in a person's life - has been widely accepted as the exemplar of Recovery (Amering and Schmolke, 2009: 9). However some service user definitions of Recovery are open to the charge of subjective and idiosyncratic bias (Mind, 2008) because by definition Recovery is a person's own lived experience. This principle of Recovery being defined (or known) by 'lived experience' alone has long been a vital axiom of Recovery, since first asserted by the Recovery writer Patricia Deegan (Deegan, 1988), to the extent that it is now accepted in the Recovery literature (Mind, 2008; Bonney and Stickley, 2008; Rethink, 2010a, 2010b; Stickley and Wright, 2011a, 2011b). This immediately creates a tension between subjective (or qualitative) definitions of Recovery and statutory services that demand measurable (that is, objective) outcomes (Stickley and Wright, 2011a, 2011b).

Recovery can be regarded in two fundamental ways. The first way is to emphasise a person's clinical and social recovery, as measured through outcome studies. The second way is to consider the personal and existential facets of recovery by resort to subjective and self-evaluated accounts of how somebody learns to live with their illness (Roberts and Wolfson, 2006; Stickley and Wright, 2011a, 2011b). The former can be considered as objective; and the latter as subjective. My personal definition of Recovery is that it is being able to live a satisfying, meaningful life, one in which the person contributes positively to and in society, and within their own social milieu, within the limitations that may arise from the infrequent experience of the symptoms of mental illness. I use the term 'infrequent' because use of that term implies that mental health

difficulties are held to be exceptional rather the norm in a person's experience. This is a notion which is in keeping with Recovery thinking.

There are a number of research studies done on Recovery which are held up as significant evidence in favour of Recovery (Fisher, 2006). However there is a marked absence of empirical studies which more formally provide evidence for Recovery (Stickley and Wright, 2011a). The most favoured of those that have been undertaken is that performed by Harding *et. al.* (1987), which was a longitudinal study. In this study the researchers defined Recovery as

• having no current signs or symptoms of mental illness
• not being in receipt of current psychiatric medication; and
• being able to function appropriately both socially and in terms of one's vocation.

The researchers reported that even after more than thirty years following a first episode of schizophrenia, more than sixty per cent of a cohort of severely and long-term mentally ill service users reported a significant improvement from (i.e., recovery from) mental illness. Another longitudinal (and international) study conducted by Harrison *et. al.* (2001) reported with similar results. In some cases the Harding study alone is taken as sufficient evidence for the efficacy of recovery (Turner-Crowson and Wallcraft, 2002). However the Harding study is open to challenge on the basis of selection bias, in that only a certain group of people experiencing mental ill-health were considered for the study, and also because it cannot readily be applied to other clinical environments (e.g. acute care) (Roberts and Wolfson, 2004). In fact the evidence hitherto on Recovery must be regarded with caution, as different studies use different definitions of Recovery in different ways, and measure different aspects of mental health using different methods (Friedli *et. al.*, 2007). One reason for this is because in Recovery quality of life, which can only ever be judged by the person who is living that life, is significant. To my mind this is like saying that the moment one defines Recovery one loses sight of what it is. In this sense Recovery is an ineffable quality.

The most compelling evidence for Recovery however lies in the narrative accounts of the very people who experience mental ill-health, rather than in the assessment of changes in the severity (or debilitatedness) of the symptoms of mental illness over time (Shepherd et. al, 2008). Such an assertion confounds the contention of traditional medical services that mental illness is an objective phenomenon that can be diagnosed according to a set of objective criteria.[12] Immediately then we can see that Recovery in its subjective and existential form does not sit easily with a system of psychiatric diagnosis and public mental health care in which budgets and resources must be planned well in advance, and which depend upon the measurement of outcomes in order to secure this.

Recent reviews have usefully been made of the British literature on mental health Recovery by Stickley and Wright (2011a, 2011b), who assert that something like sixty per cent of the literature about Recovery has been written since 2006; and by Bonney and Stickley (2008). Such reviews are relevant to this study because my research for this thesis took place in the UK while I was employed by an NHS Trust. Other studies of mental health Recovery (Turner-Crowson and Wallcraft, 2002; Allott and Loganathan, 2002) have also centred specifically on the British experience, although now some time ago. A joint position paper by the Care Services Improvement Partnership together with the Royal College of Psychiatrist and the Social Care Institute for Excellence in 2007 (Care Services Improvement Partnership/Royal College of psychiatrists/Social Care Institute for Excellence, 2007) devised a strategy for Recovery in the UK. A more global (though American-centric) review of Recovery literature was undertaken by Ralph and Muskie (2000) and Onken *et. al.* (2007).

Stickley and Wright's (2011a, 2011b) literature reviews examine both peer-

[12] The objective measuring criteria used in contemporary psychiatric care are provided by the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders 5th Revision) in the USA, and ICD-10 (International Statistical Classification of Diseases and Related Health Problems 10th Revision) in the rest of the world.

reviewed and non peer-reviewed ('grey') literature between 2006 and 2009 inclusive. They suggest that the explosion of Recovery literature in recent years is most likely due the increased presence of Recovery in UK public mental health policy. On the other hand, Bonney and Stickley's (2008) review of the UK literature on Recovery is not focussed upon a fixed time period – and is as a result a broader and more theoretical study; however only peer-reviewed texts were considered. It is evident from the Stickley and Wright (2011b) study that much understanding of Recovery can be gained from studying the non peer-reviewed literature, because much of the most authentic evidence for Recovery derives from the narrative experiences of service users. Such person-centred and humanistic accounts are arguably more authentic than outcome focussed measurements such as returning to work, because work is not the only form of meaningful activity – much as it may suit politicians desperate to cut the spiralling costs of welfare (Mind, 2008). Using such a measurement is by its nature unreliable, because there are as many outcomes to measure as there are forms of meaningful activity.

Whilst asserting that the UK literature on mental health Recovery contains no one fixed definition of the concept, Bonney and Stickley (2008) believe that it is possible to identify six general themes from the literature. This framework is generally agreed in principle by Stickley and Wright (2011a, 2011b). There are other ways of regarding Recovery (National Institute for Mental Health in England, 2005; Onken *et. al.* 2007); however I propose using the Bonney and Stickley (2008) framework, because at the time of writing it is the most contemporary framework of definition and applies specifically to the UK.

1. *Identity*

Recovery can be considered as being the reconstruction of a person's self-concept, which may have been damaged by a period of mental ill-health (Young and Ensing, 1999). However this is not a straightforward assertion for, according to social labelling theory (Double, 2006), mental illness can also be regarded as a learned behaviour. It arguably offers certain social advantages

such as providing an ‘illness identity’ that gives a person a common ground on which to relate to others, and an affinity with fellow sufferers that grants membership of a social group (De Silva *et. al.*, 2005). An illness identity provides sufferers with a sense of transcendence and heroism, having overcome their suffering in order to function in society, and providing unique knowledge of a phenomenon that non-sufferers will not understand (Roberts and Brown, 2006). According to this argument, Psychiatry participates in the reification of what is already a social construction (Walker, 2006).

Recovery is arguably an ‘illness script’, because it offers a valorised social role (that of the recovered individual and ‘expert’) which is authenticated and verified by the hegemonic structures of mental health care which have co-opted (or appropriated) the unique experiences of service users in order to plan mental health services. Even when an illness is seen as being only part of a person’s identity (as Recovery argues in the case of mental illness) rather than being its defining characteristic (as is the traditional view), *knowledge* of such experience can be viewed as a means of power and influence, providing new opportunities to the individual - making Recovery a ‘career’ as much as any mental health service user has ever derived one as a means for reconstructing the self (Goffman, 1959, 1991). Arguably whilst the contemporary mental health service user no longer seeks to reconstruct themselves as a psychiatric patient, the place of Recovery within the legitimating framework of Clinical Governance may compel self-reconstruction as a user of mental health services, as an 'expert', a 'consumer' and, in fact, as ‘being in recovery'. To accept the language that is offered to describe oneself is to legitimate that language (Wallcraft, 2005).

Similarly those who experience long-term illnesses tend to compare themselves with other people, and may become teachers or advocates for people suffering similar illnesses to themselves (Roberts and Brown, 2006). It is interesting that in Recovery some sufferers are held up as living examples of Recovery in practice. In particular I think of the noticeable trend lauded by such observers as Davidson (2005) and Roan (2011) towards the redefinition of service users as

Recovery experts. This notion of expertise slots neatly into more general Clinical Governance ideology on the role of the patient being expert in the lived experience of their own illness (Department of Health, 2001b). The patient-as-expert movement has been criticised on the basis that it seeks to minimise resources by withdrawing formal care (Wilson *et. al.*, 2007) - although in fact educated patients are more likely to access formal resources (Lindsay and Vrijhoef, 2009) - and further legitimates the existing biological-medical paradigm by implicitly assuming the reality of it (Wilson *et. al.*, 2007). Similarly the patient-as-expert programme assumes a 'one-size fits all approach' to health care, thereby not taking into account the individual narratives of patients and service users (Lindsay and Vrijhoef, 2009). On the other hand such expertness may empower patients as consumers who can influence policy (Wilson *et. al.*, 2007).

2. Service provision agenda

In the UK, Department of Health policy has become orientated towards outcomes and measurement, concomitant with the drive towards notions of efficiency and value-for-money (Pollock, 2005). Mental health Recovery can lend itself to such outcome measurement. For example, the National Institute for Mental Health in England (which is now defunct following several mergers with other arm's-length government bodies), following the government's *Journey to Recovery* document (Department of Health, 2001a) was set up and tasked with the initial implementation of Recovery into Clinical Governance. To this end it presented Recovery as a process whereby a set of criteria can be followed that identifies a service user's recovery (NIMHE, 2004) – for instance, the process of service users entering mental health services in a dependent state (dependent upon statutory mental health services, for example) through semi-independence and then to independence. This accepted as given statutory processes of mental health care such as the admission/discharge phase, and was an early indication of Recovery being made to fit with existing services. Similarly the Recovery Star (Mental Health Providers Forum and Triangle Consulting, 2008) (Figure 5.2 in Chapter 5) contains the 'Ladder of change' whereby different outcomes that measure Recovery can be plotted on a continuum. This model

also assumes as given the context within which such change takes place.

In health care services that are increasingly forced to justify their existence through the use of outcomes (Pollock, 2005) such outcome measurements must necessarily be established for Recovery - as much as for any other form of health care provision - in order to justify its continued relevance to mental health services.

3. The social domain

Recovery can also be considered as a way for somebody who has experienced a period of mental ill-health to regain their self-esteem and satisfaction with life by becoming a valued member of society. Such social value can be measured; for example, by somebody becoming available for paid employment following a period of mental ill-health (British Psychological Society, 2009). However other forms of meaningful activity, such as involvement in organised sports, are *not* so easily measurable (Stickley and Wright, 2011a). For example, Recovery might only be indicated by a person's readiness to access mainstream resources and services (such as sports centres, libraries and evening classes) instead of specialised mental health services.[13] This *readiness* cannot easily be measured, although the act of taking out a local gym membership (for example) can.

In this context, mental health Recovery is also recovery from the negative and disabling social expectations that accompany a person experiencing mental health difficulties (Office of the Deputy Prime Minister, 2004; Amering and Schmolke, 2009; Watson and Eack, 2011). Recovery aims to tackle issues of stigma and social exclusion that frequently beset people experiencing mental health difficulties, and which are seen as social attitudes that compromise Recovery (Gournay, 2009). It is argued that this is achieved by encouraging mental health service users to access the same resources as the remainder of

[13] Arguably Recovery implies a concomitant decline in the need for specialised mental health services, so that statutory providers of mental health services may close or withdraw specialised services – ironically in the guise of promoting Recovery (MIND, 2008)

the community (Slade, 2009a). I recall one service user who attended a part-time Art class because the class offered by local mental health services had been closed. The service user reported that she struggled to maintain the pace of the mainstream class and ultimately became mentally unwell through the stress of trying to do so. Similarly, Baker *et. al.* (2006) have shown that in the case of further and higher education, this inclusiveness can sometimes reinforce stigma rather than minimize or remove it, due to the way in which some further and higher education institutions immediately assume their students have particular abilities and skill sets rather than taking individual needs into account.

There are considerable economic and social benefits to people who experience mental health difficulties returning to work (Royal College of Psychiatrists *et. al.*, 2009). Indeed a return to paid employment is an avowed aim of Recovery (Boardman and Robinson, 2006). However the benefits to national government of people being in paid employment are readily apparent (such as them being economically active, paying income tax, and coming off state benefits).

4. Power and control

The Department of Health (2003) asserted that all users of contemporary mental health services should be at the centre of those services, which should be shaped around individual needs rather than being made to fit into an existing system of care. Bejerot and Hasselbladh (2007), in their analysis of the development of health services in Sweden,[14] suggest that such a tactic is a double-blind by state providers which assert on the one hand that such a philosophy corresponds to ersatz notions of 'citizenship' by positing the individual as of central significance, whilst on the other hand setting the very agenda that places expectations upon that individual as to what 'citizenship' entails. Some Recovery writers argue that the assertion that services should be shaped around the individual is rhetorical, because Recovery should always

[14] Included because Sweden is also an advanced industrialised economy of Northern Europe, as is the UK

necessarily be within the power of individuals to desire and to achieve, and should not be prescribed by apparently expert mental health professionals (Shepherd *et. al.*, 2008). Ostensibly this possibility is precluded by the notion that the service user is the expert on their own care (Shepherd *et. al.*, 2008). However this notion is itself rhetorical, because mental health professionals nevertheless continue to assert power and influence because they (i) channel what the service user desires and (ii) exclusively know what resources are or are not available and how to obtain them.

Indeed it is a double-blind for service users to be involved - often obliquely - in the very reform of the services they use. Mental health Recovery fits neatly into Department of Health strategy to 'modernise' health care services (Department of Health, 1998), when the modernisation agenda of public health care is merely a euphemism for cutting the costs to the public purse (Pollock, 2005). The discourse of Recovery achieves such accentuations and identities (Clinton and Nelson, 1999) by neatly slotting into contemporary health care policy.

5. Hope and optimism

Hope is key to mental health Recovery, and should be at its centre (Gluck, 2008; Amering and Schmolke, 2009; Perkins and Repper, 2009; Slade, 2009b). In Recovery, hope is the belief that change is possible (Southwick *et. al.*, 2011: 278). Traditionally clinical language is negative and condemnatory (Amering and Schmolke, 2009; Davidson *et. al.*, 2010). Therefore by modifying the language – in particular by infusing it with hope - mental health workers can sustain a service user's belief that they can lead a satisfying and a meaningful life despite their illness (Deegan,1988; Anthony, 1993; Southwick *et. al.*, 2011). Mental health workers who continue to use the language of traditional psychiatry, which is disempowering and disabling, stifle Recovery (Shepherd *et. al.*, 2008). Mental health workers in Recovery services have variously been described as Recovery guides (Davidson *et. al.*, 2006) and coaches (Slade, 2009a); and in this way they have an especially important role in inspiring hope and optimism in the way in which they support Recovery. For example, mental

health professionals are required to have an optimistic approach towards users of mental health services (Shepherd *et. al.*, 2008; Amering and Schmolke, 2009; Davidson *et. al.*, 2009). Whilst this is clearly articulated in the Recovery literature, it is also embedded firmly in clinical governance for mental health nursing practice (Chief Nursing Officer, 2006; Department of Health, 2009, 2011).

6. Risk and responsibility

Positive risk-taking is essential to Recovery (Care Services Improvement Partnership *et. al.*, 2007; Felton and Stacey, 2008), as it is through risk-taking that a person (i) learns self-responsibility (ii) is provided with the ability to test and grow and (iii) regains self-esteem and confidence in the gaining of social valorization. In some circumstances staff should be precluded in offering interventions unless absolutely necessary (Bonney and Stickley, 2008), so permitting service users the opportunity to learn independence. This must be balanced against the assertion by the Department of Health (Department of Health, 1999) that risk should be reduced and crisis should be prevented or anticipated, as this adversely affects outcomes. It is arguably an important learning curve for people who experience mental health difficulties to be permitted to experience the effects of illness and the consequences of certain behaviour on mental health (such as when the taking of illicit drugs leads to an episode of psychosis (Freudenreich, 2008), for example).

A brief archaeology of mental health Recovery

By the term ‘archaeology’ the French philosopher Michel Foucault meant a way of describing the recovery of hidden or forgotten relationships between various social features over time (Calhoon, 1994: 211). Recovery is not only a social discourse (Clinton and Nelson, 1999) but its efficacy is heavily influenced by social factors (Tew *et. al.*, 2011). Recovery reflects a tension between the optimism of choice and consumerism, and the relativism of an increasing preoccupation in health care services with minimizing risk (Pilgrim, 2009). An archaeology of Recovery in the UK can explicate these tensions.

Recovery as Moral Treatment

In the UK Recovery can be traced back to the moral treatment movement in Eighteenth Century England (Roberts and Wolfson, 2004). At the so-called York Retreat patients were encouraged to exercise self-control as an alternative to physical restraints or moral discipline (Davidson *et. al.*, 2010: 46), and to work and remain otherwise physically active. The York Retreat was founded in 1792 by William Tuke, a merchant of tea and coffee, following the death of a patient in a nearby mental asylum in circumstances that suggested neglect and ill-treatment. The Retreat was originally intended primarily for Quakers (the patient who died was a Quaker, as was Tuke); though there was a charge to attend it (including a further charge for servants), which implies that it was a not entirely philanthropic venture (Warner, 2004; Charland 2007). Tuke aimed to set up a family-like, spiritual environment for members of the Retreat, and his project showed that psychological forms of treatment in a peaceful pleasant environment were more successful than physical restraint (Roberts and Woolfson, 2004). Unfortunately the cost immediately excluded the vast majority of the population.

The moral treatment movement arose at more or less the same time across the remainder of Europe and included the work of Philippe Pinel and Jean-Baptiste Pussin in France (Davidson *et. al.*, 2010). This can be attributed to the enormous political and industrial upheavals prompted by Enlightenment ideas of the time. These were ideas of personal liberation and egalitarianism which on the one hand expressed themselves most ruthlessly in the form of the French Revolution, and on the other hand as the economic liberations that accompanied the Industrial Revolution (Warner, 2004). Prior to the Middle Ages much of the care for the mentally unwell was offered by monasteries (Nolan, 2008). However the opening of Bethlem Royal Hospital, the first mental ill-health asylum, in London in 1403 marked a social regression to social exclusion and intolerance of people who were mentally unwell; and those considered harmless were cast onto the streets where they sought alms (Shrives, 2008). The

Established Church considered the mentally unwell to be possessed by evil spirits or demons, or worse still to be practitioners of witchcraft – hence the fear and stigma that they engendered. Furthermore the dissolution of the monasteries during the reign of King Henry VIII had removed an important and historical form of asylum for those who were mentally unwell (Nolan, 2008).

The Tukes' project was important in that it encouraged people to want to participate in society as they are; rather than expecting them to participate in an isolated manner in 'talking cures' whereby theoretically successive layers of personality were peeled away to reveal the 'real person' (Porter, 1990).

However the moral treatment movement ultimately failed because the economic hardships arising from the Industrial Revolution meant that families were unable to afford facilities such as the York Retreat (many mentally unwell people were unable to work, for example), and forced a return to (and expansion of) asylum care in order to warehouse mentally unwell people. There followed successive statutory legislation forcing local authorities to build centralized asylums for the mentally ill (for example the Lunacy Act of 1845). This was symptomatic of the incarceration and institutionalization of the mentally unwell, a result of contemporary funding arrangements whereby the poor in the parish were placed into asylums because these were funded by county councils, who could afford them, rather than by parishes, that could not. What prompted the Lunacy Act in 1845 was that by the middle of the Eighteenth Century public opinion about mental illness had changed from a belief in its cause (namely possession by spirits) to the assertion that it had a secular origin with economic consequences. Removing the mentally unwell from the community freed their families from the burden of caring for them so that the families were now at liberty to work (Nolan, 2008: 33).

Subsequently in 1879 a voluntary organization, the Mental After-Care Association [MACA], was founded after the publication of two pamphlets written by the Chaplain of an asylum in Greater London, in which it was suggested that

an asylum patient could achieve “permanent recovery” if they met with favourable circumstances upon discharge (Jones, 1972: 238). MACA offered short-stay residential accommodation for psychiatric patients living in the Greater London Area who had been discharged from asylum care; however this was an isolated (and heavily-localized) development, as it took place amidst a second wave of asylum-building (Jones, 1972).

It was not until 1909 and the publication of a report by the Poor Law Commission, that the general principle was accepted that prevention of ill-health is less expensive and more effective than cure. The report also suggested for the first time that the oppressive Poor Law needed to be replaced by specialised social services dealing with different categories of people with different social needs. This was followed in 1926 by The Report of the Royal Commission on lunacy and mental disorder. Its most significant recommendation that can be linked to the historical development of Recovery was that local authorities were encouraged to establish and fund out-patient clinics; although after care was to remain unofficially with voluntary organisations.

Although the diagnosis and treatment of mental illness was to be exclusively medicalized, the Commission established the social significance of after care and rehabilitation (Jones, 1972). This was significant in that it was an acknowledgement for the first time of the role that social factors had to play in a person’s experience of mental unwellness. However it also indicated that the Government wished to maintain a distance from social aspects of mental health care. In 1939 The Feversham Committee on voluntary mental health associations recommended that the three major mental health organisations of the time - the Central Association for Mental Welfare, the Child Guidance Council and the National Council for Mental Hygiene – amalgamate, which they did at the end of the Second World War (though they had already all worked together during the War), as the Council for Mental Health. The Council was tasked by the Government to provide a nationwide after care service for people discharged from military service after the War on psychiatric grounds.

These developments show that much of the impetus for the development of Recovery-like practices in the UK has been based upon social philanthropy and voluntarism, and has arisen mainly from Enlightenment ideas. It is therefore apparent that principles of Recovery are closely related to historical and political and economic conditions; and that this has been the case throughout the development of the Recovery movement. The philanthropic spirit of Recovery has wrestled throughout its history with the misanthropic expedience imposed by prevailing economic and political conditions.

Recovery as a service-user led movement

Repper and Perkins (2003) identify two forms of service user-led campaign groups:

• A radical anti-psychiatry movement concerned with rejecting existing psychiatric services and asserting the right for service users to establish their own services outside the mainstream; and

• A reformist movement aiming to reform existing mental health services and for service users to have more control within them.

Recovery, as a service user movement that takes place within a contemporary culture of ideological consumerism, can be defined as being the second of these two forms, in that it accepts a) the principle of mental illness and b) that self-management of one's illness together with appropriate support offered by statutory services is the way to a meaningful and satisfying life. In other words, Recovery as it has been incorporated into existing mental health services functions both within the mainstream and is dependent upon it. The high profile that Recovery has within existing mental health services is because of its usefulness to the hegemony, for example in the way in which it slots neatly into existing hegemonic discourses such as consumerism, expertness, and citizenship. Roberts and Wolfson (2004: 37) remarked upon the “clever” use of Recovery in Clinical Governance.

It is generally believed that there has been no strong mental health self-help or user movement in the UK (Turner, 1991), or at the very least it has been patchy (Wallcraft and Bryant, 2003); and there is a common misconception that the service user movement originated with the notion of personal empowerment and equality that fired the inception of the National Health Service in 1948 (Campbell, 1996). It has also been argued that the mental health service user/consumer movement has only really been extant since the 1980s (Figert, 2010).

In fact there is a strong tradition of service users challenging their care for much longer than this (Repper and Perkins, 2003). For example, in 1620 the 'Petition of the Poor Distracted People in the House of Bedlam' was presented to asylum authorities, and in 1845 a group of ex-patients founded the Alleged Lunatics Friend Society (Barnes and Bowl, 2001).

However the main movement questioning the psychiatric care given to service users was the anti-psychiatry movement of the 1960s and 1970s and widely associated with the psychiatrist R. D. Laing. Laing saw psychiatric difficulties in a social context as opposed to them being the result of individual failing (such as faulty or incomplete personal development), which was the accepted view of the time (Caminero-Santangelo, 1998). Laing asserted that psychiatric difficulties arise as a direct result of a person's attempt to make sense of an "industrial-military complex" which engendered "socially shared hallucinations and called them reality, and a collusive madness that passed for sanity" (Laing, 1990: 57). He argued that madness is a strategy developed by some people to survive in a situation in which it is impossible to live (Laing, 1990). In other words, for Laing, psychiatric difficulties were related to economic conditions; more particularly to the ideological forms that arose from those conditions. However this is to miss the point that the anti-psychiatry movement itself arose out of the bold challenge to authority and to established norms and behaviour which typified the 1960s in the UK, at a time when civil action was taken by different groups in the cause of civil rights and individual freedoms (Barnes and

Bowl, 2001).

Undoubtedly anti-psychiatry set the timbre of challenge to established psychiatric authorities and no matter what one may think of the political success or otherwise of the anti-psychiatry movement, it gave service users the confidence to challenge psychiatric authority in a more informed and politically-charged way. Political changes in the 1980s (such as the economic liberalism of publicly-financed health care) led to the consolidation of service user campaign groups (Repper and Perkins, 2003), but is not solely responsible for this consolidation (Campbell, 1996). The UK National Health Service underwent many political and economic changes during the 1980s, mostly prompted by the inception of the so-called internal market in public health care whereby patients and other users of public health services came to be regarded as 'consumers'. In the context of health care, consumerism can be regarded as a social discourse that aims to promote the interests of the users of those services, often by those service users playing an active role in the structure and development of those same services (Figert, 2010). The term 'consumer' comes from private industry and embodies the principle that in order to maximise its profits a company must consider the preferences of the buyer (otherwise the buyer will not purchase the item or service) (McNeal, 2007).

An example of this effort to engage users of health services was the introduction into the NHS during the years of Thatcher government of general managers who were required to actively research patient and service user needs and also seek their views about the quality of care they received (Pollock, 2005). Another instance of this consumerist discourse entering UK health care was the introduction of the NHS Community Care Act in 1990, which sought to establish a public health service that was based on the views and desires of patients, carers and service users rather than on the decisions and preferences of professionals (Pollock, 2005).

Such principles of consumerism remained even after the election to government

in 1997 of New Labour (Gabe *et. al.*, 2005). The UK service user movement's co-option into this national consumerist discourse has contributed significantly to the consolidation of the service-user movement in mental health care services and the essential contribution of service users to the government's mental health strategy, culminating in (and springing from) the document *The Journey to Recovery – The Government's vision for mental health care* (Department of Health, 2001a).

Implications of Recovery for nursing practice

Recovery is now firmly embedded in the literature on mental health nursing (Stickley and Wright, 2011a, 2011b). To date the most significant document as far as the implications of recovery for nursing practice is concerned has been that of the Chief Nursing Officer (2006). In this document the Department of Health made Recovery central to the way in which mental health nurses are required to practice. Recovery is here regarded as a broad set of principles: a generalist understanding of Recovery that may be of more use to the practice of mental health nurses and to service planners than one that relates to the specific and day-to-day experiences of service users (Stickley and Wright, 2011b). Other literature has been written by practising mental health nurses (for example, Watkins, 2007). Many Recovery writers suggest that in order for mental health nurses to truly facilitate Recovery they must be supported to do so by the organisation that employs them (Stickley and Wright, 2011b). This includes, for example, practising in an 'atmosphere of hope and optimism', in which the conditions for hope are present (Lester and Gask, 2006: 402). Recovery is a collaborative process that involves the service user, the practitioner, and carers (Watkins, 2007; Bonney and Stickley, 2008; Lieberman, 2008; Mind, 2008; Shepherd *et. al.*, 2008; Amering and Schmolke, 2009; Stickley and Wright, 2011a, 2011b), The nursing registration authority, the Nursing and Midwifery Council, has indicated to pre-registration candidates that it regards the facilitation of Recovery as central to the practice of registered

mental health nurses (NMC, 2013).[15]

There are several realities to contemporary mental health nursing practice that mitigate against the fostering of optimism in order for Recovery to take place. Firstly, an atmosphere of hope and optimism is not always conducive to the emphasis currently extant in statutory services upon containing and minimizing risk (Stickley and Wright, 2011b). Secondly an atmosphere of despondency and low morale currently exists in the NHS and has done for some years (Royal College of Nursing, 2007; McSherry and Pearce, 2011; Wilson, 2011).[16] This implies that a dispirited and poorly-motivated workforce is being directed to foster an "atmosphere of hope and optimism" – an obvious incongruity. Thirdly, psychiatric care has historically (i) carried a message of pessimism and chronicity (e.g., that somebody will be prescribed psychotropic medication for all their life, and will never recover from mental illness (Roberts and Wolfson, 2006)) and (ii) been concerned with containment, coercion and social control (Shorter, 1997). It is arguable that it is difficult for practitioners to develop relationships with service users in order to facilitate Recovery in a health care system in which forced treatment is a viable and legal option (Lester and Gask, 2006). Certainly this is a tension that I embody daily in my everyday practice.

This implies that a considerable paradigm shift is required in order for both the practice of mental health nurses to become orientated towards Recovery and also for the statutory provision of mental health services to align with principles of Recovery (Stickley and Wright, 2011a, 2011b).

A Timeline of the study

The study began in 2006 whilst I was employed by an NHS Mental Health Trust as a Staff Nurse in Twelvetrees, a residential unit supporting mental health service users aged between 16 and 65. Some eighteen months later the Unit

[15] However to date Recovery has not been embedded as a regulatory standard to which registered mental health nurses are required to practice

[16] This is of course not helped by current swingeing government cuts in public services (Butler, 2011)

Manager was seconded to manage a community mental health team and I was asked to ‘act up' into the role of Deputy Manager of the Unit, with the previous Deputy Manager 'acting up' as Unit Manager.[17] However due to the former Deputy Manager's continued sick leave I found myself 'acting up' in turn as Unit Manager and subsequently gained a secondment into the role. When the original Unit Manager returned after her own secondment was completed, I continued to 'act up' as Deputy Manager until resigning the post soon afterwards. Also in 2008 the failing NHS Mental Trust which employed me was subsumed into a very successful NHS Foundation Trust at the direction of the Strategic Health Authority. In 2009 the Unit in which I worked was closed down by the new Trust and after some persistence I obtained a secondment into a community mental health team. At this point I arranged for a break in my studies due to the requirement placed upon me by the new Trust to undertake part-time study appropriate to my new role. However I continued to write narratives based on my practice during this time. In the summer of 2010 I decided along with my family to relocate to another part of the United Kingdom, having obtained a post employed as a staff nurse in a mental health unit owned by a private health care company. This was the point at which my data collection ended. Due to the upheaval of my geographical relocation I delayed recommencing my studies still further until resuming them in February 2011.

The local practice of Recovery

Twelvetrees came to be regarded by the Partnership Trust as a ‘Recovery flagship’ – that is, as the unit within the Trust that piloted Recovery. This was mostly due to the enthusiasm of ‘C’, the unit manager. I first encountered the concept of Recovery through her. This is my diary entry for the occasion, dated Tuesday 21st February 2004:

[17] It is important to note that such 'acting up' and secondment arrangements were clarified by the Agenda for Change agreement on pay and conditions in the NHS from 2003. Such arrangements were at the time of the data collection for this study commonplace as an apparently temporary measure.

C came back into the office after she'd been out to a meeting, holding a piece of paper. As she came in through the door she said, "I've got some exciting news!" Then she sat down at her desk in the corner of the office and turned to look at me. I was on my own in the office, working at the PC, and so I turned round to face her.

"The Tidal Model!" she said, and she handed me the piece of paper, which was actually about three pages printed off the internet and stapled together, and said, "Read that!" I had a quick scan through it and noted something about how a person's mental health status moves to and fro in and out of their lives like the tides of the sea.

As I handed the paper back to her she said, "That's what we're going to be doing here!" She sounded excited and enthused. I told her that I wanted more time to digest the concept; and that evening while I was at home I downloaded and printed several documents on the Tidal Model, with the intention of reading them.

Two days later the Unit Manager had further news for me and the remainder of the team:

Thursday 23rd February 2004 I am in the office talking with S, another staff nurse. From her desk in the corner of the office C suddenly turns in her swivel chair and interrupts us. "Have you heard of Recovery?" she asked. I said no, I hadn't. She said, "We're going to do that here." I said, "I thought you said we were going to work with the Tidal Model?" (I still haven't had time to read through the stuff about it I had printed off the internet.) "This is better," she says. "The Tidal model is like Recovery; but the Department of Health are pushing Recovery."

That night I went home to print some information about Recovery off the internet and the Department of Health website. I must find time to read it. Lucky I didn't read all the stuff about the Tidal Model, then.

In fact the Tidal model is sometimes conflated with Recovery (Stickley and Wright, 2011a, 2011b); although its proponents assert that it must be regarded as being distinct from Recovery (Clan Unity, 2011) in that whilst Recovery focuses upon the self-management of symptoms, which tends to take place only *after* a person has experienced a critical breakdown of their mental health, the Tidal Model begins *when* a person experiences that critical lowest ebb, in order to help the person to accept, acknowledge and learn from the experience in its rawness and immediacy (Clan Unity, 2011). This is why, it is argued, the Tidal Model is appropriate to acute care and Recovery better-suited to mental health rehabilitation (Clan Unity, 2011).

In keeping with the Clinical Governance of the time (Sainsbury Centre for Mental Health, 2001; Department of Health, 1999, 2001a, 2004a), the team in Twelvetrees undertook Recovery training in order that we should become

capable and competent Recovery practitioners. The training was facilitated by two service users:

Thursday 13th February 2005 Recovery training for all the team. It's facilitated by a man and a woman, who both said they are occasional users of mental health services. Mark has a diagnosis of depression and Sarah says she suffers Bipolar Disorder. I wonder whether this is what qualifies you to train other people in Recovery. In the afternoon tea break I had a really interesting conversation with Sarah when she told me that she is getting fed up with keeping hearing the word 'Recovery', because the government use it a lot and that she thinks that soon service users will use the word 'Resilience' instead. She said that service users want to be able to 'own' concepts like Recovery. As she was telling me this I had an image of service users being chased by a huge monster that is trying to eat up their ideas. I detect a resistance amongst service users to a colonization of Recovery by government.

Sarah's comment intrigued me because as a service user it showed her suspicion that (i) the government had already begun to appropriate and subsequently colonize the term 'Recovery' and (ii) the word 'Recovery' would lose significance for service users so that service users would need to select another term that was unpolluted by the hegemony. In fact this pollution is exactly what the mental health advocacy group Mind reported several years later had indeed taken place (Mind, 2008).

Ostensibly then, the unit was attempting to realise Recovery under C's leadership. However the day-to-day practicalities made this ambition less than realisable. C organised a first Trust-wide Recovery Conference with the intention of raising awareness of Recovery throughout the Trust, and it was attended by several high-profile speakers on Recovery from the UK. This is my diary entry from the first day of the two-day conference:

Thursday 20th April 2006 The first Recovery Conference organised by the Trust. Well, organised by C really; although the Chief Executive was there. He made a speech at the start before he had to go somewhere but I couldn't hear most of it because of the noise at the back of the room of people still coming in late. There were several different speakers on Recovery, but by the end of the day they couldn't really get their message across because everybody was running out of time. In one place it felt a bit strange when one of the speakers got people to put up their hands if they'd had a mental health problem, followed by much whooping and cheering; the speaker said we should celebrate having had a mental health problem, be proud of it. I was diagnosed with clinical depression at the age of 18 but I don't think I want to announce it to the world. Perhaps that's part of my problem. Maybe in Recovery I *should* be proud of it. But admitting you had a mental problem is like wearing a badge of honour that differentiates you from other people who won't admit to it (or who haven't actually experienced mental health difficulties). It was like dividing people against each other: those who've had a mental health problem and those who haven't, when Recovery is supposed to be *collaborative* between practitioners and service users and their carers (NIMHE, 2005). C got some of the support workers to be ushers and made them wear black t-shirts with the Trust logo on and the words

RECOVERY CONFERENCE 20th-21st APRIL 2006. The mood of the conference reminded me of being in an evangelical Christian church.

This latter comment was intended to describe the evangelical, charismatic (as in *charismati*, the gifts of the Holy Spirit) environment that the Recovery Conference seemed to engender. As somebody who has had direct experience of that particular setting, it made me feel uneasy, as though I was in the presence of a cult. The thing that concerned me is that a cult is by its nature exclusive.

(iii) Fore-grasp

My notion of the future that I was projecting myself into was directed by my understanding of and desire to achieve mental health Recovery in my practice. I wanted to see positive change in my practice as a mental health nurse; and I anticipated that at the same time I would also transform into the practitioner I desired to be. I anticipated that mental health Recovery would achieve these things. Recovery was attractive to me because it appeared to offer a change in mental health care that was revolutionary: it was the opportunity to overthrow the existing conditions of my practice, so much of which I experienced as being oppressive, to emancipate service users and practitioners alike by requiring an entirely different perspective upon mental wellness and the provision of mental health care. Recovery offered me a new paradigm in mental health care that shifted attitudes about mental health difficulties away from the traditional medical hegemony (Allott and Loganathan, 2002; Lester and Gask, 2006; Bonney and Stickley, 2008; Mind, 2008; Shepherd *et. al.*, 2008). Recovery seemed to be in tune with my own values both professionally and personally, especially in terms of justice and fairness. I felt excited to be on the cusp of this epoch-shattering movement. I wanted change and I believed it was afoot.

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CHAPTER TWO

METHODOLOGY

A methodology is

a system of methods and rules applicable to research or work in a science or art. (Chambers Dictionary, 2011)

And a method is

the mode or rule used in carrying out a task or accomplishing an aim; orderly procedure; manner.... (Chambers Dictionary, 2011)

I began the study with a fixed methodology in mind: it was to be a qualitative study using autoethnography[18] as a research strategy. Qualitative study is concerned with the quality of a phenomenon[19] in its natural setting (Cresswell, 2013: 67); as opposed to quantitative research which is based on the measurement of quantity or amount (Kumar, 2008). The qualitative researcher attempts to understand experience as it is lived and felt (McIlveen, 2008). In my case the phenomenon under study was my journey to realise mental health Recovery in my practice, and what this was *really* like. The felt-ness of my journey was to be conveyed by reflexive[20] study of a series of narratives that arose from my practice as a registered mental health nurse. Such self-study is a way of understanding our social world and how we interact with it (Pinnegar and Hamilton, 2009). However in the case of the present study not only have I attempted to convey the richness of my social world and *what that feels like* through my narratives, but I have also sought to engage the curious reader in the felt-ness of my journey of transformation towards achieving desirable practice.

I was the sole research participant to whose experiences I (as the researcher) paid attention and have interpreted. In other words I was a researcher-practitioner (McIlveen, 2008). Such autoethnographic research involves a

[18] Autoethnography is a positioning of oneself ("auto") as the subject of a larger social or cultural inquiry ("ethno") through writing ("graphy") (Noy, 2003)

[19] A phenomenon is any state or process that can be known through the senses rather than by intuition or reasoning (Honderich, 1995). Recovery is itself a social phenomenon because it takes place within a social context. Not only service users but practitioners, carers and policy makers all contribute to the social construction that is mental health Recovery (McCranie, 2011), since social reality is created and sustained through the subjective experience of people (Auerbach and Silverstein, 2003).

[20] Reflexivity is a means of 'going back' on oneself (Freshwater and Rolfe, 2001)

“journey of self-discovery” (Foltz and Griffin, 1996: 303), because it involves a crucial reflexive component, in particular in the way in which the researcher writes themselves into the text (Rolfe, 2000). It is necessary for a qualitative researcher to do this so that the reader is aware of the personal characteristics of the researcher that may have influenced the research (Mulholland, 2007). For the researcher this has the added property of encouraging reflection upon one's own life and recognizing that one is the author of one's experience (Anzul *et. al.* 1997: 336).

The author's presence in the text inevitably leads to reflexivity, because a critical consciousness develops of continuous self-critique and self-appraisal (Dowling, 2006) as the text is repeatedly scrutinised. Frank (1995: 117) describes this process as "reflexive monitoring". However the researcher must guard against the desire to appear well in their research (Furman, 2004). Similarly, s/he must guard against self-indulgence (Holloway, 2005) and even narcissism (Laughlin, 1995).

In qualitative research reflexivity is a vehicle of transformation (McIlveen, 2008). In the present study this transformation will be captured by a series of narratives that are constructed from practice and reflexively analysed along the way. This critical consciousness is best facilitated by an evocative or 'free-form' autoethnography (Ellis, 2004); rather than by analytic ethnography (Anderson, 2006). The former better provokes the curious reader into an emotional and guttural reaction to lived experience encapsulated as narrative (Ellis, 1997). The latter is representative of a traditional, scientific and positivist method (McIlveen, 2008). Autoethnography is not autobiography in the usual, literary sense, but is rather the adoption of a critical stance, because the researcher-practitioner inquires into his or her own narratives (McIlveen, 2008). This form of self-study provides “marvellous insight...that we can interpret and re-interpret our own experience across time and situation” so that we may consciously step away from our “expected place” in the world (Shields *et. al.*, 2011: 64). I was excited by the prospect that implementing Recovery in my practice was a means for me

to step away from my “expected” role as a registered mental health nurse, because it presented me with the possibility of an ontological authenticity that I felt I did not derive from my everyday practice.

I chose to describe my journey from everyday practice to desirable practice through a series of narratives that would account for unique moments in this journey, and which would as a whole account for the journey and for the transformation of my practice. Simply put, a narrative is a way for human beings to account experientially for the present and the past, and is the only way to provide a felt sense of what that experience was like (Webster and Mertova, 2007). Narratives enable us to think of ourselves as existing in the present because narratives always relate to the past at the same time as they relate to the present (McQuillan, 2000: 324). That is, we choose those elements of experience that seem significant to us, and we form them into a pattern (Bell, 2002) in ways that reflect our own (perceived) position in society. Narrative arises when experience has been captured to our satisfaction; it "takes on an aesthetic finality" (Spence, 1982: 31).

Narrative is by its nature not static or linear, as its reflexive nature can reveal the uncertainty and the complexity of experience (Johns, 2010d: 69). In other words, narrative accounts are necessarily subjective. Over time a succession of narratives is a useful way to account for and describe a person's experiences over the life span (or a part of it). In the present study they describe my practice, track its development, and over time account for personal and professional transformation.

In the present study each of my narratives derived from my practice as a registered mental health nurse and was therefore intended to represent a milestone in my transformative journey, or a signpost. Through the process of reflexivity each unique practice experience 'rolled' into and informed future ones.

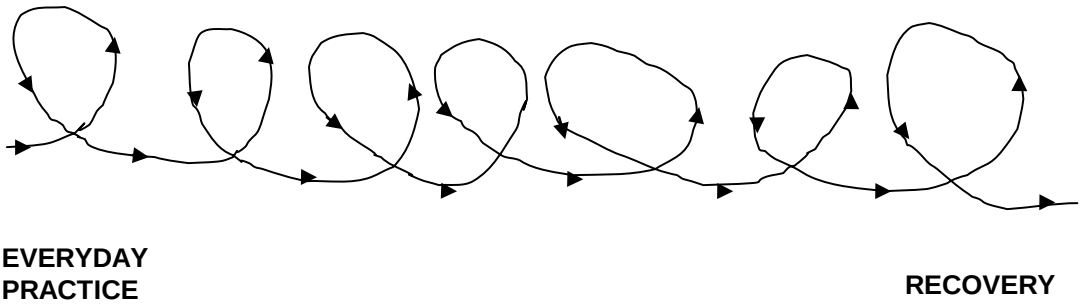

Figure 2.1: Reflexive Loops

In Figure 2.1 the circles are the experiences that comprise my journey of transformation, and the tails of the circles represent the insights that are reflexively derived from each experience and which 'loop' (that is inform – or even propel) into the next experience. This means that insights gained from one experience inform the next experience, and so on. The arrowheads indicate the direction of travel towards desirable experience. I hesitated to include these 'rough' circles in this Figure; however on reflection I feel that they best describe the rawness – the rough edges – of my practice as a registered mental health nurse; how Schön (1983: 42) described the experience of professionals as being akin to a "swampy lowland".

Johns (2009: 81) described reflexivity as a way to deepen insights into practice (Figure 2.2) gained by reflection.

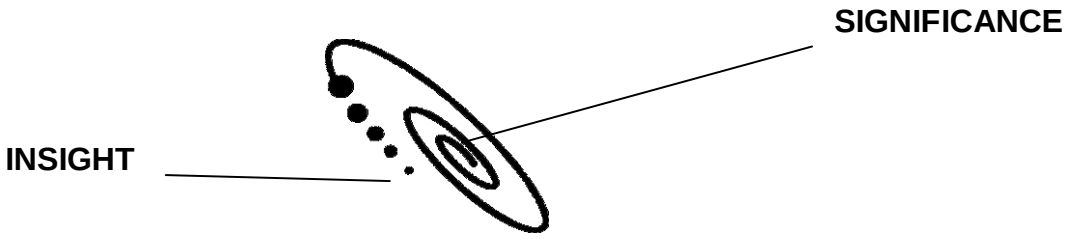

Figure 2.2: Reflexive Spiral (Johns, 2006)

The reflexive spiral offers the practitioner a graphical means of understanding

the process of deepening insight. Reflexivity offers the practitioner the opportunity to deepen insight in order to inform practice and hence further insights. Reflexivity provides propulsion, an imperative, to interrogate one's clinical practice. It is through reflection that one derives insight (Johns, 2013); and it is through reflexivity that the insight is deepened and informs future practice. Reflection is a “purposeful activity”, a process of engagement, of learning from everyday experiences (Johns, 2006); yet only narrative can provide that 'felt' sense of the journey. Consequently in 'going back on' my narratives I would deepen the insights derived through reflection, and gauge the way in which my clinical practice was influenced by previous insights, and comprehend why my narrative took a particular timbre, and use my insights to inform future practice.

Narrative inquiry

This strategy of inquiring into narratives is a means to capture the whole story, that is not only to understand phenomena at certain defined points (such as those indicated by the narrator) (Webster and Mertova, 2007). Narrative inquiry seeks to transcend narrative as a simple rhetorical structure (that is, as a story that is simply told), and seeks to analyse the underlying insights and assumptions that the story describes (Webster and Mertova, 2007). There are several ways of performing such inquiry. One such way is through narrative deconstruction (Punday, 2003); another is by narrative therapy (Payne 2006); and still another is narrative inquiry (Webster and Mertova, 2007). When narrative inquiry is the study of one's own (i.e., the researcher's) narratives then this is *ipso facto* self-inquiry. However this means that personality is crucial to the way narrative identity is constructed (McAdams, 2008); that is, the way in which one 'appears' in one's narratives and the particular way in which one interprets and represents one's experiences to oneself and to others. The major influences upon the shaping of my own personality are indicated in Chapter One.

In nursing, narrative is potentially a “liberating structure for reflexive self inquiry

and expression" (Johns, 2009: 103). Narrative is the means for transmitting practical knowledge (*phronesis*) in nursing and is not always accepted by the dominant – scientific - paradigm (Rolfe, 2000). At the same time the narratives of nurses are defined by the three factors of embodiment, tradition and power (Fay, 1987). An example of the affect of these factors upon nursing practices is for instance found in the sense of oppression that many nurses experience (Roberts, 2006) (see Chapter One).

To enable this process of self-inquiry I used the Six Layers of Dialogue[21] (Johns 2006) (Figure 2.3) because it provided me with a way to structure the process.

1	Dialogue with self (written in a journal or spoken) as a 'naive' or spontaneous story (that reflects dialogue with persons and self within the story itself)
2	Dialogue with the story (written in a reflective journal) as an objective and disciplined process (using a model of reflection) to produce a text
3	Dialogue between the text and other sources of knowing in order to frame understandings emerging from the text within the wider community of knowing (theoretical framing)
4	Dialogue between the text's author and a guide(s) to develop and deepen insights
5	Dialogue within the emerging text to deepen insights and weave the narrative into a coherent and reflexive pattern of form that adequately plots the unfolding journey
6	Dialogue between the narrative and the curious narrative reader responding to the invitation to dialogue

Figure 2.3 Six Layers of Dialogue (Johns, 2006)

As my study progressed I found that the discipline for structuring narrative was replaced by the passion of my creative flow; I started to *enjoy* writing narratives of my practice. CJ, my Director of Studies, facilitated a narrative group at the University, where PhD candidates under his supervision met monthly, and each meeting was a prompt to write a narrative and to share the plot that was unfolding before me. *Flow* (Figure 2.4 below) is a psychological state whereby somebody performing an activity feels fully involved, focussed, energized and

[21] This early phase of the Model was extant during my study, which is why it is reproduced here in its early form. However this model has since been superseded by the Six Dialogical Movements model (Johns, 2010: 28).

enjoys the activity (Csikszentmihalyi, 2008). *Flow* was attractive for me because it enabled me to escape from the world of my everyday practice which I was finding increasingly stressful..

Figure 2.4: FLOW (Csikszentmihalyi and Rathunde, 1993)	
Typified by	*How I met this*
A clear goal	Narrative inquiry as a means of achieving desirable practice
A strong challenge	Performance texts were a form I had not written in before
A high skill level	The process exacted and stretched my skills in writing
Skills that are not beyond ability and also are not too easy	I have been writing since the age of fifteen
A high degree of concentration and the opportunity to delve deeply	Deepening of insights through the reflexive process
A loss of feelings of self-consciousness	The creative process is also one of 'play', i.e.,"doing something not for real'" (Schechner, 2002: 79) and offered a resistance to the adult world that dominated my everyday existence. Play gave permission for my alternative self to do as it wished.
A distorted sense of time, as consciousness of time is altered	I became engrossed in the act of writing my narratives, which conflated and expanded time within them
Direct and immediate feedback	Obtained through peers and academics in the monthly narrative group, and work colleagues to whom I showed my work, and occasional performance workshops at the University
A sense of personal control over the activity	Dark play subverts order, dissolves frames, and breaks down its own rules...dark play is truly subversive, its agendas always hidden. Dark play's goals are deceit, disruption, excess and gratification (Schechner, 2002: 107)
	I felt empowered by indulging my phantasies of empowerment and my ridicule of powerful others
	Magical realism is an oft-used strategy of counter-narrative (Langdon, 2011)
Intrinsically rewarding	I indulged my phantasies of empowerment by satirizing powerful others
	I gained approval from my academic peers in the Narrative Group
	The experience of flow engenders a sense of being outside everyday reality; and also a sense that one is not concerned for oneself, a feeling of growing beyond the boundaries of the ego (Csikszentmihalyi, 2008)

I struggled with the inauthentic nature of my everyday practice, in the sense that I started to feel that my practice had become something I 'should' be doing, and in the way it 'should' be done. I felt that this should-ness was prescribed by Clinical Governance. In Heideggatian terms this is not an authentic mode of existence in that *Dasein* is likely to lose its unique-self in the depersonalization, mediocrity, anonymity and distraction of everyday existence (Mulhall, 2005). It was my intention for reflexivity to highlight - if not strip away - the 'should-ness' of my experience. Therefore I believed that writing my narratives would achieve a measure of authenticity, and really be ‘me’, a ’mineness’ [*jemeinigkeit*].

In fact it is not entirely useful to locate my study as a qualitative one because in contrast to their socially-critical heritage qualitative studies are increasingly being used to provide evidence for certain forms of practice and governance (Hammersley, 2008). This implies that qualitative study is itself increasingly finding itself appropriated as a hegemonic tool used to maintain certain approaches to research which support the *status quo*. This is ironic, for qualitative study tends to contain a significant critical component, because qualitative investigations deal with real people, real phenomena and real lives, and not with political rhetoric. This may be, for example, social criticism or political criticism, and any such studies are likely to be anathema to any hegemonic system whose probity is questioned as a result. This is insidious, for hegemony in qualitative research is difficult to identify because it lacks the positivist claims to truth that are offered by quantitative research (Onwuegbuzie *et. al.*, 2010). Students who think 'out of the box’– as I saw myself as a PhD candidate (though probably more to my psychological resistance) - consistently struggle against an academic hegemony that is reified within such forms as research governance and written and unwritten rules of standard (acceptable) academic research and writing (Kouritzin *et. al.*, 2009). Such students also struggle against norms and traditions of academic committees and appraisals (Kouritzin *et. al.*, 2009). As a result such students may experience uncertainty and anxiety as a result

(Kouritzin *et. al.*, 2009).[22]

Alvesson and Skoldberg (2000: 133) remark that:

> On purely practical grounds it can be difficult to undertake free research, since the critical approach is seldom supported by the funding bodies or by dominating groups within the research community at large.

In order to attempt to mitigate this anxiety I sought to maintain independence and autonomy throughout the study. This has not always been helpful however. For example whilst I regularly eschewed strategies of reflection and study required by the University, these strategies may have been helpful to my preparation had I not been resistant to them. Insofar as this study is concerned, I have continued to seek to resist what I perceived to be the hegemonic imperative to interpret research data as one 'should'; that is (i) in a particular pre-approved way (ii) mediated by hegemonic influences and therefore (iii) inauthentically.

My resistance accounts for the anxiety that I have experienced throughout this study for me to feel that I can approach it critically if necessary, without being (or feeling) constrained by any funding authority (for example, my employer, which might require data to be interpreted and/or represented in a particular way which is favourable to it). Hence my study has been self-funded throughout.[23]

My caution was borne out part-way through my study by my employer's proposal to the staff side committee of which I was a member, to be entitled to a significant percentage of any royalties that may accrue from the publication of any research done during the course of the researcher's employment by the Foundation NHS Trust, on the ground that the researcher would be using clinical experience gained during the course of their employment with the Trust.

[22] I acknowledge that my struggle may have been precipitated by my psychological resistance to any thing I perceive as being an imposition, as much as by any research hegemony.

[23] This was particularly relevant as the phenomena under study took place within a clinical setting provided by my employer. Here I would of course immediately be subject to the influences and research strictures of my employer which already regarded Recovery in a particular way.

This felt to me like the Trust wanted to colonize all aspects of nursing research, in particular for pecuniary advantage; and as a researcher myself this policy seemed to be motivated by avarice.[24]

What is reflection?

Many years ago while I was studying for my Media Studies degree, a student nurse with whom I shared a hall of residence remarked somewhat dismissively that reflection is, "Just thinking a lot about things."[25]

Reflection is indeed more complex than this. Johns (2010a: 6) remarks that reflection is "being mindful of self" either within or after experience in such a way that when this is combined with commitment one may understand contradictions that arise in practice in order to realise a vision of practice. Reflection emphasises being (i.e., presence within an experience) and becoming (the transformation or change that results from reflection). Reflexivity gives the practitioner the opportunity to look back on a series of reflected experiences and to see the self as having changed (Johns 2010a: 35).

Some reflections on Reflection

The term 'reflection' causes me to recall a painting entitled *Echo and Narcissus* by the English painter John William Waterhouse (Figure 2.5 below). In the painting the youth Narcissus is depicted as staring at his own reflection to the exclusion of all else, including the wood nymph, Echo, who loves him even though he pays her no mind. This painting is especially resonant for me because not only does it depict the property of reflection, but it also contains a psychoanalytic aspect; namely that of the narcissist who gazes into the pool and sees others only as reflections (that is, how he perceives them) and not as they actually are.

[24] When I ceased my employment by the organization this important issue for researchers was still unresolved.

[25] This former student nurse is now a nursing academic who would not have acquired such knowledge and skills without reflection.

In this case reflexivity is the interrogation of what projects those images, how and why. Reflection disturbs the waters (and shatters the reflection); whereas reflexivity examines the current of the water, its chemistry, and the nature of the silt and sand that the act of Reflection disturbed. A tension arises between a world of (pre-reflective) images which is familiar and taken-for-granted, and reflexivity, which unsettles that taken-for-grantedness.



Figure 2.5: Echo and Narcissus

The relevance of reflection to clinical practice

Unquestionably reflective practice has been adopted by national health care bodies as an essential part of training and best practice for many professionals who offer care to people (Dallos and Steadman, 2009). Reflective practice is emphasised as a qualitative and efficient means of gaining knowledge that can be 'felt'. Its significance in professional work largely resulted from Donald Schön's (1983) challenging of the accepted way in which knowledge is acquired (that is, through traditional epistemology). He suggested that the problems most important to individuals and wider society are not fully addressed by technical rationality, which was the research method dominant at the time and which held that scientific theory and technique can be applied to solve problems. Schön (1983) reinforced the value of personal, contextual and situational learning as a particular form of professional knowing that, he argued, is acquired and utilised

by professionals in practice. Reflection is an important strategy for those who work amidst the unpredictability of organizations which provide services to human beings, and is a means to counteract the sense of powerlessness which may arise from the uncertainty and complexity of these occupations (Fook and Gardner, 2007). Atkinson and Irving (2013: 3) assert that although reflection is contested as to its definition, it is not possible to be an effective practitioner without being a reflective practitioner (Atkinson and Irving, 2013: 2). Reflection addresses the process of learning, and requires an awareness of one's emotions as well as the way one thinks and acts within a cultural and institutional context. In this way reflection is to continually refine a personal authentic voice (Atkinson and Irving, 2013: 5). It is to learn through experience in order to gain new insights or to change the perception of oneself or one's practice (Johns, 2009: 3).

For nurses clinical effectiveness is to "do the right thing in the right way for the right patient at the right time" (Royal College of Nursing, 1996: 3). Hence reflection enables a nurse to achieve this effectiveness.

There is therefore a widely-accepted assumption that reflection is an exemplar for the acquisition of knowledge. This is evident by its place within Clinical Governance (McSherry and Haddock, 1999) and nursing registration (Goldsmith, 2011). Reflection on clinical practice leads to "improvements in practice and client care" (Royal College of Nursing, 2003: 3). It is also a requirement of nursing registration that the registrant provide evidence of continuing professional development (NMC, 2008). This is most often in the form of a reflective portfolio which demonstrates learning and in particular the achievement of desired outcomes (Jasper, 2003). Mackintosh (1998) points out that such a portfolio cannot provide evidence of learning if the original account (say, made in a journal) does not also have to be shown. However this may be, for example, for ethical reasons such as client confidentiality. Reflection implies hypothetico-deductive reasoning , a level to which many practitioners are not educated or do not function (Mackintosh, 1998).

My experience of reflection is that it is a means of acquiring new knowledge and thereby achieving desirable practice (the desired outcome) (Fig 1.0). Ever since I began my nurse training in 1994 I have found the Model of Structured Reflection to offer a framework for learning that is disciplined and structured (Fig 2.6). The MSR answers the criticism (for example, by Mackintosh, 1998) that as a philosophical concept reflection is vague, since the MSR leads one through the structured process of reflection. The cues contained in the MSR are prompts and not imperatives (Johns, 2009). The MSR leads the practitioner from problem to resolution.

Mezirow (1981: 6) placed critical social science at the core of reflection, arguing that reflection

> is in fact a process of becoming critically aware of how and why the structure of psycho-cultural assumptions has come to constrain the way we see ourselves and our relationships, [thereby] reconstituting this structure to permit a more inclusive and discriminating integration of experience and acting upon these new understandings.

Such a process leads to what he termed ‘perspective transformation’ (Mezirow, 1981: 6).

Insights are derived from practice through reflection, and these insights are deepened by reflexivity. As a structured and disciplined way of gaining insights, throughout my nursing career I have used the Model of Structured Reflection [MSR]. The MSR is reproduced below (Figure 2.6). Although now in its 16th Edition (Johns, 2013), at the time of my study edition 15A (Johns, 2009) was extant.

(1) Bring the mind home
(2) Focus on a description that seems significant in some way
(3) What issues seem significant to pay attention to?
(4) How were others feeling and what made them feel that way?
(5) How was I feeling and what made me feel that way?
(6) What was I trying to achieve and did I respond effectively?
(7) What were the consequences of my actions on the patient, others and myself?
(8) What factors influenced the way I was feeling, thinking or responding?
(9) What knowledge did or might have informed me?
(10) To what extent did I act for the best and in tune with my values?
(11) How does this situation connect with previous experiences?
(12) How might I reframe the situation and respond more effectively given this situation again?
(13) What would be the consequences of alternative actions for the patient, others and myself?
(14) What factors might constrain me from responding differently?
(15) How do I NOW feel about this experience?
(16) Am I more able to support myself and others better as a consequence?
(17) What insights do I draw towards self-realization?

Figure 2.6: Model of Structured Reflection (15A Edition) (Johns, 2009)

I have always found the MSR to be relevant to me as a practitioner because Johns is also a Registered Nurse. The aspect of the model that I have always found most encouraging is that Reflection is itself a vehicle to achieve desirable practice. The MSR arose during Johns' work in the Burford Nursing Development unit in Oxford during the 1990s (Jasper, 2003), and so clearly directly arose out of clinical practice.

Johns (2009) emphasized that his Model of Structured Reflection is not prescriptive, and neither is any other such model. Other models of reflection are available, such as Gibbs' Reflective Cycle (Jasper, 2003), and Boyd and Fayles' six stages of reflection (Boyd and Fayles, 1983).

Gibbs' model has six stages of reflection; whereas Johns' Model of Structured Reflection is much more intricate and requires the practitioner to pay attention to the broader process of reflection through developing an awareness of all the things that may influence practice. In other words, Johns' Model of Structured Reflection is reflexive, because his later cues interrogate the practitioner's experience of the incident; whilst Gibbs' Reflective Cycle does not do so and due to its non-reflexive nature it is perhaps more appropriate for undergraduate

students (Johns, 2008, personal communication). Likewise, Gibbs' model requires that reflection must be on critical incidents; however, Johns (2004: 38) suggests that any incident is worth reflecting upon, not only those with a critical significance. However Johns acknowledges that the practitioner will normally take extant incidents from practice upon which to reflect, because such experiences are necessarily disruptive and for that reason noticeable (Johns, 2006).

Boyd and Fayles' (1983) model of reflection can, along with Gibbs' Reflective Cycle, be described as deliberative and even prescriptive (Johns, 2009). For this reason they are not reflexive, for they do not take into account the reflexive deepening of insights that will lead to a change in clinical practice (Johns, 2004). Being reflective implies an awareness of the origin of the knowledge one has (Johns, 2006). The reflexiveness of Johns' work is indicated by his development of reflection into narrative (Johns, 2006) as not only a means of self-inquiry and deepening insight, but also of deeply engaging others; and subsequently performance as a means of social action (Johns, 2009). Reflection is not simply a technology to produce better outcomes for practice; it is actually about personal growth which can only be known through the narratives that people tell (Johns, 2009: 23). Reflection is how we learn; and narratives describe the impact of what is learned. Reflexivity accounts for why we have learned what we have learned, through questioning those narratives, and drives us further towards realising desirable practice.

The Narrative Paradigm

An important reason why my own narrative experiences are relevant is because as established in Chapter One narrative is extant within mental health Recovery (Lysaker and Buck, 2006; Brown and Kandrikirira, 2008; Carless and Douglas, 2008; Shepherd *et. al.*, 2008; Basset and Stickley, 2010; Leamy *et. al.*, 2011; Slade *et. al.*, 2012) This is in the sense that only narrative is able to convey a felt sense of a person's recovery from a period of mental ill-health.

My study gives narrative a similar centrality in describing my own lived

experience as a practitioner working to achieve Recovery in clinical practice. Therefore my study arises from within the same milieu as Recovery. I feel that I can say this with some confidence because as indicated in Chapter One numerous Government documents have engineered a central place for Recovery within contemporary Clinical Governance on mental health care. In this respect mental health Recovery is sanctioned by the hegemony. (However as I shall indicate in Chapters Four and Five, this location presents considerable complications to Recovery as a phenomenon.)

However there have been no practitioner narratives of the lived experience of a mental health nurse working towards realising Recovery in practice. This may be because mental health practitioners feel discouraged from telling their stories due to the three constraints of Embodiment, Force and Tradition (Fay, 1987) (see Chapter One), and the emphasis upon *machismo* that continues to exist in mental health nursing (Clarke, 2008), This is again ironic when the past several years have seen developments in the idea of the Narrative Practitioner (Lloyd, 2009; Roscoe and Madoc, 2009) although arguably this is in order to encourage practitioners to be able to identify elements of service user narratives and to plan care appropriately as a result (Hovey and Paul, 2007; Engel *et. al.*, 2008; Aloi, 2009; Hall and Powell, 2011). If one assumes that the nature of narrative is language-based (because, for example, it is descriptive) then it can be argued that traditionally researchers have regarded language as symbolic (i.e., as referring to something else) and failed to examine the meaning or the significance of the language used (Wells, 2011). This has significance for the examination of the language contained in the narratives of service users and practitioners, and is why in Recovery the use of language is so important.

There has been scant attention paid to the *lived* experience of the mental health practitioner as to how they are able to (or not) realise Recovery in their practice. In other words, what is the lived experience of the mental health practitioner who encounters constraints to their practice that may preclude the realisation of Recovery in practice? Or even how it may feel to realise Recovery in practice,

and how that was achieved? It appears that it is *assumed* that mental health practitioners will realise Recovery in their practice by, for example, practising in accordance with Clinical Governance (of which Recovery is a part), or by paying attention to the narratives of service users. I am concerned to make the lived experience of mental health practitioners accessible to others so that they may know what it is *really* like to attempt to achieve desirable practice.

Several research projects have been undertaken to appraise the 'lived' experiences of mental health nurses in the form of narratives about different aspects of their practice. These have always been general in the sense that the narratives of a sample of mental health nurses have been gathered and then analysed by either a research team or a third-party researcher. For example narratives of burnout (Taylor and Barling, 2004), of nurse education (Lyon, 2005; Stacey *et. al.*, 2010), of exit strategy (Crawford *et. al.*, 2008), feelings about self-harm by service users in forensic settings (Sandy and Shaw, 2012), recruitment and retention (Ward, 2011), personal mental health difficulties (Joyce *et. al.*, 2012) and practice in residential care (Hellzén and Asplund, 2006).

Hardcastle *et. al.*, (2007) offer a variety of insights from different perspectives (including from mental health nurses) on the difficulties and constraints experienced when attempting to facilitate a therapeutic environment; while Stacey *et. al.* (2010) focus exclusively on the experiences of mental health nurses upon those perceived constraints.

There have been other studies of the narratives of other practitioners working in care work (for example Floersch, 2004; Riley and Hawe, 2009; Roscoe and Dollis, 2009; Kristiansson et al., 2011); in other humanities (e.g., Payne, 2006; Mattingly, 2008; Gabriel and Casemore, 2009; Patsiopoulos and Buchanan, 2011) and in teaching (Phillion and Connelly, 2004; Tsui, 2007). Many of these studies have been outside the UK and were not specifically related to the experience of a practitioner realising Recovery as desirable practice.

It can therefore be seen that there is an absence of narrative self-inquiry used as a reflexive strategy by mental health practitioners seeking to realise mental health Recovery as desirable practice. The closest that comes to this is the notion of nurses and service users co-creating a Recovery narrative with the service user (Borg and Kristiansen, 2004; Barker and Buchanan-Barker, 2005; Hall and Powell, 2011). However this is perhaps not fully mutually creative because the nurse always necessarily inhabits a position of (i) power in terms of subtle coercion (that is forms of coerciveness by mental health nurses that are not readily apparent) (Lutzen, 1998) (ii) partiality in having a directly vested interest in the continuance of the service (iii) authority in knowing what resources are available to the service user and/or to what version of Recovery the health care provider is working to.

The ethics of the nurse as researcher

The term ‘ethics’ has several different meanings; but one of the most frequent definitions is that it is a code or a set of principles by which society (or smaller social groups within the broader society) live (Popkin and Stroll, 1969).

For nurses, at least several sets of ethics apply: such as that of the Nursing and Midwifery Council, of the employer, and if a researcher then also the Economic and Social Research Council and the NHS (National Research Ethics Service). All nurses have a duty of care to their patients (Royal College of Nursing, 2009) and to this end i sought ethics guidance from the ethics lead at the University, Mr Ron Driver (now retired). Johns (2002: 58) asserted that “Researching and developing self in the context of self's own practice demands no ethical approval from others”. Ethics was only a consideration insofar as I might identify service users ('vulnerable persons') and since my narratives were heavily anonymized and fictionalised, and as they focussed upon processes and discourses rather than upon individuals, ethics approval was not required.

Later in the study, once I had started to become concerned with the discourses

that positioned me as a registered mental health nurse within the organisation, I used characteristics and idiosyncrasies of colleagues with whom I have worked (some present, some past), exaggerating them to the point of caricature, often to the point of farce, in order to reveal the discourses that constrain mental health Recovery and other aspects of my practice as a registered mental health nurse. Service users were never parodied.

There are various ways in which I can consider my 'research activity' during this research project. I like the idea of myself being an *accidental tourist* because when I started I was a citizen of the fair land of Nursing, believing i was a full and functioning citizen. Through reflection however I moved from this plateau land to live on the swampy lowlands (Schön, 1983) of practice. Reflection proved a tension for me because whilst I realized that I laboured under an everyday *illusion* of practice, I also found myself to be what Gerrish (1997) describes as a 'marginal native': that is as a registered mental health nurse I am 'native' to the group under study yet as a researcher cannot permit myself to be so. This is of course one of the great dangers of ethnography, i.e., that the researcher 'goes' native (fully becomes a member of the group under study) so that consciously remaining on the margins of native-ness guards against this. My ethical dilemma was (i) should my colleagues be aware that i was conducting research even when I was legitimately there as a fellow practitioner[26] or (ii) should they know would they behave differently, so affecting the scope and quality of data that i collected? My rationale for not disclosing the exact nature of my data collection was that the research would not identify any of my colleagues. Johns (2002) suggests that self always exists in relationship with others, and this relationship is seen through the (necessarily subjective) narrative. Within such relational ethics the observer focuses upon their mode of being rather than the decisions they make (TN, 2005: 36). If the narrativized relationship is critical of others, these others may recoil from being seen in a 'bad light' (Johns, 2002: 58). However any such bad light permits that other to

[26] Lee and Roth (2003) describe this as "legitimate peripheral participation"

reflect upon their own practice (Johns, 2002). Taylor (1992) stated that as individuals we all necessarily occupy ‘moral space’ as a condition of our humanity, so how we use that moral space has an ethical significance. As a nurse researcher, the choice of where i positioned myself (i.e., used that moral space) was necessarily a moral (and therefore) ethical one.

As both a nurse researcher and a practitioner therefore my role comprised a tension. This dilemma has been discussed elsewhere, for example the notion of the "border ethnographer' who exists in “the in-between space of clinician/academic... one who inhabits the slash rather than the territory on either side” (Walker, 1997). Such anxieties on the part of the researcher are what Dickson-Swift et. al. (2007: 343) describe as the 'ethical hangover' of fearing that you betray those you work with by 'researching' them. Cudmore and Sondermeyer (2007) anecdotally reported hostility and suspicion thinly-veiled as jocularity from colleagues who were aware that they were the focus of research by a nursing colleague.[27] The fecundity of terminology for a practitioner-researcher indicates that in many ways it is a difficult role to negotiate.

I admit that I may reasonably be suspected of coversion in that colleagues were largely unaware of my status as an observer of the processes in which like me they found they were embroiled. However my observation was more particularly of their role in those processes and how those processes related to me, and their impact upon me as an individual practitioner. On the other hand my coversion meant that my observations were not polluted by colleagues' conscious awareness of me as a researcher[28]; that is the environment was fully natural, and processes took place and unfolded as they normally would do.

My caricatures of others were in no way intended as a criticism of them or of their individual practice, because i wrote about my practice with a degree of

[27] Fortunately I did not encounter any such hostility from colleagues during the study
[28] I should like to emphasise that I was a *researcher* of my own experiences of practice, and an *observer* of processes which involved me and colleagues.

respect, and during the course of my study i treated and wrote about colleagues and service users alike respectfully. I feel that my observations equated with my beliefs about how service users should be cared for and treated within Recovery. I also feel that my study was conducted in the best interests of service users, with the truthful intention of establishing a better clinical world.

Six Dialogical Movements

This model of narrative structure (Figure 2.3) enabled me to signpost my transformation through a series of narratives and, by moving through each level, to direct my narratives towards my goal, as described in Chapter One, of ultimately influencing the practice of other registered nurses (level 6). Through a series of narratives informed by various insights I would both record and propel my transformation from everyday to ideal practice.

The Layers of Dialogue (as was) model was attractive to me because its systematic approach offered a disciplined and reflexive tool for self-inquiry and a means of mapping and 'tracking' my personal and professional transformation. It was also particularly useful in that I was able to remain in practice yet research my self through my experiences of practice. Other work on narrative research did not provide me with the particular tools with which to examine the transformation of my practice from everyday practice to desirable practice; for example, strategies of narrative deconstruction would be laborious and therefore unsuited to my need to remain in practice.

Relationship is central to Recovery, whether this be relationship of the service user with professionals or service user relationships between each other (Slade, 2009). Relationships are facilitative, enabling and produce meaning (Slade, 2009). Therefore, due to this emphasis on the relationship between the practitioner and the service user being the primary vehicle to facilitate recovery I chose to depict my own journey to realise Recovery as desirable practice in the form of a relationship between me and Recovery.

In order to illustrate my ongoing relationship with Recovery I translated Recovery into the metaphor of another person. Personification is:

> a form of metaphor whereby we speak about one thing in terms of another. In using metaphor we are spotting a thread between two dissimilar objects or events or whatever, one of which is better known than the other, and using the better known one as a way of speaking about the lesser known. Personification, as a form of metaphor, brings to expression something which cannot be expressed in plain language. […] It is to express that which cannot be expressed otherwise. (Boas, 2006: 52)

I did not set out to use personification as a literary strategy. Rather, I used it as a way to say what I could not otherwise say about my lived experience of implementing Recovery in my practice. This is because I found my embodiment as a nurse oppressive and disempowering and constraining. Personification enabled me to convey the effects of my sensuous world upon Recovery - since Recovery takes place in a social world that is by its nature sensuous. Personification grounded my experience of Recovery and enabled me to describe my everyday experience of it in terms of the metaphor of relationship. My goal would therefore be to unite the two - myself and Recovery - in the form of a symbolic marriage, and this was the unfolding narrative I aimed to achieve. Due to the way in which personification eased my flow, this is a literary device that I have extended into the final chapter, Chapter Five.[29]

There follows an explication of how each dialogical layer (Figure 2.3) is related to my study.

1st layer: dialogue with self as a 'naïve' or spontaneous story to produce a story text

I used myself as a tool with which to collect data directly from my own experience as a mental health nurse. This data was subsequently recorded in a reflective diary or journal. Reflective journals are evidence of continued professional development, which is a requirement of NMC registration (NMC,

[29] **A note about referencing.** The text contains explanatory footnotes and references at the end of the chapter (that is, Chapters One, Two and Four). The narratives (that is Chapter Three and Chapter Five) contain footnotes which when they are not explanatory direct the reader to references contained at the end of each narrative. This is so that notes and references do not interrupt the flow of my narratives.

2008). A reflective journal is an important method for nurses to focus their thoughts and of learning about their inner world, and has therapeutic benefits such as the reduction of stress (Johns, 2004). In autoethnographic nursing research keeping a reflective diary is similar to the gathering of field notes (Cudmore and Sondermeyer, 2007) upon which the conclusions of a study are based.

The first two cues in the Model of Structured Reflection (Figure 2.6) relate to this first Layer of Dialogue in permitting experiences from my practice to penetrate my consciousness naively and spontaneously. The cue to ‘Bring the mind home’ requires me to find a still place within my Self amidst the demands and distractions of my life (not to mention the busy-ness of my practice) from which to identify an experience that appeared significant for me to want to write about.

This ‘still place’ was often the study in my house, usually after finishing a work shift, so that the experience was still fresh in my mind, where I closed the door of the room and sat at my desktop PC to use a word processing program. I can still remember (even though I have moved house since) the bare wooden floorboards that I had previously prepared and varnished myself, and the echo in the room of the sound of the computer keyboard.

Any experience that broke through to my consciousness during these quiet moments was because it seemed significant in some way (as the second MSR cue suggests). This was often because the experience was discomfiting in some way (Boyd and Fayles, 1983); for example that it didn't seem to 'fit' with either the norms or values of Clinical Governance or with my perception of the original aims of Recovery. Often I experienced a 'nag' in my stomach about something that had happened at work, and it was this 'gut instinct' that I chose to reflect upon, as to why it felt discomfiting in some way. Such intuition may correspond to that habitually felt by the expert practitioner (Crook, 2001).

My stories were created naively and spontaneously because I wrote them by the process of ‘automatic writing’, which is

...writing that is done through your hands using a pen, pencil or typing your words on a keyboard....It is called by some "trance" writing because it can be done quickly and without thought, whatever pops into your mind. (Richardson, 2008: 7)

The process of automatic writing is an invaluable means of gaining self-knowledge through the process of reviewing what has been written.[30] In fact this is how I like to write in general; however I do not leave the text at this 'automatic' stage. I subsequently go back on what I have written, and refine it, for example by consulting a thesaurus in order to expand ideas or to change words (which suggests that even this casual edit stage is reflexive). Therefore it is true to say that only my initial accounts were truly 'automatic' and spontaneous – but only insofar as they were already inevitably mediated by the psychological schema or cognitive frameworks that pre-exist unconsciously in each of us (Comer and Gould, 2010). As revealed in Chapter One about my own personal schema, every person's personal schema is different, so that the same event will have different significance for different practitioners.

As I typed my stories out on my computer, I attempted to write them automatically; that is, without conscious thought. When an element of consciousness entered this process (such as considering my use of the spell check, for example), this mechanism (when there is an identifiable moment between the thought and its transfer onto the page) allowed for interstices between words and between images to become visible: as though reflection were a wind that blew away a fog of unconsciousness covering the page. These gaps came to be significant – I found myself questioning the spaces between words, between sentences, and between recollections. Even the act of periodic spell checking, essential when using a word processor, requires a 'going back on' what one has written, a discovering of a space that had previously gone unnoticed in my haste – or automatic-ness - to transfer my thoughts onto the page.

[30] This is not the usual meaning of automatic writing, which is somewhat metaphysical (Richardson, 2008) and normally eschews review, adjustment and reflexivity.

2nd layer: dialogue with the story as an objective and disciplined process
At the start of my research study I worked in a diligent and disciplined manner through the cues in the Model of Structured Reflection, recording my response to each one. After a while I found that I needed to pay less attention to the cues because they had become habitual and seemed natural to me (Johns, 2006). It is like using the foot pedals on a motor car: the learner initially finds them clumsy and confusing, but with repetition and practice the actions become instinctual. At this point I became able to write a reflective text directly without the requirement to formally attend to the initial cues.

From this time the MSR served more as a prompt, an *aide memoire*, rather than as a rigid structure that broke up the reflection into component parts to later be reassembled as a narrative. I was now able to construct my reflective text as a spontaneous, narrative whole.

The dialogue that I undertook with the 'naïve story' was by means of the cues of the MSR. For example the cue “How were others feeling and what made them feel that way?” caused me to make the decision *not* to anticipate what other people from the world of my practice may feel, because this study was about *my* transformation and about *my* self-inquiry. I intended to consciously maintain a distance from work colleagues so that I felt more able to observe their behaviour from a position of non-involvement and detachment. This method of research has variously been described as being a marginal native (Gerrish, 1997), or a "border ethnographer' who exists in “the in-between space of clinician/academic... one who inhabits the slash rather than the territory on either side” (Walker, 1997); yet one who has “legitimate peripheral participation” (Lee and Roth, 2003). The fecundity of terminology for a practitioner-researcher indicates that in many ways it is a difficult role to negotiate.

Any personal or social characteristics exhibited by work colleagues were exaggerated for comic effect in my narratives in order to emphasise an insight that I had derived through reflecting on my interaction with (or observation of)

them. However by contrast service users inhabit a different moral dimension than do employees, because service users are cared-for and supported, and so are *ipso facto* vulnerable. I therefore decided that any service users represented in my narrative texts would be composite characters or heavily anonymized, in particular because I found myself focussing much more on processes rather than on individuals; therefore consent was not deemed necessary. This strategy was approved by the head of the University's ethics committee.

The cue 'What was I trying to achieve and did I respond effectively?' caused me to continually question the nature of my effectiveness as a practitioner. This is more than merely an anxiety about semantics, because whilst 'effectiveness' can be measured against my own notion as a practitioner of desirable practice, 'effectiveness' may also have a privileged meaning - that is, as defined by the hegemony. If the two definitions of effectiveness are not congruent or even aligned then inevitably cognitive dissonance and discomfiture for the practitioner will result.

I have always found that I am often not fully aware of the influences that affect my practice. However, the cue in the MSR, 'What factors influenced the way I was feeling, thinking and responding?'', forces me to consider this. Through reflexivity I feel I have discovered the dark psychological factors that influence me the most. (This is discussed further in Chapter Five). Sometimes I feel that even knowing what the influences are which may affect my practice makes little difference to me as a practitioner, as those influences can sometimes be considered invariables, such as nursing practice prescribed by Clinical Governance. For instance, Recovery may be seen as one such invariable because it has been incorporated into Clinical Governance (Roberts and Wolfson, 2004; Stickley and Wright, 2011a), and Clinical Governance carries the risk of being prescriptive (Keaney, 2001). I may be encouraged as a practitioner to practice according to the principles of Recovery, but when Clinical Governance itself defines what those principles are, and as a function of my employment I am required to work according to Clinical Governance, then

obviously my options for autonomy and/or personal expression are limited. I do not believe that this incongruence is always a *creative* tension because one pole of this struggle (that of Clinical Governance) is necessarily intransigent and rhetorical. As a practitioner I sometimes find myself paralysed by Clinical Governance: I ask myself whether I have acted for the best for the service user, or the best for my employer. I feel that principles of mental health Recovery (such as empowerment, justice and equality) caused me throughout the time of my data collection to increasingly wrestle with this ethical cue.
The cue 'How does this situation connect with previous experience?' causes me to attempt to connect my reflections together and to examine the possibility that there may be patterns of behaviour or belief that affect my practice, such as framing them in particular ways. In fact, as later Chapters reveal, reflexivity enabled me to discover a connection between reflective experiences that was immensely unexpected yet profound.

The cue 'Given the situation again, how might I respond differently?' assumes that reflection has been prompted through a discomfiting experience from practice. This may not be the case (although this is unlikely). Reflection is for self-affirmation as much as for the examination of discomforting experiences (Johns, 2004). Registered mental health nurses crave affirmation and recognition as these offer them validation (Crawford *et. al.*, 2008); in the absence of formal processes of validation, reflection can provide this (Lauterback and Becker, 1998). Generally following reflection I tend to feel more positive about any essentially negative practice experiences, because the process of reflection invigorates and empowers me to make changes in my practice, or refocuses me upon achieving desirable practice.

The cue 'What factors might constrain me from responding differently?' is important because by it the practitioner may prepare themselves for the real world of practice rather than simply indulging in fantasy and idealism (Johns, 2010b:41), by identifying what may be preventing them from acting in new and more desirable ways. At this point the practitioner can hit a “reality wall” (Johns,

2010b:41), which may mean the practitioner being confronted by the reality of their practice and the issues that may constrain them from achieving desirable practice. In any event this cue always requires a decision from the practitioner, in particular once any constraining factors have been identified, as to what they are going to do when faced with the 'wall'.

The MSR forces the practitioner to ask whether of not they are better able to support themselves and others following the reflection. This cue challenges me to question my support systems within practice (Johns, 2009). Reflection can be empowering for the individual practitioner (Johns, 2009); however the practitioner himself or herself needs to have a system of support in place, as an encumbered spirit is not helpful for therapeutic work (Gordon, 2005). A practitioner may find support from colleagues, from managers, from clinical supervision, from a peer supervision group (Royal College of Nursing, 2002). The health care organization will itself benefit by providing support for practitioners so that those practitioners can support others (Bond and Holland, 2010). Unfortunately this does not always take place and many nurses are left feeling unsupported (Zwygart-Stauffacher, 2010; Kidd and Finlayson, 2010). During the period of several years during which I collected data I had only one session of clinical (as opposed to management) supervision.

Johns (2006: 48) described the gaining of insights obtained through reflection as requiring systematic framing; I achieved this systematic framing by writing a series of narratives with a plot based on the insights obtained, and subsequent narrative inquiry deepened them. It was my intention at this point to go back on the experiences in order to ascertain what I have learned from reflection on them and how it does (or does not) contribute to my realisation of desirable practice.

3rd Layer: Dialogue between the tentative insight and other sources of knowing in order to inform and frame insight.

Therefore having derived tentative insights through the use of a structured

model of reflection, it was necessary for me to deepen these insights and to increase their robustness in order for them to substantially influence my journey to desirable practice. I did this by resort to wider sources of knowing such as literature and through academic and peer supervision. Throughout my study my search strategy was primarily conducted electronically, using the University's own electronic library resource (for example CINAHL and EBSCO) and the Google electronic search engine. I used the University's electronic resource to identify books that I might borrow using my University library card. I also regularly browsed the University's physical library. On a few occasions I somewhat fruitlessly browsed my local public library.

I found Google Books and Google Scholar to be particularly invaluable. As an NHS employee at the time, I also had access to the NHS.net database of relevant articles. Being able to receive instant results for such electronic search terms such as 'practitioner narratives', 'narratives by nurses', 'nurse narratives' and 'nurse researcher' was an immense time saver. I consider public search engines to be the same as browsing through a physical library, opening a book, consulting the index for relevant information, noting the information down, and then placing the book back on the shelf.

For the literature search on mental health Recovery I used the Stickley and Wright (2011a, 2011b) papers as the basis for my own search. I augmented Stickley and Wright (2011a, 2011b) using the strategies outlined above, which also resulted in some more contemporary texts. I investigated the references used by Stickley and Wright (2011a, 2011b), and investigated further the references used in those other relevant texts. This was a strategy I also used on a wider and more general scale for the thesis.

Unfortunately I was not able to derive support from my clinical area in the form of clinical supervision. The Deputy Manager at Twelvetrees was frequently on sick leave and paradoxically the Unit Manager was often away from the unit promoting Recovery to the remainder of the organisation. Perhaps due to time

constraints on the part of the Unit Manager, any supervision that I did have was in fact management supervision, which was disciplinary in tone and was very clearly weighted towards the performance of my role as my employer required. I therefore experienced supervision in my clinical area as disciplinary and coercive, and as conveying established meaning rather than co-creating it. This always felt antithetical to creative practice, so that my narratives started to develop a cathartic significance for me.

However I was at the same time a member of a peer supervision group of fellow PhD students, established and facilitated by CJ who was Academic Supervisor to me and the other candidates. The group met monthly and each group member read aloud short narratives from practice to the remainder of the group and received peer comments. As a group we agreed to refer to ourselves as the 'Narrative Group'. An electronic interface was established for the mutual exchange and discussion of ideas and narratives amongst group members using the social networking facility Google Groups.

One of the most useful but unexpected outcomes from my involvement with this group was CJ's introduction of three drama academics into the monthly PhD supervision meetings, due to his own desire to explore this development in his work (Johns, 2010c). My own narratives had until this time been formal and prosaic but the introduction of the drama academics suddenly presented me with the possibility of looking at my narratives in a different and exciting way. I had experimented with several different forms of narrative but the introduction of the drama academics into the narrative group created a set of propitious circumstances that enabled *flow* (Figure 2.4). Over time my continued membership of the Narrative Group enabled me to acquire more sources of knowing from peers and guides. One regular such suggestion, for example, was that I might attend to a particular book or play in order to deepen a particular insight that arose from my narrative texts. The deepened insight subsequently became an embodied source of knowing that informed future narratives.

The texts that I now produced from my reflections were performance narrative texts. I cannot say that they were deliberately intended for performance; however they were intended to be “playful” and “creative.” Writing narrative is to be like clinical practice in that it needs to be imaginative, playful and joyful in order to release the creative spirit (Johns, 2006: 59). It is creativity that will help the practitioner to realise desirable practice, because narrative is the natural expression of clinical practice (Johns, 2006: 60). In other words, my narratives *flowed*. By using wider sources of knowing I found myself ‘connecting’ my reflections to other knowledge, some of it deeply-buried, which in turn helped me to contextualise the experiences, render them individual and also encouraged creativity. The significance of much of this deeply-buried knowledge is discussed in Chapter Five.

4th layer: Dialogue between the text’s author and a guide(s) to develop and deepen insights

Guides are necessary to help the narrative-writer because they can challenge the practitioner, and ‘shake up’ the practitioner’s inner world where perhaps they have lost their commitment or interest (Johns, 2006). Co-creation of meaning is a vital useful stage in deepening insight (Johns, 2010d). The guide is a facilitator and not an authority.[31] A guide and peers may facilitate a fusion of ideas between themselves and the practitioner to derive new or deeper insights; and may facilitate new ideas that the practitioner may be resistant to if they are trapped within habitual patterns of thought that derive from the safety of their practice. A guide and peers may offer support, remoralization and guidance when things seem difficult; and offer a checking-in facility to ensure that the practitioner maintains focus.

One particular benefit that I found from peers is the ‘checking function’. Throughout my narrative production period I was able to confirm the accuracy

[31] Since the latter part of the 'writing up' phase of this study an added important guide has been my psychotherapist, who has supported me in clarifying the deepened insights that I have derived from reflexive study of my narrative texts, in particular as to how many of them in fact have great personal and psychoanalytical significance.

and context of my narratives with colleagues and family. For example, I was able to confirm that my narratives were coherent, even with those who were not also mental health nurses, by sharing them with others.

There follows a brief summary of the narrative groups I attended, to indicate their influence upon me in offering guidance and a 'checking-in' function.

23/01/07 (The inaugural group meeting)
Narrative: *Martin*
I was surprised that other group members did not seem to notice the homo-eroticism in my narrative. Perhaps the group was still raw in that we hadn't developed sufficient trust between each other to discuss such intimate matters as sexuality or to fully explore the insights arising from each other's narratives.

26/02/07
Narrative: *Ward Round*
This narrative gave me the opportunity to share literature with my peers, and expand their own sources of knowing as well as mine.

27/03/07
Narrative: *Good Cop, Bad Cop*
Group members were shocked by the horrific image I narrated of a service user's psychotic self-loathing. This shock was paradoxically reassuring to me because it was the feeling I wanted to create, and the way that I wanted to convey the intensity with which some people experience mental health difficulties – the reaction proved the effectiveness of my written style.

24/04/07
Narrative: *A Dance for Sunday*
The group encouraged the mindfulness that informed the narrative, and praised my use of language and metaphor. One group member said that she liked the metaphor of the dance, and suggested that many of our interactions with

patients and service users in health care use the social conventions that are contained in dance.

27/06/07

Narrative: *The Watcher*

CJ suggested that my description of the shambles that was an historical re-enactment might be expanded to apply to clinical practice, adding that his own experience of clinical practice was that it could sometimes appear to be chaotic.[32] I had not considered this previously as an option, but it intrigued me.

26/0707

Narrative: *Gurjuan*

My narrative included a poem for the first time, which formed a Prologue to the narrative.

30/08/11

Narrative: *Never got to say*

I felt that I had failed to convey to the remainder of the group my sadness and disappointment at causing harm to a service user through administering medication which had been incorrectly titrated by the prescriber. It caused me to reflect on why I had failed to convey my feelings in the text.

27/09/07

Narrative: *The Director's Cut*

Once again I was disappointed that I failed in my narrative to convey to the remainder of the group my feelings (in particular my frustration and my anger). I decided to try a more experimental style for my next narrative.

[32] Within chaos is inherent order (Johns, 2006: 58). By its nature self-inquiry seems chaotic, although self-inquiry seeks to find a pattern to practitioner experience through reflection and deepening meaning (Johns, 2010c: 23).

22/10/07

Narrative: *Not the Only Unicorn*

This was written in a breathless, experimental style, which I read in one sitting. It was influenced by the author Jack Kerouac's writing style in his novel *Lonesome Traveller* (Kerouac, 2000). Being in the presence of drama academics I was aware of the need to punctuate the texts with appropriate breaths. I wondered to what extent this style was conspicuous by its experimental nature.

22/11/07

Narrative: *No postscript*

This narrative dealt with my feelings of loss and disappointment that the Unit Manager, who had inspired recovery in the Unit, was to leave for a seconded post in the Community. I was surprised at the depth of my feelings.

20/12/07

Narrative: *The Away Day*

This narrative was prompted by an away day of the Twelvetrees team. The Narrative Group agreed with me that my cynicism had truly started to show through for the first time. CJ suggested that I rein my cynicism in, lest it smother my practice.

24/01/08

Narrative: *What shall I?*

This narrative dealt with my further feelings of loss at the departure of the unit manager who provided the team with its inspiration to practise Recovery. CJ mentioned the possibility of introducing drama academics into the Narrative Group.

27/02/08

Narrative: *Man enters room*

For the first time in a narrative I was aware of the position of subjects sharing a

space with me, and I directly reported dialogue in an attempt to make the clinical experience described by the narrative more 'felt'.

This was also the first occasion that the drama academics joined the Narrative Group. From henceforth I shall refer to them as AP, AN and AB.

22/03/08

N1: *Voices for Radio*

I experimented with this narrative form by having five separate channels each interpreting a service user's psychotic dialogue in a slightly different way. The sound was cacophonous as I expected it to be. However I felt it was a successful experiment in narrative form insofar as it conveyed the cacophony of tensions within my practice. This was despite the comment by the drama academics that whilst it had merit it was literally impossible to listen to! I called it *Voices for Radio* because I imagined it as a multi-channel radio broadcast.

03/04/08

WORKSHOP

At this workshop in the University one of the drama studios had been booked for use by the narrative group. I enacted the narrative, *A Darkened Stage*, that I had just written, and I played the Manager opposite one of the drama academics who played the Woman. It was my first narrative written directly for performance. I was encouraged by its reception by the group, as it was immensely well-received, in particular as none of the other PhD students in the group had themselves attempted the form before. I felt self-conscious as I was acting (and had not before) and I was not prepared for the Woman's emotionality, anger and frustration as played by AN, and felt disconcerted and confused by it. Perhaps Recovery was already shrieking hysterically and frightened in my mind. CJ made a suggestion about the Manager (that is, me) being less passive in the situation as a means to empowerment and action.

25/06/08

Narrative: *Another sunny day in paradise*

This narrative took the form of contemporaneous thoughts from different aspects of my clinical practice all described at the same time. It was different from *Voices for Radio* because *Voices* was about service user experience (or my projection of it) of mental illness, whereas *Another sunny day* was trying to capture my own experience as a practitioner. It was interesting for me to hear different voices/influences all speaking at once; although it inevitably sounded cacophonous and the drama academics in the group suggested that I explore other ways of representing the different strands in one moment, rather than everything aurally at once! I was struck that I hadn't been able to convey how one voice at any one moment would have to be extant and decisive. However I was pleased that I was able to convey the psychological paralysis that I felt in my clinical practice, from all the psychological noise[33] generated by my practice.

07/07/08

With CJ and another PhD candidate I travelled to London to watch a performance of the play *Unstated* at the Southwark Playhouse. The play was in-the-round, a term which means that it can be viewed from all sides and the audience was free standing. I was never more than touching distance from the action. It was an immensely formative experience, as it helped me to gauge the extent to which the audience could physically (as well as intellectually) identify with the action. I used this perspective when writing future narratives, in that I wrote them as though I inhabited the action with the characters (rather than as an observer). That is, I could be 'a participant observer of the self' (Johns, 2006).

24/07/08

Narrative: *Twist*

This narrative continued from *A Darkened Stage*, in that the two main characters

[33] A term used to describe the way in which a person may respond to a message they receive from others (West and Turner, 2010: 13)

(The Manager and the Woman) resumed their friendly antipathy in this narrative. In an email I told another group member that I realised that I had started to connect my narratives as a coherent plot. This was not intentional.

25/09/08

Narratives: N15 *The Eclipse;* N16 *A Full Moon;* N17 *The Commissioner's Visit*

I had started to look forward to having my narratives read out by other group members. At this time I was so creative that sometimes I was submitting more than one narrative to the group. I was very encouraged by the laughter that *The Commissioners Visit* generated in the group, because I intended it to be funny.

15/10/08

Narrative: *A Scene in Grey*

Personally I like this scene, because it suggests romance between the Manager and the Woman, as they are already fond of each other. (The relationship was consistently a descriptor of my own relationship with Recovery.) The feeling of the group was that it didn't really 'fit' with the theme of the previous performance narratives, because of the overt flirting between the two characters.

12/11/08

Narrative: N19 *The Magic Man*

This narrative was well-received by the group, because it introduced new characters and imported the relationship between the Manager and the Woman directly into the clinical environment.

17/12/08

Narratives: N20 *An Invisible Woman;* N21 *A Glamorous Assistant*

Again I enjoyed the laughter generated by *A Glamorous Assistant*. AP said that she could not get as much out of the narrative as she would have liked. She commented that the characters were oblique for a non-nurse, and so suggested that I write commentaries to accompany each narrative in the future so that the non-nurse could understand the context and significance of the narrative. I

reluctantly agreed for of course it would be more work for me. However I agreed this would be useful, because it would indicate the extent to which my narratives are based on my practice.

14/01/09

Narrative: N22 *Livin' in the grotto*

This narrative again generated laughter in the Narrative Group; this gave me the confidence that the narrative style I was using successfully conveyed the messages about my clinical practice that I wanted it to.

04/02/09

WORKSHOP

AP had already asked me to re-write Narrative N14: *A Darkened Stage* in order to incorporate the insights suggested by the group at its first workshop on 03/04/08.

On this occasion it was acted by three drama students and directed by AP. I felt self-conscious watching the direction and the performance; it seemed alien in some way, as though it were not mine. I felt self-conscious in sitting watching something I had written being interpreted by others.

11/02/09

Narrative: N23 *The wall: a postscript.*

This narrative indicated a cessation of my data-collecting period concomitant with the closure of Twelvetrees. In the narrative group AP said that my narratives sounded as though they took place in a seedy old music hall theatre with creaking floorboards. I liked this image, because it sounded like my experience of the NHS! It gave me encouragement to continue to write my narratives, even though the data-collection period had ceased, though for my own pleasure and that of others.

06/07/09

PhD School

I was given a slot in the big dance studio at the university for one afternoon. I experimented with a rap, a reading of a poem about narrative, and presented an experimental paper. I felt it didn't work out and although people were polite about it I felt despondent. I hadn't researched the paper enough. The poem didn't make sense. I felt that the rap was satisfactory but that I didn't dramatize or rehearse it enough. I felt that I had experimented but that the experiment had failed.

24/09/09

Narrative: N24 *A New Job*

I posted this narrative onto the group internet message board. It was written following my redeployment to a nursing post working in a local community mental health team within the Trust. A fellow PhD candidate and group member, M, was very generous with her praise, which she emailed to the group, and which was tinged with encouragement.

25/11/09

Narrative: *That's it, I'm out.*

The title of this narrative is a meme from the BBCtv programme called *Dragons' Den*, whereby successful business people (known as 'dragons') are given the opportunity to invest in newly-founded businesses. If the dragon is not interested in making an investment then he or she says, "That's it, I'm out."

This narrative was informed by the anger and frustration I felt at my experience of nursing, and at yet another redeployment of the Unit manager to another role within the organisation. I felt like I'd had enough. I sensed a cold shiver go around the room as the reading ended.

By now my new role in the local community mental health team unfortunately precluded me from joining many of the Narrative Group afternoon meetings.

16/12/09

Narrative: N25 *A Jesus Meeting*

This was again posted to the internet message board of the Group. It described my practitioner experience of working in the community mental health team.

02/02/10

Narrative: N26 *Stick but no Carrot*

This was again posted to the internet message board of the Group in lieu of my no longer being able to attend the monthly narrative group meetings.

12/05/10

Narratives: N27 *Target Practice;* N28 *Disposal Day*

The narrative group had agreed to a break to last several weeks. However I continued to write narratives in the meantime.

At this meeting in May 2010 I felt enormously privileged to attend a Guided Reflection day of CJ's Masters students together with a group of Canadian students taught by another of the PhD candidates; even more privileged to have my final two narratives read aloud by the assembled group. I felt that some of the humour and cynicism contained in my texts were not fully appreciated, possibly due to cultural reasons or even that the format of the texts was unexpected.

These two narratives finally did indicate the ending of my data-collection period, as they also marked the cessation of my employment by the organisation.

An applied example of how I used The Six Dialogical Movements model to derive a narrative is represented below (Fig 2.7) A more detailed analysis regarding Narrative N12: A Jesus Meeting, can be found in the Appendices.

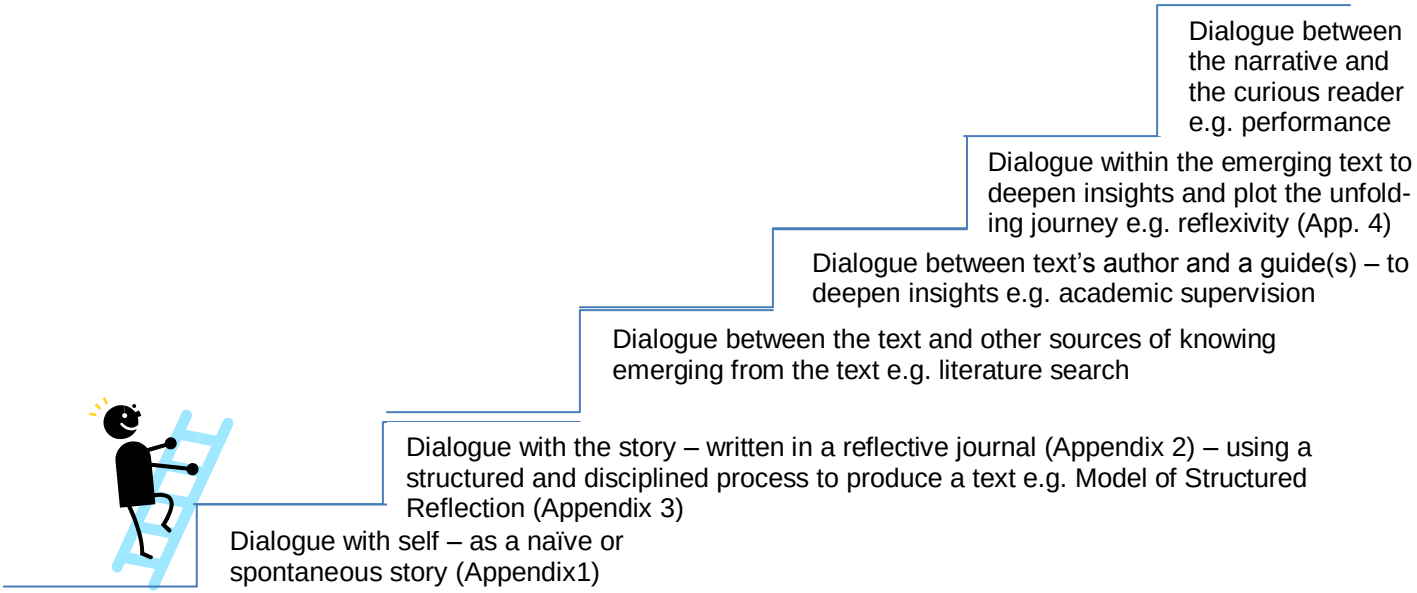

Fig 2.7 The Six Dialogical Movements applied

5th layer: Dialogue within the emerging text to deepen insights and weave the narrative into a coherent and reflexive pattern of form that adequately plots the unfolding journey

The dialogue that I had with my emerging narrative texts encouraged me to construct them as a coherent form containing an unfolding plot. My 'performance turn' was heavily influenced (if not precipitated by and then facilitated) by the fact that three of my academic guides were drama academics. Following AP's encouragement I decided to increase my knowledge of performance, as this was now the form that my narratives consistently began to take, and the medium in which I was finding myself to be most creative (and that was most cathartic). I found this form of narrative to be energizing and perspective-transforming for my own practice.

In fact I was immensely excited by the prospect of performance providing a conduit for me to influence other nurses.

> Drama (or 'live' performance) offers immediacy, a lack of mediation, nothing in-between self and other, self and event, self and action....Live performance is immediate; you share the same space and time with performers, and you - as audience - impact the performance itself with your attention and reactions. (Bell, 2008:240)

This immediacy and lack of mediation was exactly the means by which I wanted to enable nurses to learn of their own oppression and of the reality of mental health Recovery as it is implemented by existing mental health services. Live performance is an immediate experience for audience members (Pratt and Kirby, 2003).

It is precisely the act of the audience not knowing what is real and what is not real, in spectating a fictionalized account of nursing, that forces them "to play around with norms and conventions" in forming meaning (Pratt and Kirby, 2003: 19). My intention in writing performance narratives is precisely to bring about such a questioning by registered mental health nurses who seek to practice mental health Recovery, of the existing norms and conventions of nursing. Depiction of my practice as farce was not only a form of personal catharsis, but also a means to show my reality of working in practice in an oblique yet entertaining way. It was my intention for "fictionalised and farcical parts of the script [to] allow space to raise hard-hitting and very specific criticisms" (Pratt and Kirby, 2003: 19). Theatre is a particularly appropriate form for the depiction of nursing struggles, in that it "is able to convey a physicality that is itself integral to the professional lives of nurses" (Pratt and Kirby, 2003: 21).

Performance is "interactional in nature and involving symbolic forms and live bodies" (Stern and Henderson, 1993: 3); and always takes place within the context of the culture that influences us and which provides us with the means by which we will interpret it (Davidson, 1998). Through performance I intend ed for nurses to question the symbolic forms that they deal with everyday, and to interrogate the assumptions and norms embodied in their practice.

Representing clinical experience as performance also provided a creative

challenge for me, and was exacting, because performance is a form that I had not attempted directly. Curiosity is an essential component of creativity (Csikszentmihalyi, 1998). My creative curiosity was also evidenced by the various experiments in representational style that my narratives underwent prior to my performance turn, but which unfortunately are not included in the present study for reasons of space.

My performance narratives served to frame the insights that I had gained through my reflections. I liked to write the narratives as performance scenes because they required discipline, plot, coherence and *flow* (Figure 2.4). I found that my way of being "imaginative" and "playful" in constructing my narratives (Johns, 2006) was to dramatise them as allegory:

> Allegory is that aesthetic genre which lends itself par excellence to a description of man's alienation from objective reality. (Lukacs, 1979: 40)[34]

Lukacs (1979) contended that in the visual arts (such as in performance) allegory can be more apparent than in other milieu because descriptive details are both individual and typical, which is what can make it more illustrative of reality as a representational form (Schor, 2006). In my narrative texts I found myself amplifying both individual and typical characteristics of my nursing world in order to convey effect. To my mind allegory is most effective when one is observing or reading something that is apparently unconnected and *at the same time* realises the message that the creator of the piece intended. I wished for other nurses to experience this when reading my performance narratives (or seeing them staged).[35]

Play

However there is also a sinister side to such imagination and playfulness. 'Play' is "doing something 'not for real'" (Schechner, 2002: 79) and is intrinsically part of performing because it creates and frames the speculative (Schehner,

[34] The notion that there is an objective reality to be 'known' - and to be alienated 'from' - is itself of course problematic. (See Chapter One, p9)
[35] This is indicated by Level 6 of Figure 2.2 above

2002). ‘Dark play’ is furthermore irrational, because humans are irrational and dark games are enjoined for the thrill of them.

> Dark play subverts order, dissolves frames, and breaks down its own rules - unlike carnivals or ritual clowns whose inversions of established order is sanctioned by the authorities, dark play is truly subversive, its agendas always hidden. Dark play's goals are deceit, disruption, excess and gratification (Schechner, 2002: 107)

I connected with this idea that dark play explores and explodes the parameters of power, because that is what I sought to do in my narratives, which came to offer and describe a resistance – a counter narrative - to the world of practice that dominated my everyday existence. I sought to disrupt the taken-for-granted nursing world that I felt confronted me. My narratives played with my perceptions of my world, and this play extended to wish-fulfillment and magic and an indulgence of my own dark urges.

I chose to use humour in my performance narratives because it is an oblique strategy for conveying an important message (Adair 2011). This is neatly put by the character of Waters in the play *Comedians* (Griffiths, 1976). Waters is a former stand-up comic who has taken to teaching the next generation of stand up comedians at an evening class, tells his adult students:

> It’s not the jokes. It’s not the jokes. It’s what lies behind ’em. It’s the attitude. A real comedian – that’s a daring man. He dares to see what his listeners shy away from, fear to express. And what he sees is a sort of truth, about people, about their situation, about what hurts or terrifies people, about what’s hard, above all, about what they want. A joke releases the tension, says the unsayable, any joke pretty well. But a true joke, a comedian’s joke, has to do more than release tension, it has to liberate the will and the desire, it has to change the situation. (Griffiths, 1976: 20)

My reading of this speech is that humour offers more that is profound to an audience than simple text does. Sigmund Freud suggested that the invention contained in (and required by) humour bypasses taboos and allows primitive underlying impulses to express themselves in ways that the conscious mind would normally preclude (Smith, 1989: 8). Historically the use of humorous stereotypes is associated with the idea of the clown in theatre, whereby the grotesque body is a central feature of a topsy-turvy world which

> interrogates our familiar, stable world and questions its authoritarian monism. The grotesque body offers a symbolic subversion of the 'real' world, and questions its cultural authority with

various other carnivalesque postulations. (Brown *et. al.*, 2003: 250)

I wanted humour, farce and caricature to reveal the discourses that constrained my own desire of realising Recovery in my practice as a registered mental health nurse. In the carnivalesque, grotesque farces depicted in my narratives I felt that I was 'hitting back' at the nursing world in which I often felt I was struggling for air.

Dramatic farce has historically been regarded somewhat pejoratively as one-dimensional, shallow, insignificant and even lazy (Smith, 1989). However, notwithstanding that it is entertaining when done well, farce is nevertheless “the disguised fulfillment of repressed wishes” and is by its nature aggressive in that it requires a “ruthless, demonic energy” (Smith, 1989:9). The aim of farce is to make us accept that the impossible is possible, and to accept “the deranged as normal” (Smith, 1989:10). As my narratives reveal, I experienced much of my clinical practice as being “deranged” and bizarre; indeed sometimes the ridiculousness of my clinical practice seemed relentless.

Writing my narratives as fictionalized farce was a way for me to transmit the significance of the real practice experiences I encountered. Whilst in one sense all narrative research texts are fictionalized in that they are constructed (Barone, 2007), fiction can heighten the researcher's creativity and reflexivity because it is a way of allowing for characterizations (Nagy Hesse-Biber and Leavy, 2006). I found that resort to such characterizations enabled me to further abstract colleagues and individuals whom I encountered in my everyday practice, so rendering them anonymous. Fictionalization also permitted a range of emotional expression (Fayard and Metiu, 2009) that was not available to me in the anxiety-provoking world of my everyday practice.

Magical Realism

Magical Realism couched my narratives, because it seemed to correspond with the imagined nature of play. As a child I grew up enchanted by the magical tales

of *Alice in Wonderland* and *Through the Looking Glass* (Carroll, 1998) – and by subsequent media representations of them, such as Walt Disney (1951), BBCtv (1966), Joseph Shaftel Productions (1972), Hallmark Entertainment (1999). This enchantment flowed into my narratives, and I found that I naturally and spontaneously used magical realism in my narratives. Perhaps my resort to this device implied a resort to a child-like state that was innocent of the concerns and anxieties of the nursing world I experienced as an adult practitioner.

I find Magical Realism intriguing as a genre because it presents two different narrative modes ('magic' and 'realism') that must be loosely held together in suspension with neither having primacy (Slemon, 1995). Magic is the power of appearing to influence events through the deployment of mysterious or supernatural forces (Paperback Oxford English Dictionary, 2012), and in this way it is closely associated with play (Schechner, 2002). I resorted to magic in my narratives in order to influence reality in a way that I was unable to in my everyday practice. To use magic is to describe reality in a different way than the reality that is commonly known or privileged (Rogers, 2002).

Magical realist narratives offer a felt experience in their unreality, hyperbole and magic that “simulates the overwhelming effects of extreme experiences” (Langdon, 2011: 14). This resonated with me because I experienced many moments in my nursing practice as overwhelming and deranged. Magical realist narratives also offer a counter narrative in that they confound usual (or privileged) structures of space, time and perception (Langdon, 2011), in that magic questions the taken-for-grantedness of reality. For this reason magical realist narratives are well-suited to the reflexive process of narrative self-inquiry because they beg examination of the many different influences upon a text that have been drawn from the narrator's experience and imagination (Langdon, 2011).

Magical realism was a useful strategy for me because it enabled me to set up a counter-narrative to that I encountered in my everyday practice, at the same

time as empowering me to represent clinical experiences that engendered emotions that were otherwise too extreme for me to cope with and to manage.

6th layer: Dialogue between the narrative and the curious narrative reader responding to the invitation to dialogue

Magical realism is a means for the reader to access a felt sense of the struggle of my everyday practice as a mental health nurse. My intention is for the nurse who reads my texts to recognise this felt sense in him or herself and to act upon that; and for the style of the narrative to disrupt the curious reader's taken-for-grantedness of reality.

Dramaturgy

However my intention does not end at the stage of narrative text, for a further dimension that my texts offer is that they are written drama, which is one of the simpler definitions of the term dramaturgy (Luckhurst, 2008). Hunt and Benford (1997) contend that the process of dramaturgy is like social research in that both processes share four characteristics:

● scripting (constructing a set of directions that define the scene, identify actions and describe expected behaviour)

● staging (the process of gathering and administering materials and audiences; in particular of using symbols that are understandable and known to the audience)

● performing (actioning and presenting one's research)

● interpreting (the process of determining 'what is going on' through understanding the meaning of symbols, talk and action)

This sociological sense of the term evolved from Goffman's adoption of the metaphor of theatre (Goffman, 1990), whereby for people social life is like actors appearing on the stage with a social self, and a real (or 'back stage') self that is not seen (Macionis and Plummer, 2008: 2004). In this way not only do my narrative texts offer the curious reader the opportunity to dialogue with them,

but dramaturgy (both in the sociological and in the theatrical-dramatic sense) offers the curious spectator the opportunity to dialogue with the performances as the member of an audience. The postmodern questioning of all modes of representation forces the curious spectator of a performance to question their own perceptions (Shaughnessy, 2011). On two occasions during the course of this study I witnessed separate performances of one of my narrative texts. This showed that my narratives can readily be staged and consist of both depth and character at the same time.

I feel that the impact that I wish my narratives to elicit from the staging of them is most aptly described by Ellis (2004: 208), who described the live performance of narrative as:

> a forum for ongoing and open dialogue that involves the text, performer, and audience. Performance is not so much representational as it is dialogic and conversational. Performance of personal narrative doesn't skirt representational issues; it complicates them.

I do not lay claim to present events *as they really happened*. Rather, my depictions of events and processes from my nursing practice are as I experienced them whilst I was employed by one particular organisation – no more, and no less. They are the way that I have chosen to represent my lived reality most closely. If any of my colleagues were to report on the same events and process, their own experience of them may very well be different from my own. Similarly nurses working in other organisations will report their own experiences of transformation differently. From my privileged position as narrator, I can lay no claim to truth except that it is *my* truth. My own truth is entertaining, playful, passionate and angry; my perceptions arise from within a psychological schema as indicated in Chapter One. Perhaps my narratives may resonate with the curious reader who may share my perceptions, or they may choose to dismiss them. I can ask for no more other than that they are considered. In the following chapter they are laid out chronologically.

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CHAPTER THREE

THE NARRATIVES

N1

A darkened stage

10/12/07

(Revised 16/11/08)

DRAMATIS PERSONNAE:

NARRATOR[1]

COMPERE

STAGEHAND

THE MANAGER[2]

WOMAN[3]

HECKLER

DOCTOR[4]

[A darkened stage, empty except for a lectern spotlighted in the middle of the stage.

A second spotlight follows a man walking towards the front of the stage, accompanied by applause. He is dressed in a velvet velour suit, wearing a white dress shirt with frills on the front and a bow tie. His hair is slicked back. He holds a microphone limply in his hand, the cable of the microphone dragging across the stage as he walks. He speaks.]

THE COMPERE: [*Blows into the microphone twice and the sound system squeals agonisingly*. *He looks to the wings*.] Is this working? Is it working? Am I on? [*After a pause he turns to the audience*] Oh, hello, ladeezangenlemenn – a liddle technical probleemo there, ladeezangenlemenn – welcome to our liddle – hey hey hey – theatre tonight where we have for you an exciting show, ladeezangenlemenn – lader there are appearances from Sam the Dancing Fireman, Igor the Flamethrower – his only appearance in the UK this year, ladeezangenlemenn – and the Silesian State Circus. But first – please put your hands together for his first appearance in front of an audience – he's a very nervous fellow, bless him – let's all say [*audience participation*] "Aahhh" –

[1] Reads the stage directions
[2] Newly-appointed and 'acting-up' into a management role
[3] Personification of mental health Recovery
[4] A non-speaking part, but always on-stage and always in the way of the action so that characters often have to move around him/her

ladeezangenlemenn I'm sure you'll be jennul with him – please give it up for – The Managerrr….!!!

[*THE COMPERE raises an arm in the direction of one side of the stage at the arrival of a man dressed in an ill-fitting suit. THE COMPERE leaves the stage. A stagehand scurries onto the stage and moves the lectern closer to the audience, then scurries off stage again. As the man in the ill-fitting suit walks across from the wings he is accompanied by respectful applause. The spotlight halts as he stands at the lectern and grips the edges with his hands. In front of it the lectern has a microphone on a stand, into which the man leans forward to speak.*]

THE MANAGER: [*Waits for the applause to subside*]. Ladies and gentlemen – since I became a manager….

[*Pauses to let the last few ripples of applause peter out*]

…. Since I became a manager my priorities have changed….

[*Boos and hoots of derision*] [*Shifts uncomfortably on his feet. Leans forward earnestly*]

[*Protestingly*] Even Davidson et al[1] said that mental health Recovery will take "at least a generation" to fully influence mental health services….

…I have inherited a team that was once a beacon of light for Recovery in the organisation – a team that was once, as our SERVICE MANAGER described it, a paradise island but is now a deserted one….

[*More laughter*]

[1] Davidson *et al*. (2006)

[*Raises his voice*] …But it is time to rebuild those bridges to the mainland! [*Gestures with a clenched right fist, to great cheers*] Ladies and gentlemen – this is where it all began!!

[*More cheers and great applause, drowning out the musical accompaniment of Fanfare for the Common Man*[1] *that strikes up*]

But, ladies and gentlemen, I am sorry to say, when we dreamed of Recovery we were asleep while we dreamed!

[*Laughter*]

I'm not a fan of Key Performance Indicators[2] – but, as you all will know, we came out very badly in the organisation's recent KPI Audit Report…

[*Boos*]

…And I wasn't even managing the unit at the time the audit was done!

[*Laughter]*

[*Another spot light focuses on a huge backdrop of former Conservative Prime Minister John Major*[3], which hangs from the ceiling]

So, from that point on, it was back to basics. New Labour might say it was time to hit the ground running…

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[1] Copland, A (1980)
[2] Key Performance Indicators [KPIs] are quantifiable measurements that reflect the critical success factors of an organization (Reh, 2012)
[3] British politician who was Prime Minister of the United Kingdom and Leader of the British Conservative Party from 1990 to 1997, known for his "Back to Basics" morality campaign, which somewhat backfired when the UK media exposed the moral hypocrisy of some MPs in Major's own Party.

[*Laughter. The spotlight on the picture of John Major goes out*]

But how can one run when one has forgotten how to walk…?

[*Cheers*]

Even I – even I -, ladies and gentlemen, didn't know what I was supposed to be doing!

[*Much tutting and clicking of tongues*]

When fortuitously the organization's new Practice Development Practitioner had emailed me to introduce himself and set a meeting up. [*Pause*] And I mentioned this to the SERVICE MANAGER who was also meeting with me because she was new in post. [*Pause*] It seems she then had a word in the Practice Development Practitioner's shell-like…

[*Laughter*]

… and he told me what to do in order for us to pull ourselves up by our bootstraps. [*Pause*] Serendipity, my friends! Serendipity! [*Cheers*] The best things happen by chance! [*Pause*] [*Earnestly*] Ladies and gentlemen, he is full of ideas. In fact, I am humbled that he has so many. He keeps saying, "I tend to talk a lot so do stop me if I go on too much" But, you know, ladies and gentlemen, I never want him to, I want to build a firm foundation on which to build our Recovery house. Just like…

[*Pauses and lean forwards, looking intense*]

Just like the man who built his house on the rocks instead of the shifting sand!

[*Applause*]

HECKLER: So what's your insight from all this, then?

[*Laughter*]

THE MANAGER: [*Thinks self-consciously for a moment. Shuffles his feet*] That a baseline to practice is necessary so that we can plot how we can achieve ideal practice.

HECKLER: But whose baseline?

[*THE MANAGER leans back and removes the microphone from its stand in front of the lectern. He steps out from behind the lectern. The lights come up, though still dimmed*]

THE MANAGER: Well, in terms of clinical governance[1] what chance do we have?…

[*THE MANAGER's attention is drawn by a scuffle in the wings followed by a shout. A WOMAN looking dishevelled, with long black hair and a torn print dress and wearing no shoes, scatters onto the stage*]

WOMAN: [*screaming the words*] But what about me? What about myself and my sisters, Compassion and Mercy? What about us?

[*THE MANAGER takes a step backwards, is obviously discomfited. WOMAN marches up to him and looks him in the face. She jabs a finger in his face*]

[1] A systematic approach to maintaining and improving the quality of patient care within a health system (NSW, 2011)

WOMAN: [*Still screaming her words*] But what about Recovery? You bastard! [*She falls to the floor. Her left leg stretches along the floor and both arms clutch the ankle. She leans her head towards her knee so that her lank hair falls across the leg.*]

THE MANAGER: But I don't know what to do!

WOMAN: [*screams*]

THE MANAGER: [*Panicking*] Look. Please. I don't know what to say. I don't know what to do!

[*WOMAN is lying on the floor in front of him; she is screaming and her body is quaking with rage*]

THE MANAGER: But I can do – THIS! [*He tears open his suit and shirt to reveal a T-shirt that contains the legend JESUS LOVES THIS GUY, in huge white letters*] And I will pray for you, my sister; I will pray for you. I can do that. [*Shuts his eyes tightly and raises a hand which hovers above her*] Lord, I pray that you may take away this woman's spirit of despair…

[*WOMAN looks up, now touching her ankle lightly with both thumbs*]

WOMAN: Are you mad? Are you fucking mad? You don't get it do you? You simply don't get it!

THE MANAGER: [*Opens his eyes*] Er….

WOMAN: [*Leans backwards, both palms behind her and flat on the floor, and looks up at him*] You've lost the plot. Where's your anger? Where's your rebellion? Where's the cynicism that fired you? Where's your "inner émigré"? Your "wood kern"? Where's the exposure[1] that frightened you away from that company of wolves, forcing you to grab heat and solace where you could find it? Where's your *soul*? Now you're just like one of them!"

THE MANAGER: But it's not up to me. The organization's made the rules. 'He who pays the piper', etc.…

WOMAN: You've sold out. The devil's bought your soul. People like you always have an excuse for giving up….

THE MANAGER: Things have changed. I've changed…. Now I can change things.

WOMAN: [*Starts sobbing*] But I can't wait.

[*The man moves an arm as if to comfort her, but he withdraws the arm*]

WOMAN: By the time I've finished waiting it'll be too late.

THE MANAGER: [*Soothingly*] I know, I know.

[*WOMAN springs to her feet. She takes a step backwards and stares at him. She clenches her fists at her sides*]

[1] Poem: *Exposure*, by Seamus Heaney (Appendix 5)

WOMAN: [*Screaming*] Don't say "I know I know" when you don't know, when you don't understand, when you don't even know me, when you don't know how long I've waited already.[*Shrieks*] When I can't wait any more. I can't wait; I can't. [*Breaks into sobs*]

THE MANAGER: But I have to do it this way. This is the only way. Now – now I can change the system from the inside.

WOMAN: [*Holds her arms out wide*] But just look at me. Just look at what you've done to me. Can't you see? [*Pauses*] And you'll end up just like them. Just like them. You're deluded if you think otherwise.

THE MANAGER: But I am sufficiently reflexive not to be…

WOMAN: [*Mockingly*] "But I am sufficiently reflexive…" - Oh, you're so pompous. I trusted you when you were cynical, when you were exposed. Greedily, I would watch you. When you used to hide around corners and inhabit the margins[1] so that you wouldn't be seen. I had such high hopes of you. You seemed so much more in touch with my own oppression in those days.

THE MANAGER: I still am. In that way nothing's changed. Not really.

WOMAN: Nothing's changed? You're telling me nothing's changed? Everything's changed! I don't know you anymore.

THE MANAGER: Yes. Yes. All right. I'm wrong. I'm sorry. Things *have* changed. A lot has changed. But I still want you to be around. I still see myself in terms of you.

[1] Rinehart (1994)

WOMAN: [*Faltering*] And I – and I – I have no choice but to believe you. I *have* to believe. [*Stands proudly*] I have to believe in myself. [*Pauses*] But sometimes I feel…I feel…

THE MANAGER: Yes? You feel what…?

WOMAN: …Sometimes I feel like I'm drowning; not waving, but drowning[1]

THE MANAGER: And if somebody is drowning you help them out of the ocean. [*Pause*] Take my hand. [*WOMAN hesitates*] Take it – take it….

[*WOMAN takes the man's hand. She links her arm in his. The lights dim and they depart stage left, her in animated discussion with him, he listening. Applause.*]

[SCENE ENDS]

[1] Smith, S. (1998)

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N2

Eclipse

12/01/08

DRAMATIS PERSONNAE:

NARRATOR

THE MANAGER

WOMAN

SERVICE MANAGER[1]

DOCTOR

[*THE MANAGER and a WOMAN (The SERVICE MANAGER) are dressed for the sunshine, lying on sun loungers on an empty stage, spotlighted. She is wearing a turquoise sarong and is lying on her front, having WOMAN, wearing a faded white linen dress, is rubbing suntan lotion into her shoulders. THE MANAGER is dressed in a pair of swimming shorts, with is suit folded over the back of the lounger, and is lying back with a straw hat over his face*.]

SERVICE MANAGER: [*To THE MANAGER*] It's hot today.

[*Silence*]

WOMAN: Here, you'd better use this. [*Throws the bottle of sun tan lotion toward THE MANAGER. He sits up with a start as it lands on his stomach. He picks it up and places it on the ground beside him. WOMAN exits. THE MANAGER lies back down and replaces the hat over his head*.]

SERVICE MANAGER: [*Turns & leans on one side towards THE MANAGER*.] I'm sorry…. [*Pause*] I'm sorry to have to tell you…I'm afraid you weren't successful at interview. [*She takes a deep breath*] …So I'm not going to offer you the post of team manager.

THE MANAGER: [*Still with his hat over his face*] Oh.

[1] Oversees the mental health service, part of which is managed by The Manager. Reports to the Service Director who sits on the Trust Board

SERVICE MANAGER: [*Lies back on the sun lounger*] You just didn't do as well as the other candidate on the day. [*Silence*] I'm sorry.

THE MANAGER: Oh.

SERVICE MANAGER: [*Sits up, leans on one elbow and looks at him*] So how do you feel?

THE MANAGER: [*Pause*] Disappointed. Very disappointed. [*Rueful grin*]

SERVICE MANAGER: It's the hardest thing I've had to do in a long while – tell you. You've done a really phenomenal job here. [*Silence*] And the Deputy Manager's vacancy will be coming up soon: you could apply for that.

THE MANAGER: But there's no point me applying if I give a bad interview.

SERVICE MANAGER: [I*rritated*] But your interview was fine. [*Lies back on sun lounger*] Just…not the best one.

THE MANAGER: But that's not what you've just said! [*Pause*] So why didn't I do as well as the other candidate?

SERVICE MANAGER: [*Thoughtful*] I can't remember why exactly – I should have brought your score sheet with me – but I do remember you didn't mention the work you've done with the KPIs – which is an enormous piece of work – and perhaps with a little bit more confidence….

THE MANAGER: But I only answered the questions you asked me. You didn't ask me about things I'd done, how I'd developed the service. If you'd asked me, I would've told you.

[*Pause*]

SERVICE MANAGER: But I really want to develop you. [Smiles] You are like an iceberg. We've only just started to see flashes of what you can do. All that knowledge…all that experience….

[*Silence*]

THE MANAGER: You don't know me at all. Do you.

SERVICE MANAGER: I can understand why you are angry, and I'm hoping that two weeks away now will have eased the hurt by the time you come back. [*Silence*] What I want is for you to work alongside the new team manager for a week. I thought you had another week before going on leave. It'll have to wait until you get back.

THE MANAGER: And then I'll go back to being Deputy and in the meantime the substantive Deputy post will be advertised? [*The SERVICE MANAGER nods*] But the new team manager is someone who was promoted past me. I should resign in protest.

SERVICE MANAGER: I hope you won't. I hope you will still carry on as Deputy for the time being – so long as you still want the job.

THE MANAGER: I understand. It's a business. And you've made a business decision. You want what you think is best for your service, that's all. One thing about you is that you are always scrupulously fair.

SERVICE MANAGER: [*Thoughtful*] So how *do* you feel now?

THE MANAGER: [*Rueful smile*] I feel as though I am waiting for the universe to realign itself. For the chaos to reorder.

SERVICE MANAGER: [*Looks puzzled*] But what will you do now?

THE MANAGER: I'll turn this into art. This moment. My moment in the sun. Well not art – into drama. [*THE SERVICE MANAGER continues to look puzzled and confused*]

[*WOMAN enters carrying a round tray on which are placed two cocktails, each containing a bendy straw and a miniature paper umbrella*]

WOMAN: Your drink, madam *[hands The SERVICE MANAGER a glass. WOMAN walks around to face THE MANAGER and throws the other drink over him*.] And here's yours, dickhead….

[*THE SERVICE MANAGER looks alarmed. WOMAN exits*.]

THE MANAGER: [*To the SERVICE MANAGER*] Well, you know, she's just a little bit *tetchy today….*

SERVICE MANAGER: So I see. [*Embarrassed. Pauses*] All right then…[*looking at her watch*] I've got an appointment over the road at half past. I've got to go.

[*As the SERVICE MANAGER stand up the stage folds into darkness. SCENE ENDS*]

N3

A FULL MOON

02/04/08

DRAMATIS PERSONNAE:

NARRATOR

THE MANAGER

WOMAN

SERVICE MANAGER

DOCTOR

[*THE MANAGER and WOMAN are sitting next to each other on a stone wall, at dusk. Church bells can be heard in the distance and the sound of children playing. THE MANAGER is without his tie and ill-fitting jacket. His shirt sleeves are rolled up*]

THE MANAGER: All my hopes, all my dreams. What will happen to them all?

WOMAN: You can still have them. Don't lose them.

THE MANAGER: How can I ever realise them now? My face doesn't fit, that's all. Never has and never will.

WOMAN: Carry your hope. Two steps forward, one step back. That's what you always say.

THE MANAGER: I woke up one night. It was so quiet. I thought of how badly I wanted to die. I realised how utterly, utterly alone I was. I thought how I would drive down to the beach at midnight… [*a video backdrop appears of a benighted lagoon. THE MANAGER is seen from behind, looking out to sea. He slowly undresses and walks into the sea. We watch him go into the sea. We then see him dip his head under the water*]…strip naked and walk into the sea. And hold my head underneath the water until my lungs fill with water and I can't breathe. I would expect to feel a few seconds of panic and then… quiet…nothing. Release… [*Pauses while the video display behind suddenly erupts with the noise of water, spluttering and gasping as THE MANAGER emerges from the*

water]…I wanted to die. It's too much. The last 3 months have been too much. I was disadvantaged at the interview – I was so tired.

WOMAN: [*Puts an arm around him, squeezing his shoulder*] You know I love you, don't you. Despite everything. Don't give up. We still have us. Don't give up. We don't need much of anything. Don't give up – somewhere there's a place where we belong.[1] We need each other.

THE MANAGER: I'm so unhappy.

WOMAN. It's not over. It's not. It's not.

[*Video display shows the same lagoon with WOMAN also staring out to sea. She undresses and walks out into the sea. THE MANAGER and WOMAN are swimming together.*]

[*A pause as the audience watches the video*]

Hello? [*A voice from the wings. A WOMAN walks onto the stage across to where THE MANAGER and WOMAN are sitting on the wall. It is the SERVICE MANAGER.*]

SERVICE MANAGER: Hello.

WOMAN and **THE MANAGER** [*together*]: Hello.

SERVICE MANAGER: [*addressing THE MANAGER*] There's been a change in the management situation.

WOMAN and **THE MANAGER** [*together*]: What's that?

[1] Gabriel (1986)

SERVICE MANAGER: [*Wearily*] The successful candidate decided not to take up the post after all.

THE MANAGER: Oh.

SERVICE MANAGER: [*Wearily*] So I can offer you the post.

THE MANAGER: I want to say yes but can I think about it? [*WOMAN kicks him lightly on the shin*]

WOMAN: [*Whispers to THE MANAGER*] Why won't you take it?

SERVICE MANAGER: [*Looks at WOMAN then at THE MANAGER*] Of course.

THE MANAGER: When do you need to know by?

SERVICE MANAGER: Well really as soon as possible. Otherwise I will have to think about re-advertising the position.

THE MANAGER: Okay – can I let you know before the end of tomorrow.

SERVICE MANAGER: Sure. [*She exits*]

WOMAN: So you got the job.

THE MANAGER: But I'm second best – nobody can change that.

WOMAN: [*Thoughtful*] Yes, I suppose you might think that.

THE MANAGER: And I figure that I'd carry on doing the job anyway even until she finds somebody who will do the job. So at least this way it's official.

WOMAN: So are things better now?

THE MANAGER: Not really. I know I am second choice, second best -and that really sticks in my craw.

WOMAN: So what about us now?

THE MANAGER: I've changed. The damage is done. I feel more…more…well, less committed – because the Trust doesn't want me. ME. And I've realised something: it's not me who has betrayed you – they have. You see – when it was just me you could see my face, so you could blame me. *They* hide their faces and speak great words until times like now when they have to emerge from the shadows and ask and appoint. I've realised that they don't want me because it is me – they want me because I'm already here. Now I know it isn't because of me.

[*SCENE ENDS*]

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N4

THE COMMISSIONER'S VISIT

20/06/08

DRAMATIS PERSONNAE:

THE NARRATOR

MAJOR MAULING[1]

THE MANAGER

WOMAN

SERVICE MANAGER

DOCTOR

[*The SERVICE MANAGER, together with THE MANAGER, WOMAN, and a large, rotund woman wearing an army uniform with jodhpurs and carrying a pointer stick in one hand. THE MANAGER is wearing his ill-fitting suit. WOMAN is wearing a faded white linen dress. The SERVICE MANAGER is dressed smartly but not formally*]

SERVICE MANAGER: This is Major Mauling from the commissioners.

THE MANAGER: [*Nods in the direction of the MAJOR*] Hello.

MAJOR: Good day, my good fellow. Now, let's have a look around this place.

SERVICE MANAGER: The Major will particularly be looking at ligature points and at risk management.

WOMAN: [*Whispers to THE MANAGER*] Whatever happened to positive risk taking?[2]

THE MANAGER: Ssshh! [*Laughs]* I know. They don't want to be sued into a black hole…

[1] A lead member of the body – the Primary Care Trust - which locally purchases mental health service from the mental health NHS Trust

[2] Promoting Safety and Positive Risk Taking is one of the ten essential capabilities for mental health workers (Department of Health, 2004)

MAJOR MAULING: [*Ostentatiously clears her throat*] Are we talking to somebody, there? No? Now then, let's start. [*Looks at the SERVICE MANAGER*]. I'm on a schedule. Quite a tight one as it happens. [*She taps her pointer on a door frame*] This, for example – could do with a lick of paint. [*The SERVICE MANAGER nods obediently*]

WOMAN: [*Aside to THE MANAGER*] Well give us some more money and we can afford to do it! [*Receives a withering look from the SERVICE MANAGER. The MAJOR marches on ahead*]

SERVICE MANAGER: [*To THE MANAGER*] Whatever she says – don't argue. We are just there to answer her questions. And don't make excuses; she'll hate that.

MAJOR MAULING: Come on then, chaps. I want to see some examples of areas in the house where patients are unobserved. Where's a good place to start?

WOMAN: [*Aside to THE MANAGER*] Why doesn't she call us "service users" instead of "patients"! I hate being called a "patient"![3]

SERVICE MANAGER: [*Quickly*] Ssshh!

MAJOR MAULING: What happens here then?

THE MANAGER: People wash their clothes.

MAJOR MAULING: [*Slaps her pointer down on the top of a nearby washing machine*] I did not come here to be derided, young man. A bit of respect, if you

[3] In Recovery, language must be used which meets the needs of service users and not of professionals (Turner-Crowson and Wallcraft, 2002)

please. [*Has a quick look around, like a dog sniffing the breeze*] [*To THE MANAGER*] Can patients be seen when they are in this room? [*THE MANAGER shakes his head*] All right, then, that's not good enough. [*Walks out of the room*] Close this room, it's dangerous.

SERVICE MANAGER: Well this room is used all the time for….

MAJOR MAULING: [*Turns to the SERVICE MANAGER*] Could you at least install some cameras? Which can be viewed from the office?

SERVICE MANAGER: [*Nods*] Yes. Of course.

MAJOR MAULING: [*Tapping her pointer against the walls as she proceeds, as though she were non-sighted and carries a blind stick*] Nice house. Robust. [*Turning to THE MANAGER*] Is it Victorian? [*THE MANAGER nods*] They certainly don't build houses like they used to, what?

WOMAN: [*Sniggers*] "What, what?" I didn't say anything! [*The SERVICE MANAGER fires a withering look at WOMAN. THE MANAGER smiles broadly.*]

MAJOR MAULING: [*Discomfited by the others*] What's the joke? Please share the joke, eh? I hate to be excluded from such levity [*Slaps her pointer down on top of a washing machine to such an extent that the others jump.*]

WOMAN: [*Aside to THE MANAGER*] She can't see me, can she?

THE MANAGER: I don't think she can….

WOMAN: [*Pulls a face at the MAJOR, and wiggles her fingers in her ears*] Ddlddlddlddlddlddlddlddlddl!! [*No response from the MAJOR*] See? [*With both hands repeatedly gestures V-signs in the MAJOR's direction.*] You're a crazy woman, you are! [*To THE MANAGER*] I'm going to love this!!

THE MANAGER: [*To WOMAN*] Come on – can't you see we're trying to be serious?

MAJOR MAULING: Serious? Serious? I can assure you, young man, if somebody hangs themselves here it'll be your neck on the old chopping block. [*Thinks to herself. Caught out by an unintentional pun*] So I suggest you pay attention.

THE MANAGER: Sorry, Major….

MAJOR MAULING: It's not 'Major'. [*Tenderly*] Please call me, 'Felicity.'

WOMAN: [*Bursts out laughing behind her hand*] Felicity?!! [*Releases her hand*]Hahahahaha!

SERVICE MANAGER: Certainly, Felicity….

MAJOR MAULING: [*Passes a staircase that leads upwards. Raps her pointer on the wall*] Asbestos, so I see, judging by the yellow label high up on the wall there. Of course, this wall is sealed, I trust?! [*The SERVICE MANAGER looks at THE MANAGER*]

THE MANAGER: Yes, Felicity.

WOMAN: [*Teasing*] "Yes, Felicity. No, Felicity. Three bags full, Felicity." [*Giggles*]

THE MANAGER: [*Pushes WOMAN gently*] Will you give us a break, please? This is bad enough without you being a complete idiot.

WOMAN: But she can't see me – The old bat can't see me. [*Calls to the MAJOR*] Felicity, Felicity? Ooo-oo – over here! [*Waves her hands above her*

head] [*Pauses upon realising*] If she can't see me, she can't see Recovery, can she?

THE MANAGER: Recovery isn't her priority.

WOMAN: Her priority seems to be waving that stupid stick in the direction of anything. God help us.

THE MANAGER: But she's got the money. [*WOMAN is suddenly sullen*] And they who pay the piper, etcetera…Now do you see what I've meant all along? It's never been up to me!

MAJOR MAULING: What? What? What's not up to you?

THE MANAGER: Oh, I'm sorry Felicity, I was just thinking aloud. I was distracted.

MAJOR MAULING: Well, let's focus please. I don't have much time. I want to see as much here as I am able. [*Marching off again*] Now – the main kitchen, where's that?

[*They all arrive in the main kitchen. A service user is making a cup of tea at the side*]

MAJOR MAULING: [*To the service user*] I say, my good fellow, do you like living here, what?

[*The service user looks at her blankly, mutters something under his breath and strolls out of the room, his cup of tea quivering in his hand*]

MAJOR MAULING: I say – what a rum fellow!! [*Points her stick at a corner of the room*] Cobwebs!! Does nobody clean here?

THE MANAGER: In keeping with the philosophy of care in the unit, service users take it in turns to clean one area of the house each week day…

MAJOR MAULING: [*Still pointing*] Well somebody's missed this. Don't you have cleaners here?

THE MANAGER: The residents *are* the cleaners, Felicity…

MAJOR MAULING: Well, we can't have that, you know. [*Looks at the SERVICE MANAGER*] What about patient safety? The house looks dirty.

WOMAN: [*With disgust*] What about positive risk taking? You stupid woman….

THE MANAGER: Well, Felicity, the philosophy of the unit is about mental health Recovery… [*The SERVICE MANAGER gives him a withering look*]

MAJOR MAULING: We don't want any of those namby pamby ideas, you know. We just don't want to get sued if somebody catches some old lurgy and dies. And we want what we pay for.

SERVICE MANAGER: [*Arms folded, tense*] Yes, Felicity. [*THE MANAGER gives the SERVICE MANAGER a questioning look*] Where would you like to look now?

MAJOR MAULING: [*Raps the refrigerator with her pointer stick*] The padlock on this refrigerator [*stoops to squint closer at it*]. What's this for?

THE MANAGER: To be able to circulate stock.

WOMAN: It's because they don't trust us. The fascists!

SERVICE MANAGER: It enables the unit to rotate stock…

MAJOR MAULING: So the new stock is locked away until it can be used…?

THE MANAGER: [*Together with the SERVICE MANAGER*] Yes, Felicity.

WOMAN: [*Taunting*] "*Yes*, Felicity…."

MAJOR MAULING: But I'm not sure you should be doing that…

THE MANAGER: Oh?

MAJOR MAULING: Human rights. Not permitted and all that. [*Pause*] Let's go! Upstairs now! [*Pulls her left arm ostentatiously out in front of her face. Peers at the watch on her wrist. Scowls*] Only got time to look at a couple more things. A patient's bedroom. Have you got bathrooms here?

THE MANAGER: Yes…

SERVICE MANAGER: [*Looks hopefully at THE MANAGER*] They've recently been refurbished.

THE MANAGER: Yes - they were completed three months ago

WOMAN: But, oh, the problems since then. The subcontractors were a bunch of cowboys. Done just to save some money, I'll bet. Estates are here every week to sort out some problem or other. [*Turns to THE MANAGER*] Aren't you going to tell her that, then?

THE MANAGER: [*Whispers to WOMAN*] I don't think she needs to know.

WOMAN: [*Loudly*] Oh, *I* think so. That's what we have to suffer because the bunch of shysters at the top of this organisation keep trying to cut corners on

cost. But they can always find money for new directors, oh yes….

THE MANAGER: [*To WOMAN*] It doesn't matter how loudly you say things, she still can't hear you.

WOMAN: [*Petulant*] Well, she should be able to!

[*By now they are upstairs, THE MANAGER is proudly showing the new bathroom, adjacent to an equally new shower room*]

THE MANAGER: And these are the new…

MAJOR MAULING: [*Looks upward into the bathroom*] Yes, I can see that. Very nice. [*Turns her attention to the shower room. Raps the shower cubicle with her stick*] I don't like that.

THE MANAGER: [*Together with the SERVICE MANAGER*] What's that, Felicity?

WOMAN: [*Taunting*] "*What's that,* Felicity?" [*THE MANAGER turns to look at WOMAN*]

MAJOR MAULING: The shower cubicle. Very nice. But…

THE MANAGER: But…?

MAJOR MAULING: It's a ligature risk. Somebody can hang themselves from that. It's fixed to the wall. [*Walks away*] Close it. [*Silence*] Is there one on the second floor?

SERVICE MANAGER: Yes.

MAJOR MAULING: Close that one also.

WOMAN: [*First to THE MANAGER, then to the SERVICE MANAGER*] Is this woman mad? How are we going to get clean?

SERVICE MANAGER: But Felicity; people need to wash and these rooms also have en suite toilet facil…

MAJOR MAULING: They can bathe in the bathrooms of course…but…very well. Restrict access to the shower rooms. Until they can be sorted out.

SERVICE MANAGER: [*To THE MANAGER*] Can you do that?

THE MANAGER: Yes, sure, we can lock them while they're not in use….

WOMAN: [*To THE MANAGER*] Can't you get rid of this woman? She's ripping this place apart! [*THE MANAGER shakes his head, and shrugs his shoulders with his arms outstretched.*]

MAJOR MAULING: Do that then. [*Stands in the middle of the corridor. Sees a light on the wall. Points to it with her stick*] What's that light for then?

THE MANAGER: Well, it's an…

MAJOR MAULING: Part of the patient call system is it?

THE MANAGER: Yes, Felicity.

WOMAN: [*To THE MANAGER*] No it's not, its part of the personal alarm system that staff use. Why did you tell her something else? Liar, liar – pants on fire hahahaha! [*With one hand pushes him playfully*] You're afraid of her, aren't you?

THE MANAGER: [*Wearily, and to WOMAN*] No, I just want to get this over with….

MAJOR MAULING: [*Has marched into a service user's room, the door of which was open. The room is light and empty*] Big room, this, what?

THE MANAGER: Yes, they are good sized rooms here.

MAJOR MAULING: Are all the patients' rooms this size? [*THE MANAGER nods.*]

WOMAN: [*Laughing*] No, they're not all this size. Some of them are *tiny*….

MAJOR MAULING: [P*oints to a brown stain on the ceiling*] Is that damp there?

THE MANAGER: Yes.

MAJOR MAULING: How long has it been there?

THE MANAGER: Oh, I don't know. At least as long as I've been here, which is six and a half years.

MAJOR MAULING: And it's never been painted over?

THE MANAGER: No.

WOMAN: [*Leans across THE MANAGER in a threatening manner towards the MAJOR. THE MANAGER restrains WOMAN with his forearm outstretched.*] Yeah, well, if you gave us some more money, you old witch, perhaps we could get it repaired. This lovely old house is falling apart, you tight wad…

THE MANAGER: [*Rounds on WOMAN*] Look will you shut up – this really isn't helping…

MAJOR MAULING: [*To the SERVICE MANAGER*] Make sure it's done, will you?

SERVICE MANAGER: Yes, Felicity. [*To THE MANAGER*] Will you make sure that gets reported? [*THE MANAGER nods*]

[*The MAJOR marches back downstairs. The others follow. A brief conversation ensues in front of the entrance door*]

MAJOR MAULING: Well, I've seen enough, thank you.

[*SERVICE MANAGER and THE MANAGER both give an audible release of breath*]

SERVICE MANAGER: I hope it's been informative, Felicity.

MAJOR MAULING: [*Vigorously shakes THE MANAGER's hand*] Nice place you have here, young man.

THE MANAGER: Thank you, I'm glad you….

MAJOR MAULING: Good bye, then! [*Opens the entrance door and exits. The SERVICE MANAGER follows her. The SERVICE MANAGER as she leaves turns to THE MANAGER and mouths the words "Thank you" to him as though she is immensely relieved. He smiles in return*]

WOMAN: [*Watches the MAJOR leave. Shouts after her*] Goodbye and good riddance! And don't come back!

THE MANAGER: [*To nobody*] Well that's it then.

WOMAN: That's what?

THE MANAGER: We're stuffed. Like turkeys waiting for Christmas. It's over. Recovery: our great mental health experiment….

WOMAN: It's not over. It's not. It's not. [*Thoughtful*] It seems like I've said *that* recently….[*Turns to smile at THE MANAGER*. *He smiles in return*]

[SCENE ENDS]

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N5

THE MAGIC MAN

12/11/08

DRAMATIS PERSONAE:

THE NARRATOR

BOB and DAVE[1]

MAGIC MIKE[2]

THE MANAGER

JOHN[3]

DOCTOR

[*A large room in a Victorian house. The walls are separated by a grubby dado rail that travels all the way around the room. The lower walls are coated in rough plaster. The top walls have peeling salmon pink wallpaper. The furniture in the room is covered with plastic; and a large corrugated box is one corner of the room, with a picture of a wide screen television on it. Two men, BOB and DAVE, are standing in the centre of the room. Both are dressed in cerise-coloured trousers and polo-shirts. They have tattoos on their forearms. The room is dominated by a bay window containing UPVC sash windows on one side of the room, where light floods in because there are no lined curtains and only a few net curtains.*

A figure clad in black – black boots, black balaclava – is wearing a pair of red underpants on the over their trousers, and swings from a rope into view of the window and thuds against it.

BOB and DAVE look up.]

BOB: What the fuck was that…?

DAVE: Oh, some knob head just hit the window. That's not something you see every day….

[1] Workers in the Trust's own Estates Department
[2] The new Trust Chief Executive and Superhero, Class Two
[3] Service user

[*The black-clad figure stands up and motions with their arms, palms raised, to open the window. The letters 'MAGIC MIKE' are emblazoned in white across the figure's chest. BOB goes over the window, followed by DAVE, and opens it slightly, using the same motion*. *The black clad figure bends down to where the gap in the window appears.*]

MAGIC MIKE: [*A man's voice, muffled through the balaclava he is wearing*] Can't you open this any wider?

BOB: [*also bending down at the gap to speak*] Sorry, mate – HTM55[4] – can't open it more than 100mm. We had to put stoppers on the frames. [*Pauses*] Can't have people jumping out of ground floor windows, don't you know. [*DAVE sniggers*]

MAGIC MIKE: [*still muffled*] So how can I get in? I'm the new Chief Executive.

BOB: Dunno, mate. Didn't they tell you about this Trust? Once you're in you can't get out – but you have to get in first!

Dave: [*to BOB*] He can go round the front.

BOB: [*to DAVE*] Oh, yeah – that's right. [*To MAGIC MIKE*] You can go round the front. Second door along on the right.

[*BOB stands up as the black-clad figure disappears and a few seconds later we hear the sound of an electric buzz. A pause. Then another buzz, this time slightly longer. Another pause. Then a very long buzz. A cufuffle is heard off stage including raised voices and then the black-clad figure emerges into the room through the doorway. He pulls the balaclava off his head.*]

[4] Safety alert on restriction of window openings (Department of Health, 2007)

MAGIC MIKE: [*extends his right hand, whilst holding the balaclava in his left*]: Hello, I'm Mike – Magic Mike – Superhero, Class Two. [*BOB and DAVE each shake his hand in turn.*] And I believe in patient safety and in service quality. And I used to be a nurse. But not now. Now I'm a Chief Executive. But you can call me, 'Mike'.

BOB: Well, good luck, mate, is all I can say. After what happened to the last one. After he was sacked and all.

MAGIC MIKE: He wasn't sacked; he was asked to step down.

BOB: Well, I dunno about that. Sounds like a sacking to me.

MAGIC MIKE: Well, he remains a personal friend of mine – in fact we only met for lunch the other day – my brief is to continue the excellent work he started. He was doing a superb job….

DAVE: [*to BOB*] He sounds like Mark Anthony come to bury Caesar…

BOB: *throws DAVE a quizzical look*] What the fuck are you on about now…?

DAVE: [*discomfited*] You know, the scene in *Julius Caesar* where….

BOB: [s*uddenly realises*] Ohhh – you mean like pissing on somebody's funeral pyre….

DAVE: [*shocked*] Yes, I suppose so….

[*A pause*]

MAGIC MIKE: I'm sorry I took so long to come round. The staff told me they couldn't answer the door because there was nobody in the main office as they were sitting with the patients; and then they couldn't recognise me on the CCTV so they had to use the intercom….

[*THE MANAGER walks into the room, dressed in his ill-fitting suit. He extends a hand to MAGIC MIKE*]

THE MANAGER: Hello, I'm the manager here. Sorry I wasn't around when you arrived; I was working on the fourth draft of our anti-ligature survey.

MAGIC MIKE: [*shakes THE MANAGER's hand*] Hello, I'm Mike…

BOB: But you can call him 'Magic'… [*DAVE chuckles*]

MAGIC MIKE: I'm the new interim Chief Executive.

THE MANAGER: Oh, interim? In what sense 'interim'?

MAGIC MIKE: Two and a half days a week.

BOB: You'll need more than, mate, if you're going to sort out this shambles.

MAGIC MIKE: [*to THE MANAGER*] But I'm already working for my own Trust. And I also do inspections for the Department of Health.

BOB: So what does the missus say, she must hardly ever see you?

MAGIC MIKE: I'm married to the job; just ask my colleagues.

THE MANAGER: So how long are you working with this Trust for?

MAGIC MIKE: Three months, maybe more. But initially three months.

THE MANAGER: So why are you here?

MAGIC MIKE: The SHA[5] have dropped me in.

BOB: Wot? Bloody fly in, did ya? Did ya? [*Looks at DAVE and smirks*]

[*BOB and DAVE giggle loudly. MAGIC MIKE gives them a withering look and continues*]

MAGIC MIKE: [*Sternly*] They asked me to help out. The Commissioners[6] were about to pull the contract for mental health services provided by this Trust, as it was worrying so much about becoming a Foundation Trust[7] that it was forgetting what it should be doing,

THE MANAGER: But the Commissioners aren't helping us. We had a visit from one of them recently, and she tore the place to pieces.[8]

MAGIC MIKE: But you must understand that after that patient hanged themselves on one of the other units…

THE MANAGER: Fine, but that's a bit like closing the stable door after the horse has gone – if this Trust had listened to the safety reps when the proposal was made originally – and there are only two of them in the organisation – you can't staff a crisis unit with just one support worker, which is what happened . It was an accident waiting to happen….

[5] Strategic Health Authority
[6] The Primary Care Trust
[7] Foundation NHS Trusts are intended to devolve decision-making from central government control to local organizations and communities. They are permitted much more financial independence of the NHS, such as the ability to raise money on the open market and control over its own assets (Pollock, 200)
[8] Narrative N4:*The Commissioner's Visit*

MAGIC MIKE: It's done in the community. [*Changes the subject*] And anyway, well, I'm sure this Trust took their concerns into account when it made its decision. I always listen to what my staff side is saying. In fact, only the other day the Staff side Chair said to me, "Mike, I'm really glad that you're the Chief Executive of this Trust". After all it's the staff who deliver the service on the front line.

THE MANAGER: But now the nurses can't do what they should be doing because we're crippled by having to minimise every single ligature risk. And Estates can't do what they should be doing because [*turns to BOB*] Bob – tell him what you told me the other day. I was going home at a quarter to six one night when I met Bob and Dave outside the house….

BOB: [S*miling*] You mean how we have to do all the anti-ligature work in our normal hours and all our normal work as overtime…. [*DAVE nods his head and smiles*] Which is okay for us, like, as two weeks ago we weren't even allowed to do any overtime at all….

THE MANAGER: [*To MAGIC MIKE*] And what about Recovery?

MAGIC MIKE: What's that?

THE MANAGER: [*To BOB and DAVE, exasperated. Throws his arms in the air*] Do you see what I'm up against?

BOB: No. Sorry mate, what's it to us? Our job is just to sort this room out after the damp proofing's been done. Your job is to choose whether you want wallpaper or paint on the walls and what colour.

THE MANAGER: Ah, yes, important things like that. [*DAVE sniggers*]

MAGIC MIKE: Hmm. I see. [*Looks around the room*] Some windows have net

curtains, some don't.

THE MANAGER: For some net curtains we had only wire to hang them up; and we didn't have enough collapsible curtain tracks. So the wires had to come down.

MAGIC MIKE: Because…?

THE MANAGER: Because… Because apparently people are likely to garrotte themselves using curtain wire….

BOB: And we can't change them because we're too busy elsewhere in the Trust doing all the anti-ligature work. This place'll have to wait until we can get around to it.

MAGIC MIKE: So why aren't there more of you?

BOB: Because they sacked half of us all when we were Shared Services.[9]

THE MANAGER: [*to MAGIC MIKE*] So - do you really want this job?

MAGIC MIKE: Well, we'll see how much I can do.

[*A man – JOHN - enters the room.*]

JOHN: Oh, hello. Is it okay if I watch the television in here?

THE MANAGER: Hello, John. [*Indicates towards MAGIC MIKE, as JOHN already knows BOB and Mike*] This is the new Chief Executive - Mike.

[9] A means of one organisation providing a particular service (e.g., Human Resources, business, finance, estates, or IT) across several NHS Trusts, so pooling resources and improving efficiency. (Ormsby and Vincent, 2009)

[*MAGIC MIKE moves towards JOHN and shakes his hand*.]

MAGIC MIKE: Hello, JOHN, I'm Mike. I believe in patient safety and in quality of service. And I used to be nurse.

JOHN: [*shakes MAGIC MIKE's hand limply*]. Oh, yes, hello, mate. [*Looks in the corner of the room at the large box and then turns to THE MANAGER*] I thought you said you'd got a bracket to put the television on the wall?

THE MANAGER: [*Looks pointedly at MAGIC MIKE*] Well, yes, I did buy one – for two hundred quid as you know – but then all this anti-ligature work started in the Trust and I got told that we can't put it up on the wall in case somebody tries to hang themselves from it.

JOHN: Oh, fuck that – who would want to do something as stupid as that in a place like this?

THE MANAGER: [L*ooks at MAGIC MIKE*] Exactly. Do you see what I mean? [*Pauses. Bows his head*] Please excuse me - I'm just leaving the room to shoot myself….

[*THE MANAGER exits*]

[*SCENE ENDS*]

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N6

AN INVISIBLE WOMAN

26/11/08

DRAMATIS PERSONAE:

THE NARRATOR

THE MANAGER

WOMAN

MAGIC MIKE

THE QUEEN[1]

A COURTIER

DOCTOR

[*The stage is in darkness. We hear THE MANAGER calling out*, "Rita? Where are you?" *The lights suddenly go up to reveal THE MANAGER wandering the stage with his arms outstretched in front of him. He is wearing is ill-fitting suit but without the jacket, and with his tie slung loosely around his neck]*

THE MANAGER: Rita? Rita? Where are you? I can't see you!

[*WOMAN's disembodied voice calls out,* "I'm here. I'm here."]

THE MANAGER: But I can't see you. Where are you?

WOMAN: [*Still her disembodied voice*] "I'm here – I'm over here."

[*THE MANAGER moves in the direction of her voice*]

THE MANAGER: [*Still with his arms outstretched before him*] But I can't see you! Why can't I see you?

WOMAN: I don't know. Because I'm here. I'm right in front of you.

[*A light nosily spotlights her as he collides with WOMAN. There are now two*

[1] Unit Manager

spotlights – one on him and one on her. She is wearing her dirty white shift. She laughs].

WOMAN: You really can't see me, can you? [*She starts to walk around him; the spotlight remains fixed, and she moves in and out of it as she walks*]

THE MANAGER: No – but I can hear you. And I don't understand why I can only hear you.

WOMAN: [*Thinking*] But you know how the Major couldn't see me?

THE MANAGER: [*Ponderously*] Yes.

WOMAN: Well – she couldn't hear me either, do you remember?

THE MANAGER: No – I mean, Yes.

WOMAN: Well…well, perhaps you can't see me but you can only hear me. [*She halts, in the fixed spotlight*]

[*THE MANAGER turns, to face away from her, side-on*.]

THE MANAGER: Yes. And? I know that!

[*She resumes the walk around him as she talks*]

WOMAN: Well, suppose that she couldn't see me and she couldn't hear me because she doesn't know about Recovery…she didn't want to hear and she couldn't see….

THE MANAGER: [*Turning around on the spot as if to catch her moving voice*] So…?

WOMAN: So – suppose you can only hear me because right now you can only hear my voice and not see me. As if…as if…

THE MANAGER: As if…what?

WOMAN: I don't think you're going to like this….

[*THE MANAGER turns to face the other way, confused.*].

THE MANAGER: So try me….

WOMAN: Perhaps you're losing touch with Recovery. All you have is my voice. [*Pause*] Which, so it seems, you can hardly follow.

THE MANAGER: Nonsense. Now you're talking nonsense.

WOMAN: Well, it makes sense to me.

THE MANAGER: But you're being irrational. You've always been irrational. You're not making any sense.

WOMAN: [*Halts in the spotlight*] Okay – so you explain it then.

THE MANAGER: [*Hesitates*] But I can't.

[*A cheery voice sounds from the back of the stage. It is the figure of the Grim Reaper, carrying a scythe. The figure is spotlighted, marches forward and stands..*]

MAGIC MIKE: [*For it is he, dressed as the Grim Reaper. Removes his Grim Reaper mask.*] Helloooo!! It's me – MAGIC MIKE. Do you remember me?! Superhero, Class Two. I believe in patient safety and in service quality. And I used to be a nurse. [*Turns to WOMAN*] Hello my dear…. [*Pause. Then to both*] I'm sorry that you may both not have recognized me – I'm in one of my many disguises, in case you hadn't noticed. Devilishly effective, don't you think? Could you tell?

THE MANAGER: [*Blustering*] Hang on, hang on - two things….

MAGIC MIKE: What two things?

THE MANAGER: Firstly, why are you dressed as The Grim Reaper?

MAGIC MIKE: Well, I've just come from the Trust Board's welcoming party for me. I was going to go either as The Grim Reaper or as Long John Silver – [*cackles and hops on the spot on one leg as he says*] "Pieces of eight! Pieces of eight!"…But I wanted to make a statement, you see. Being dressed as the Grim Reaper sort of indicates to the Board that I mean a certain type of business – don't you think? You should have seen the reaction! It really gave them the willies, I can tell you! [*Chuckles to himself*]

THE MANAGER: And why can you see Rita but I can only hear her voice?

MAGIC MIKE: Well, I've already been here in this Trust for a few weeks and the Directors have been telling me all about the young lady over there [*cursorily nods in her direction*] …

THE MANAGER: [*Incredulous*] Young lady?! Which young lady? I don't see a young lady?! [*WOMAN giggles*]

[*A paean of trumpets from the wings. Six men walk onto the stage, dressed as mediaeval trumpeters, with hairstyles to match. Flags hang from their trumpets. They stand in line as they play them. A female figure bustles noisily into view, dressed in a huge black-and-gold-hooped ball gown with a train held up by a group of maids who have trouble keeping up with her busy movements. Other courtiers hover around THE QUEEN, fawning and fluttering. The courtiers and the maids are all singing,*

"Feed me, feed me
You know you need me
I'm your one and only Queen Bee[2]

[*PIM*[3] *follows the throng, carrying a clipboard which she periodically scribbles upon throughout THE QUEEN's ensuing address. Also following is RAY*[4]*, who stands throughout THE QUEEN's ensuing address, his arms folded across his chest and from time to time shaking his head wearily. Also SERVICE MANAGER, who stands patiently with her hands clasped in front of her thighs*]

THE QUEEN: Now, now, stop all this fawning and fluttering about me. Tut, tut. Goodness me, anybody would think I've been away on a long voyage.

A COURTIER: But ma'am, you have indeed been away for some time….

THE QUEEN: [*Shouts*] ENOUGH! How dare you address me without first being very graciously asked to take part in a three hundred and sixty degree appraisal [*to the audience, and fluttering her fan*] which incidentally I shall probably ignore anyway…tut…these people are *such* peasants….[*Louder*] Guards – OFF WITH HIS HEAD!!

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[2] Wootton (2003)
[3] Personification of 'Personal Information Management' i.e., the data recording system in operation at the mental health Trust. Introduced in a previous Scene not included here, entitled *A Game of Twist*
[4] A cynical, experienced mental nurse, also introduced in *A Game of Twist*

[*Two soldiers come on stage and remove the offending courtier, who protests.*]

THE QUEEN: [*To the assembled company*] Now – does anybody else nurture such insolence in their heart?

[*A guilty silence*]

THE QUEEN: Good. I have something to say.

[*THE QUEEN takes a folded piece of paper from her bosom and flaps it open with one hand. She gestures to a maid who walks up to her and pinches THE QUEEN's nose and holds it as she talks. THE QUEEN reads from the paper.*]

THE QUEEN: [*nasally and in a posh voice*] Upon this, my glorious return to my realm, my SERVICE MANAGER and I have resolved to reintroduce recovery throughout this land. [*The courtiers all applaud and chatter excitedly amongst each other*.]

[*Pause*]

THE QUEEN: I am pleased at this opportunity to reacquaint myself with you, my loyal subjects, to the extent that I wonder what on earth you have all been doing for the past twelve months during my absence. [*Pause*] Since my glorious return I have observed you all and quite frankly it doesn't look like recovery to me. [*Turns briefly to nod in the direction of THE MANAGER and then back again*] I and my deputy are both committed to the ideals of recovery. But I am going away for a while to visit the neighbouring realm of Business Management as one day I shall be an Empress, so in the meantime my deputy will be holding the fort. [*Pause*] Here endeth my glorious speech. Your Queen has spoken.

[*The maid releases her grasp on THE QUEEN's nose*]

THE QUEEN: [*To the courtiers*] Now, now, come on, come on, let's go - I've got an assignment to finish…. [*A paean of trumpets, accompanied by much bustling and clumsy fawning as THE QUEEN departs. The paean of trumpets dissolves into a half-hearted cacophony.*.]

MAGIC MIKE: Hmm. Right. Looks like my cue to leave as well. Jolly ho! Another opportunity to go and terrorise a few directors. [*As he exits he makes exaggerated, Ninja-esque movements and wild faux-warrior shouts whilst waving his scythe in the air, as if attacking an invisible enemy.*]

[*A long pause after MAGIC MIKE exits*]

THE MANAGER: What the…?

WOMAN: Is that you? Aren't you the deputy?

THE MANAGER: [F*or he can see her now*] Yes. That's me.

WOMAN: What are you going to do?

THE MANAGER: I'll give it some time, see what happens. I'm not going to do her job for her, though.

WOMAN: But what about Recovery?

THE MANAGER: Oh, you heard her. She said she's reintroducing it. [*Pause*] But as far as I'm concerned it never left.

WOMAN: It wasn't very visible, though. I think that's what she's saying.

THE MANAGER: Yeah, yeah. But the Organisation didn't help me. I had no management support and the team was carrying half-a-dozen vacancies all that time. In fact, I'm fed up with saying it - nobody seems to listen. Even *your* eyes glaze over when I start talking about it.

WOMAN: That's because you say it so often. You must draw a line under it; take this as an opportunity.

THE MANAGER: I don't know, Rita, I really don't know. This doesn't feel like an opportunity to me. I'm not a dreamer. I'm not a visionary. I'm Oliver Cromwell to her Prince Charles the First.

WOMAN: But you don't have to be a visionary. Recovery is very earthy. It is something everyday, mundane, ordinary. It's not something you 'do' – it's something you are, it's something that infuses practice.

THE MANAGER: Tell the Organisation that. Tell them to stop auditing us to death, and perhaps we'll have time to breathe. In this organisation, Recovery is like swimming above the Great Barrier Reef with your face in the water but without a snorkel. You see the beauty and you want to see more, but you can only see it for as long as you can hold your breath. And all the time the experience is spoiled by you wandering how much longer you can hold your breath for.

WOMAN: [S*miles*] You know I can't stop them auditing. You know they have their own priorities.

THE MANAGER: Ha! That makes me smile. Do you remember how once *you* used to accuse *me* of making an accommodation with them? Now you should hear yourself!

[*Pause*]

THE MANAGER: It's you who've changed, not me. And it's me who sees you as you are, standing here in that dirty white linen dress. They dress you in fine clothes and extravagant lace before they will even look at you, and demand that you hang onto the crook of their arm as if you are a trophy wife.

WOMAN: [L*ooks at the ground in front of her. Moves her foot slightly*.] I think…I think you're not too far from the truth, there. About what's happening to me. I don't like it.

[*One of THE QUEEN's trumpeters walks onto the stage. He stands at the back of the stage and raises his trumpet. He sounds several off-key notes from the instrument and then walks off again*.]

[*Lights fade to black*.]

[*SCENE ENDS*]

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N7

A GLAMOROUS ASSISTANT

17/12/08

DRAMATIS PERSONAE:

THE NARRATOR

THE COMPERE

THE MANAGER

THE AUDIENCE MEMBER

MAGIC MIKE

RITA[1]

THE QUEEN

THE COURTIERS

DOCTOR

[A darkened empty stage. A spotlight follows a man walk onto the stage, accompanied by applause. It is THE COMPERE, from previous scenes. He is dressed in the same velvet velour suit, wearing the same white dress shirt with frills on the front and a bow tie. His hair is still slicked back. He holds a microphone limply in his hand, gently trailing the cable of the microphone through his other hand as he walks across the stage to the centre where he stops to speak.

[*The microphone squeals as he leans into it. He taps it several times with a finger.*]

THE COMPERE: Ladeezangennulmen – good evening, ladeezangennulmen, welcome to our liddle show this evening I'm sure you will have a wonderful time ladeezangennulmen - let me just first off let me introduce to you an exciting new act who have worked hard to come this far in a comparatively short length of time… Ladeezangennulmen…will you please give it up for…welcome please…THE MANAGER and his glamorous assistant…the very lovely Reedaaaaaaaa!

[1] Was WOMAN

[*Applause. THE COMPERE raises an arm in the direction of one side of the stage as THE MANAGER, dressed in a top coat and tails, strides confidently into view followed by an elegantly-gaited RITA, who is dressed like a Las Vegas showgirl, all arms and gesture. THE COMPERE leaves the stage. On it the stage has a small table containing a magician's props, a larger table covered by a silk cloth on which there are several random objects, and a long rectangular box on stilts at the back of the stage and draped with a silk cloth.*]

THE MANAGER: Hello, ladies and gentlemen. [*RITA continually sways and feints sideways Vs with her arms, continually changing from one leg to the other and smiling forcedly*]. For my first trick I will ask a member of the audience to choose a card – here, sir, pick a card, any card. [*THE MANAGER gestures with the pack of cards towards a member of the audience, who reluctantly comes up onto the stage to the sound of applause and takes a card*] Now – [*THE AUDIENCE MEMBER is about to show THE MANAGER what's on the card*] don't show it to me, don't show it to me! [*To the audience, then back to THE AUDIENCE MEMBER*] Now, sir, if you would please…take a good look at the card [*THE AUDIENCE MEMBER looks at the card*] and put it back into the pack [*THE MANAGER proffers him the pack of cards, and the man inserts the card back into the pack*]. Now sir – and here is the trick – [*to the audience*] prepare to be amazed at this one [*giggles*] – Sir [*still giggling*], sir, just imagine you are a Director of the Trust, somebody on the Board perhaps [*THE AUDIENCE MEMBER nods*]. Sir, what was the card you looked at?

AUDIENCE MEMBER: [C*onfused*] The Jack of Spades.

THE MANAGER: Yes, sir, that's right – [*swings around to face the audience*] it was the Jack of Spades! [*Met with silence by the audience*] [*Turns back to the AUDIENCE MEMBER*] And what was the last thing you thought of, as you took the card, looked at it and then put it back? [*AUDIENCE MEMBER looks confused*] What was the last thing, sir – oh, come now, what was it? What was it? [*AUDIENCE MEMBER continues to look confused*] [*THE MANAGER, tersely*

now] What, sir, was the very thing furthest from your mind? [*AUDIENCE MEMBER still confused*] I venture to you, sir…I venture that the thing furthest from your mind at that moment was…Recovery!!! [*Turns to the audience, his arms outstretched to the sides, and bows, to be met with an unenthusiastic ripple of applause*]

[*Then THE MANAGER walks over to the small table which has a number of objects on it.*]

THE MANAGER: And now, for my next trick, ladies and gentlemen – for my next trick – imagine…just imagine with me for just one moment will you, that what is on this table represents the Trust, is established mental health services, and I shall pull the tablecloth away from under all these objects and nothing – not a thing – shall be disturbed, and everything will be as usual, which is what established mental health services want from Recovery. [*Takes a hold of the cloth.*] Well, ladies and gentleman, let us see – let's see shall we whether I can do this, let's see what I can do [*Whips the cloth away from the table. Everything crashes to the floor.*] [*Smiles*] Oops! [*A Pause. Opens his body to the audience, arms triumphantly outstretched, holding the cloth in one hand. Bows.*] And that – ladies and gentleman – THAT is mental health recovery!!

[*A stunned silence. Occasional muted clapping as some people in the audience realise the analogy.*]

THE MANAGER: [*Addresses the audience*] Ah…I think perhaps we may have some Board members here tonight, ladies and gentleman, WHO DO NOT KNOW WHAT THE FUCK I AM TALKING ABOUT!! [*He smiles*]

[*The embarrassment of the audience is almost audible. A very lengthy and uncomfortable silence follows.*]

THE MANAGER: [*Gestures towards the large rectangular box on stilts at the*

back of the stage. RITA self-consciously teeters over to the box and still forcedly smiling to the audience removes the cloth. She throws up her arms in a gesture of welcome, one knee bent towards the other, smiling, and as she does so throws the silk cloth offstage.] Ladies and gentlemen, ladies and gentlemen – now the lovely RITA will, in the absence of any management support for me and also insufficient staffing, and in order to comply with the demands of the Directorate[2] – attempt to saw me into fifteen equal parts so that I can supervise everybody in the team and do their IPDRs[3] with them.

[*Silence*] [*Enter the Magic Man. He is dressed from head to toe in a white suit, shirt and tie, and white shoes.]*

MAGIC MIKE: [*Confused*] Hello, oh hello everyone, sorry I'm a bit late – am I in the right place?[4]

THE MANAGER: For…?

MAGIC MIKE: Well, I was sort of in another dimension a moment ago, the SHA want me to be in so many places at the same time, and I do have my proper job as well, you see, that they gave me this time machine[5] to help but, really, it's very difficult to keep a track sometimes of where I actually am. It's very stressful….

THE MANAGER: [*Incredulously*] Well, yes, I'm sure it is…especially if you're doing time travel and everything….

MAGIC MIKE: Yes, well, Einstein was sort of right when he said that time bends – or was that gravity? – I don't know, I am so disorientated by all this business –

[2] In the organisation mental health services are divided into Directorates based upon the age of each service user group
[3] Individual Personal Development Review
[4] Based on the exceptionally late Second Coming of the Great Prophet Zarquon (in Adams,1991), only moments before the universe itself ended
[5] Based on the character Reg in Adams (1988)

anyway, he was only partially-correct you see, because time doesn't so much bend as fold over on itself….

THE MANAGER: Is that so.…

MAGIC MIKE: Well, yes, indeed, it's a very interesting thing, you see, very interesting[6]…now [*looks at THE MANAGER*] oh yes, and one other thing…did you know I can make myself invisible…it's a very useful thing, you see [*clicks his fingers in front of himself and momentarily squints as he does so*.[7] Opens his eyes. Tries again. And again. Turns to the audience and waves a hand as he leaves] Then I really can't stay, I'm afraid. Goodbye, everyone. Goodbye….

[*Loud applause from the audience. The applause ripples away and there is a moment's silence*]

THE MANAGER: [*To RITA*] So shall we still do the sawing thing then?

RITA: No. I think the audience get the message: you're fed up. [*Pause*] Anyway, now THE QUEEN is back isn't she supposed to do most of it?

THE MANAGER: I don't know, I'd like to get the chance to even ask her. Where is she? I can never find her when I want her. She manages by email.

RITA: So email her then….

[*A clarion of trumpets is heard from the wings. THE QUEEN makes her usual entrance.*]

[6] I base this character on that of Slartibast in *The Hitch Hikers Guide to the Galaxy* (Adams, 1979), who won an award for designing all the fjords around Norway

[7] Based on the character Bert Campbell, from the US sitcom, *Soap* (1978). During the series, Bert spends time as a patient in a mental hospital in order to be treated for his delusion that he is invisible.

THE QUEEN: Goodness me, goodness me, this is a poor apology for Recovery…. Didn't you get my letter saying that the whole team really need to pull their socks up a bit?

THE MANAGER: Well, this is sort of more *about* Recovery than being Recovery itself. [*Pause*] And anyway you showed me the letter before you sent it out. I should have told you not to: it's really upset the team.

THE QUEEN: Well, you know how it is – oh, of course you don't, because you're not Royalty like I am, tut, how remiss of me to think that YOU might understand – I have to make my mark now that I have so gloriously reascended to the Throne of Recovery.

THE MANAGER: Somebody told me that you might be leaving again soon.

THE QUEEN: I can't help it if my people love me. I am a very popular Sovereign.

THE MANAGER: [*To RITA*] Oh, really?

THE QUEEN: [*Scrutinising him, can't decide whether or not he is being insolent.*] Yes, really…

RITA: [*curtseying*] I am sure Your Majesty will have a long and glorious reign.

THE QUEEN: [*waving her fan before her face*] Oh, thank you, my dear. [*Then, as an afterthought*] At least until I get my degree.

[*THE COURTIERS all cheer and say, 'All hail our great and glorious and well-educated Queen!'*]

THE QUEEN: [*looks at RITA suspiciously, up and down*] My dear, whatever possessed you to dress like that? My dear, you look like a concubine.

RITA: This? Oh, this – I'm just helping him [*nods at THE MANAGER*] with some magic tricks.

THE QUEEN: Goodness me, oh goodness me, what on earth is this 'magic' thing?

THE MANAGER: [*bows in an exaggerated fashion*] Your Majesty, if it so please Your Majesty…these are just analogies by which I may show to others in an accessible way how difficult it is to integrate mental health Recovery with existing mental health services….

THE QUEEN: Tut, really, I have never heard such nonsense. I want you to implement recovery, so just implement recovery. What could be easier than that? I really fail to understand why you people simply cannot take orders.

RITA: If it so please Your Highness, some of the team have not had an IPDR for three years….

THE QUEEN: Well, that has nothing to do with me, my dear. I wasn't here for most of that time….

THE MANAGER: [*under his breath*] Which is exactly my point….

THE QUEEN: [*heard THE MANAGER but is not sure what he said*] [*To RITA*] But, my dear, can't you help this young man with his predicament?

RITA: [*curtseys*] Yes. But if it so please Your Majesty….

THE QUEEN: And as for you [*looks at THE MANAGER*] – I shall advertise your post. [*Sternly*] As a permanent one….. [*THE QUEEN exits to a paean of trumpets which fades cacophonously at her hurried departure.*]

[*SCENE ENDS*]

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N8

LIVIN' IN THE GROTTO

(A risk to Christmas)

14/01/09

DRAMATIS PERSONNAE:

NARRATOR

CHIEF ELF[1]

ELVES #1, **#2**, **#3**, **#4**, & **#5**[2]

BOB and **DAVE**

SANTA[3]

JOHN

DOCTOR

[*Backdrop: 'Toytown NHS Trust' and underneath it the legend 'Santa's Grotto'. THE MANAGER dressed as CHIEF ELF. Five other ELVES.]*

CHIEF ELF: Has anyone seen the new observation policy yet?

ELF #1: No

ELF #2: No

ELF #3: No

ELF #4: No

ELF #5: No

CHIEF ELF: [*Holding a piece of paper in one hand*] Well, this has been given to us by Santa Claus.

[*All the ELVES groan*]

[1] Aka THE MANAGER
[2] Colleague nurses and support workers
[3] Aka MAGIC MIKE

CHIEF ELF: Actually, it's now called the 'Observation Through Care Engagement' Policy.

ELF #1: So what does *that* mean?

CHIEF ELF: It means that we now have to talk to somebody when we check on their whereabouts.

ELF #2: Why?

CHIEF ELF: Er…to make sure they're breathing.

ELF #2: [*To ELF #1*] Only this Trust could state the obvious like that. I think they think we're all hopeless…..

CHIEF ELF: And so that you can say that you've [*makes the inverted commas sign with his fingers*] 'engaged' with service users in a [*again*] 'caring' way.

ELF #3: But it's just talking to somebody for God's sake. Like we don't already.

ELF #4: And if they're not breathing then you can't [*mimics the same quotation marks gesture*] 'engage' with them…because they'll be dead.

CHIEF ELF: [*Smiles*] And I couldn't stand the paperwork. And all the telephone calls from the Risk Management Department. Did we do this, did we do that. Constantly - all day, all day.

ELF #5: And it's like teaching your grandmother how to suck eggs.

ELF #3: Yes, it's a bit obvious, don't you think? Do we really have to be told to talk to somebody?

CHIEF ELF: Yes, it's obvious, I know. [*Sarcastically*] But it's all supported by evidence in the policy. [*Pause*] The problem with evidence is that it's always so selective. I mean, there's no evidence in the new policy document saying that it's a load of crap.

ELF #4: Which it sounds as if it is.

ELF #3: Yes…are you sure Rudolph didn't write it?

ELF #2: Heehee. He probably dipped his antlers into some ink and just dribbled it over the page.

ELF #4: Yeah – that sounds more like it.

ELF #1: You see that couldn't happen in real life. Did you know that in the reindeer world only the females have antlers?

ELF #3: [*Feigns interest.*] Oh?

ELF #1: Yes. Only females do. So Rudolph was in fact a girl.

ELF #4: So she was really Rudolpha.

ELF #2: [*Exasperated*] All right, then SHE probably dipped HER antlers into some ink….

CHIEF ELF: And now we have to record on the hour instead every two hours where people are and what they're doing. Using activity and location codes. And write it down.

ELF #4: So we're going to be running up and down the stairs all shift. No sooner have we completed one observation when we have to do the next one.

ELF #3: Yes, a bit like the painting Forth Bridge.

ELF #5: How so?

ELF #4: You know, how as soon as you finish painting the Forth Bridge it's taken so long that you have to start it again.

ELF #1: Which of course is an urban myth because these days the process of painting the Forth Bridge – or any bridge in fact – only takes a fraction of the time it used to because of the effectiveness of modern machinery and so forth.

[*ELVES #2, 3, 4 and 5 all groan*]

ELF #2: Is there a code for [*bashfully*] doing man things?

ELF #4: Man things like what?

ELF #2: Man things like masturbating.

ELF #1: Why is that a man thing? [*Genuinely irritated*] Why? Do you think that women don't do it?

ELF #5: Anyway, don't you knock before you go into somebody's room?

ELF #2: Of course I do. But sometimes they haven't finished by the time you open the door….

ELF #3: So – just make sure you get an answer first before you open the door. Duh.

ELF #1: What about the Privacy and Dignity Policy?

ELF #5: Oh, screw that – it's just normal politeness. [*To ELF #2*] I mean how would *you* feel if you were beating the bishop and somebody just walked in on you…

ELF #2: That's all right, I don't masturbate…

ELF #4: Says you….

ELF #2: [*Flash of anger*] Hey, are you calling me a….

CHIEF ELF: [*Exasperated*] Hey, hey - can we all stay focussed here, please?

[*Embarrassed silence*]

[*ELF #3 reaches for the piece of paper in the CHIEF ELF's hand. The CHIEF ELF gives him the paper. ELF #3 quickly scans it.]*

ELF #3: So these codes here – Sleeping on back, sleeping on front, sleeping on right side, sleeping on left side…. It's a bit obsessive, don't you think?

ELF #5: Is there anything they do that we don't have to know?

ELF #3: [*To ELF #5*] Well, they're free to do what they want for the hour in between observations.

ELF #4: Big deal. [*Leans forward in an exaggerated fashion*] Do we have to bend over them while they're asleep to see which side they're sleeping on? And wake them up to see if they were asleep?

ELF #3: That is so invasive….

CHIEF ELF: You could use a torch.

ELF #3: What? And poke them with that? That's *really* going to wake somebody up! [*Realising*] Oh, yes, of course….I could shine it into somebody's face…to wake them up…. in order to check they were asleep….

ELF #2: But a) we've got no torches – not that work anyway – and b) we've got no batteries either.

ELF #5: And how is that recovery?

CHIEF ELF: [*Takes a deep breath; mildly irritated*] Yes, I can understand that it might be difficult to see recovery in all of this. To some extent I suppose the organisation is being defensive.

ELF #1: Yeah – they won't want to get sued into a black hole.

ELF #2: Yes, they've got to cover that eventuality.

ELF #5: [*To ELF #2*] I'm surprised you're taking their side.

ELF #2: No – I'm just being objective. And my objective opinion is that the Trust is really only looking out for itself.

CHIEF ELF: But Santa says….

[**BOB** *and* **DAVE** *enter*]

BOB: [*Waves a piece of paper at the CHIEF ELF; is impatient*] What's this - you've put in a job for convex mirrors to be put up in the corners of the corridors

at the top of the staircases. [*Pause*] Something to do with 'NICE Guidelines'.[4] 'Ere – what's 'NICE' when it's at 'ome'?

DAVE: They make Nice biscuits…..

BOB: [*To DAVE*] What? Are you being clever or something? Nice biscuits are…nice?

CHIEF ELF: The Major didn't like there being so many blind spots in the building. She said we couldn't see the service users. Except she called them 'patients'.

BOB: So you want to be able to see around corners, then?

DAVE: Don't you need a periscope for that? [*Says,* "Going down!" *and holds his nose with one hand whilst pretending to yank at a cord with the other one. Bends down onto his haunches. The joke falls flat. Suddenly leaps up.*]

BOB: [*To DAVE*] You knob 'ead – what was all that about?

DAVE: You know: periscope, submarine, diving etcetera. [*Pauses*] You didn't get the joke then?

BOB: Listen, mate, if it was a joke then it would've been funny. But it weren't funny, so it weren't no joke. [*To CHIEF ELF*] Well, where d'you want these mirrors then? We'll have to get the Trust architect in.

CHIEF ELF: Why's that? We're just asking for some convex mirrors to be put up in some of the corners. There'll be no structural changes.

[4] NICE (2005). See also Healthcare Commission (2007).

BOB: It'll make the place look like a bloody prison, if you ask me. Change of purpose….

[*The QUEEN and entourage make their usual entrance*]

The **QUEEN**: [*To THE COURTIERS*] Stop fussing, stop fussing! [*To the assembled company*] Mirrors? What's that about mirrors? Tut. I gave up on mirrors ever since mine stopped telling me I am the greatest Queen in the land. [*Pause*] Oh, and by the way, King Wenceslas has been indisposed for a time – he fell off his horse – or did somebody push him [*looks at the audience, smiles coyly, pauses*] – anyway I may need to return to Lapland at short notice.

[*A groan from the ELVES and CHIEF ELF*]

ELF #2: [*To the CHIEF ELF*] And tell them about the rubber seals around the windows.[5]

CHIEF ELF: [*Sighs*] [*To BOB*] Yes. We were told to get them cut into 6 inch strips so they wouldn't be a ligature risk and now they're falling out of all the window frames and doors because they're too short to stay in. One of these days a pane of glass is going to fall on somebody.

ELF #4: Which is ironic really, as it's safety glass….. [*DAVE sniggers.*]

QUEEN: [*To BOB and then DAVE in turn*] Yes, where is the recovery in that? [*Pause*] [*To BOB*] Do you have a mirror that'll make me look busier?

BOB: [*To the QUEEN*] Sorry, love, can't help you there. We just do what we're told.

[5] Department of Health (2008) marked the rubber seals around windows in UPVC frames as potential ligature risks in the event of their removal from the frame

QUEEN: [*Huffily*] Well, would you believe that? I am not used to people saying 'No' to me. [*Nods n the direction of CHIEF ELF*] Here, you sort this out, will you? I'm busy. I've got a meeting to go to. [*To self.*] Goodness me, I don't know where it is. [*Sighs*] Oh dear me, oh dear me. So many meetings, so little time. [*Departs hurriedly*]

THE COURTIERS: [*Chant*] All hail our great and glorious, well-educated and very busy Queen…. [*They follow her out, a disorganised rabble.*]

[*Enter SANTA CLAUS, carrying a heavy sack. It is MAGIC MIKE. He is smudged with black as if with soot.*]

SANTA: [*Throws the sack onto the floor with relief*] Oh, thank heavens for that. I wish the SHA had told me I didn't have to go down all those chimneys. [*Dusts himself down, which seems to make him even grubbier*] Tut, the soot. Have you seen the new policy, yet?

CHIEF ELF: You mean the –

SANTA: The new observation policy, yes, yes, what do you think?

ELF #2: Why "observation through care engagement"?

SANTA: Observation through what? "Care engagement?" Observation through care engagement? Oh no, that wasn't me. Oh no. Definitely not. Observation only, that was what I said. I didn't care how they did it, I told the Board, just make it happen. [*To ELF #2*] Do you know I used to be a nurse? And I'm interested in patient safety? Hence the new policy…. [*Extends a hand to ELF #2, but quickly withdraws it just as ELF #2 reaches for it*] [*To all*] How's it going so far?

CHIEF ELF: Well, we've only just had the new policy posted on the intranet. [*Hesitantly*] Don't these things normally go out to consultation first? They tend to require a bit of a cooling-off period before they are implemented.

SANTA: That? Oh yes, consultation, what's that, oh yes, far too busy, patient safety don't you know, it's a priority, no time for consultation, things like that really can't wait, can't wait at all [*Pats the pockets of his tunic*] Now where did I leave those keys for the sleigh? I've got to get back to my proper job….

CHIEF ELF: And while you're here – what about the new anti-ligature equipment that's being installed everywhere? Where's the sense in nailing windows shut on the acute ward? In fixing all the beds to the floor?

ELF #3: So the beds can't be put on one end and used to hang from, of course. And so that people can't jump out of windows….

CHIEF ELF: Meantime everybody suffocates or boils to death; and staff break their backs bending over beds that can't be moved. And where are the risk assessments for all that work? Staff side asked for them a month ago and still haven't seen anything.

SANTA. [*Distracted, still patting the pockets of his tunic*] That, oh yes, that. Well – did I tell you I am especially concerned about patient safety – now [*plucks a key from a pocket*], now, oh good found it, I'm sorry, I must go, I've got to get to Switzerland in the next forty-five minutes, some presents there, do you see, oh another heavy sack, goodness me. I do apologise – I am in such a hurry. Do you know the postcode, so's I can put into the TomTom? [*Departs, takes a few steps, stops, squints and clicks his fingers in front of his face. Does the same again. Exits.*]

CHIEF ELF: [*To BOB*] So when are you going to start the anti-ligature work?

BOB: Well, you see, it'll be whenever Phase One is completed. It's almost finished now.

CHIEF ELF: And Phase One is all the acute units?

BOB: Yeah, yeah. And, you see, you are Phase Two. Not so acute.

CHIEF ELF: [*Bewildered*] So if we're only Phase Two because we're less risk than the acute wards – then what's all the fuss here about ligature risks?

BOB: Well, I don't know that, I'm just [*together with CHIEF ELF*] doing my job….

ELF #4: Well, don't they know that if someone wants to do away with themselves they will.

CHIEF ELF: [*impatient*] But the Trust has to show that it has taken all reasonable precautions.

ELF #5: These precautions aren't reasonable. They're mad.

DAVE: So quite appropriate for a madhouse, then! [*The CHIEF ELF and all the ELVES glower at him. DAVE cowers.*]

BOB: [*Smiling*] Oops – looks like you said the wrong thing there, mate! [*To CHIEF ELF*] So, where do you want these mirrors, then? [*Motions in the direction the QUEEN departed*] And she's as much use as a handbrake on a canoe….

CHIEF ELF: Oh, she's busy. She's studying.

ELF #3: Oh, yes, that'll be why we don't see much of her, then….

CHIEF ELF: [*Back to the point.*] Oh, yes, the mirrors. You'll have to ask the Queen [*Thinks*] Well, on second thoughts, I'll…I'll let you know.

[**JOHN** *enters. Yawns loudly and stretches his arms.*]

CHIEF ELF: Hi, John. Are you tired?

JOHN: Er, yes. Of course I'm fucking tired. I was woken up every hour. On the hour. [*Glares at the elves.*]

CHIEF ELF: Well, I'm sorry about that. We're only doing –

JOHN: 'What you've been told'? Yeah, yeah, I know all that. [*Pause*] I'd like to take a shower. But I can't use the shower because it doesn't have a hose. Why doesn't the shower have a hose?

ELF #3: Because the shower hose is a ligature risk….

JOHN: Oh. Right. I'll just go and drown myself in the bath then, shall I? [*Shakes his head, mutters*] This place is fucking mad….

CHIEF ELF: [*To JOHN*] Do you remember the Community Meeting when I told everybody that we can't use the showers until the hoses are replaced? You were there.

JOHN: I don't know, was I there? I don't remember. The Community Meetings are always too early in the morning when I'm still too sleepy to concentrate.

CHIEF ELF: Well, the rest of the day everybody's out, so we can't really have it any other time.

ELF #2: Or, at least, they should be out….

ELF #5: See. It's only so we can tick the box. Say we've done it.

JOHN: Yeah, yeah. I reckon that's why you do it.

ELF #3: That's all they're interested in. Not us. Not service users. Not even Recovery.

ELF #4: Even though they call us a Recovery Service.

ELF #5: It'll take a while[6]; and I for one know that I won't be around when it happens.

ELF #4: And I think it's just to appease the Commissioners. And the Department of Health. What's that thing called? What's it called? [*Clicks fingers whilst thinking. Disappears.*]

CHIEF ELF: Clinical Governance? [*Pause*] So that invisibility thing of the Chief Exec's – it does work, after all. How bizarre….

[*ENDS.*]

[6] "At least a generation" (Davidson *et al*. 2006: 645)

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N9

THE WALL: A POSTSCRIPT

11/03/09

DRAMATIS PERSONNAE:

THE NARRATOR

TWO DANCERS

MANAGER

RAY

RITA

COMPERE

DOCTOR

[*Two dancers - one dressed like the MANAGER and the other like RITA - dancing badly but passionately across the full area of the stage to* Omen *by* The Prodigy[1] *played very loudly. As the music ends huge curtains enclose the stage followed by silence for thirty seconds. The COMPERE walks onto the stage in his usual fashion, flustered, from behind closed stage curtains. The microphone he is holding squeals painfully.*]

COMPERE: Laydeezangennulmen - led me innerduce to you for his last appearance in the role laydeezangennulmen [*to the audience, confidentially*] He resigned, don't you know, laydeezangennulmen, what a silly silly boy, and just because he didn't get the job, how's that for cutting off your nose to spite your face, laydeezangennulmen - [*Louder*] laydeezangenulmen in his last appearance on our stage, please give it up for...The Managerrrrrrr! [*holds his left arm out & backs away into the wings as the curtains swish open, to reveal the MANAGER on his knees in front of a wall, He is scrubbing at some writing with a scouring sponge and a bucket of soapy water. RAY is resting his forearms on top of the wall from the other side.*]

RAY: I sometimes think that nobody in this place knows what they're doing.

MANAGER: [*Still scrubbing, futile. Doesn't look up*] Why?

[1] The Prodigy (2009)

RAY: When I started we knew. But not any more. There's too much paperwork and crossing the 't's and dotting the 'i's. There's too much to do now.

MANAGER: [*Leans back from the wall and still on his knees looks up at RAY*] Yes. I know what you mean. I'm starting to feel that. You can't be naive all the time; some time you've got to stop bullshitting. Tell the Queen how it is. How she is.

RAY: I'm just waiting for my retirement.

MANAGER: [*Back to scrubbing*] I know - you've said.

RAY: Eight years and nine months left. [*Chuckles*] And I'll retire on Mental Health Officer status. So I'll get better pension than you, anyway.

MANAGER: I know, they stopped it. It was too expensive.

[*Pause*]

RAY: So what're you doing, then?

MANAGER: [*Scrubbing harder for a moment*] Someone's written graffiti on this wall. And I've got to get it off.

RAY: Why?

MANAGER: Because it shouldn't be on there.

RAY: [*Leans over the wall, and looks down*] That's funny, it looks like the Queen's handwriting.

MANAGER: [*Kneels backward, hands on his thighs, looks at it.*] No, can't see it, mate.

RAY: [*Looks again*] Yep. It's definitely hers. [*Chuckles*] What does it say? Probably something fatuous about Recovery I expect.

MANAGER: [*Looks at the wall. Reads.*] 'I am the Queen. You aren't. Remember that.'

RAY: [*Sighs*] How could we forget? She'd never let us.

MANAGER: Did you hear that I resigned?

RAY: Yeah. She sent an email round. You know how she manages by email. She thanked you for your work during the past twelve months, including when she wasn't here. [*Pause*] I don't believe her, though.

MANAGER: You know, what I said to her, I said I can't work with her. I said I'm her deputy but she never discusses anything with me and she never shares information. And can you guess what she said?

RAY: Something about you should know your place, I expect [*Chuckles*].

MANAGER: She said if I want to know things then I should ring her in order to find out. That she told me that before. And I haven't done that once so it was my fault I couldn't cope. Honest, she's a fucking nightmare. And she said I haven't done things she asked me to, I haven't been supporting her. She can go to hell. I'm there to support the team not her.

RAY: You sound angry.

MANAGER: Of course I'm angry. Wouldn't you be?

RAY: Yeah, well, you're a mug for going for the promotion in the first place. I wouldn't have bothered. [*Pause*] I'm just keeping my head down until I can retire, that's all.

MANAGER: [*Returning to scrubbing the wall*] Yes, that about sums you up, doesn't it?

RAY: That's as maybe - but look at you now, you're the one who's upset, not me.

[*RITA ENTERS*]

RITA: Hi!

RAY: Oh, shit, you again, I'm off. You're half the problem, causing all the extra work. [*Leaves*]

RITA: Oh, right, thanks a lot! [*Calls after him*] Peasant!! [*To the MANAGER*] What did *he* want?

MANAGER: Oh, the usual. Just to gloat. [*Pause*] But you know, he's right, there's no point in putting yourself out for this Trust. No point at all. You get nothing for giving everything.

RITA: Yes. I'm sorry you didn't get the job. Really, I am.

MANAGER: Thank you. But I don't think it's going to affect you at all. They'll still love you. They're having a cull up top in the organisation now, as well. The new Chief Exec, he visited across the road the other week and they were leafleting it well in advance like it was a royal visit. Talk about a Cult of Personality. I don't know if it's like that in his other place.

RITA: You should count your blessings. They get three days a week of him - you only get two! [*Laughs*]

[*Silence*]

RITA: So what now?

MANAGER: I don't know. I did tell her right there and then to bust me back down to staff nurse. Which she did, to her credit. I suppose there was no point making me work out a period of notice when I didn't want to do it anyway.

RITA: Are you sure you should have done it?

MANAGER: She asked me that; she asked me am I sure I'm not being hasty, did I want some time to think about it. I said, no, I'm sure, honest she was doing my head in. From day one. [*Pause*] Do you know which interview question she failed me on? [*RITA shakes her head*] No, why would you, of course you weren't there. [*Pause*] She said I didn't give her the answer she was looking for when she asked me how I would motivate staff. She said I didn't say supervision and IPDRs. [*Pause*] I mean, you don't motivate staff with supervision and IPDRs. You use those to *manage* staff. To discipline their docile bodies.[2] [*Smiles*] I've read so much Foucault that I've even started thinking like him! That was my downfall: I just can't bullshit any more.

RITA: You shouldn't have done your thesis, you see. You would have stayed naive and....

MANAGER: [*Exasperated*] I would have been even more cynical than I am now! Cynicism would have been my only release![3]

[2] Foucault (1977)
[3] Cynicism is a means of concealing the perpetually depressed mood (Zizek, 2007)

RITA: But now you think that the truth isn't the truth after all. Now you think that all my suitors will admire me but they will never dance with me. [*Pause*] Mind you, I heard something the other day that scared me a bit.

MANAGER: What was that?

RITA: I heard a director read out a memo from somebody or other, talking about recovery-orientated services. It used to just be 'recovery services'.

MANAGER: So now it's only a *sort* of recovery, instead of the whole thing.

RITA: Yes, and I don't think I like that. [*Pause*] But I have to go with it, because it's all I have left.

MANAGER: You are the still small voice beneath the rubble of a desecrated Israel.[4]

RITA: What? Leave religion out of it, will you.

MANAGER: It's not religion, it's just the way I think....

RITA: [*Looking at the wall*]. So are you going to give up on that, then? It'll never come off. Not without using something industrial strength. [*Laughs*] It was there before, and it'll be there afterwards. Are you going to tell me you've only just noticed it?

MANAGER: [*Looks at the wall*] Well, I suppose I've always known it was there. It's only recently started to bother me, that's all. When things started to get really tough.

[4] 1 Kings 19, *Holy Bible*.

RITA: Yes, it's funny how this is a mental health Trust but they treat their staff so badly that many of them have mental health problems as a result.

MANAGER: Yes. Recovery helps service users to feel in control of their own lives - but the Trust disempowers its own staff! So how can we practise Recovery?!

[*They laugh*]

MANAGER: So will I see you again?

RITA: I don't know; I honestly can't say. I'm meeting the Queen later.

MANAGER: Yes, well, I won't ever know the outcome of *that*, then [*RITA giggles*] - so I can perhaps expect an email instead. If I'm lucky.

RITA: I'll be there when you look up from your CPA paperwork and wonder why you're doing it. You might catch a fleeting glance of me then. I might be there; or I might not. I'm sure you'll see me around.

[*The stage curtains swish shut hastily, as though unexpectedly. The COMPERE rushes out from the wings and trips over the cable of the microphone he is holding and falls forward onto his front. He picks himself up embarrassedly and dusts himself down. He resumes.*]

COMPERE: And that, laydeezangennulmen is the end of our evening's entertainment for tonight. I'm sure you will join me in giving the Manager and Reda a final round of applause as we all say goodnight and thank them for entertaining us. And we wish them well, of course, laydeezangennulmen. [*Extends an arm to the side.*] Laydeezangennulmen - the Manager and the lovely Reedaaaaaaa! [*He takes several steps backward, but there is only the curtain that covers an empty stage*.]

[*A few ripples of applause*]

[SCENE ENDS and *The End* by the Doors[5] plays. The dancers come back.]

[5] The Doors (1967)

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N10

A SECRET MEETING

11/05/09

DRAMATIS PERSONNAE:

NARRATOR

MAJOR MAULING

MAGIC MIKE

RITA

DOCTOR

[MAJOR MAULING and MAGIC MIKE centre stage. RITA watching.]

MAJOR MAULING: (*Tapping her pointer against MAGIC MIKE'S chest*) I don't like it. I want you to close that unit down….

MAGIC MIKE: Because?

MAJOR MAULING: Because the commissioners are paying for respite there and respite is social care not health care.[1]

MAGIC MIKE: Well, really its mental health care, you see…sort of, really….

MAJOR MAULING: …and the commissioners aren't paying for that.

MAGIC MIKE: Well, all right then, I'll close it. We could do with the real estate anyway. We haven't invested in the fabric of the building nor the staff for a while now just in case of such an eventuality. And anyway, it's such an old building it doesn't have disabled access or en suite facilities.

MAJOR MAULING: Good, that's sorted then. Shall we say…within the month?

[1] The Primary Care Trust commissions mental health services for the area. The County Council commissions social care. One body will not want to fund the other's service.

MAGIC MIKE: Yes, certainly. We can move all the staff to Acute services – it's always short there. (*Pause*) And the service users…we'll find beds for them in the south of the county…yes, that'll be fine. We can manage that.

MAJOR MAULING: (*Taps her pointer against the heel of her boot as she is standing.*) Good then. A month. Are we agreed?

MAGIC MIKE: Agreed.

RITA: (*To them in turn. Neither can hear nor see her.*) And me? What about respite? What about it? There's nowhere in the north of the county now. How can you shunt people about like this? What about helping people manage their own mental health by using respite now and again? (*Exasperated*)

[*ENDS*]

N11

A NEW JOB

19/08/09

DRAMATIS PERSONNAE:

NARRATOR

COMPERE

MANNY[1]

RITA

MAGIC MIKE

QUEEN

COURTIERS

DALEK[2]

SERVICE MANAGER

BOB and **DAVE**

DOCTOR

[*Lots of paper on the floor which the DOCTOR picks up, reads cursorily, and throws back down again. COMPERE is on the stage, microphone in hand, singing to the loud and distorted accompaniment of a big band*.]

COMPERE: "Annow-a, da en is near-a;
And so I face-a da final kurdunn-a.
Ma frien-a, I'll say id clear-a,
Il'l stade my case-a, ov which-am surdunn-a.

Ahve lived-a life dad's full-a
(oh yes, laideezangennulmen!)
An ahve-a travellan-a each-an evra highwayyy-a;
An-a more-a, much more dan diss-a,
I dididd-a myyyyyyyy wa-"

[1] Formerly THE MANAGER
[2] Performance Manager. Replaces PIM (former Performance Manager) in the new Trust. The Daleks are a fictional race of extraterrestrial mutants from the British science fiction television series Doctor Who. They are organisms integrated within a tank-like mechanical casing. The resulting creatures are a powerful race bent on universal conquest and domination, utterly without pity, compassion or remorse.

[Music suddenly stops as the MANAGER ENTERS waving his arms frantically across his face.]

MANNY: Wait, wait, wait! Stop! Stop! STOP!

COMPERE: [*Musical accompaniment has ceased*] -ayyyyyyyyyyy....

[*A few scattered, confused ripples of applause from the audience.]*

COMPERE: [*BOWS graciously*] Why, thank you, ladeezangennulmen. Thank you....

MANNY: [*Also BOWS to the audience, hurriedly, half-heartedly, then to the COMPERE says:*] I've got a different job[3] - I've got a different job! [*Breathless*] It's not over - it's not!

[*As the MANAGER is proclaiming this RITA dashes onto the stage after him.*]

RITA: Hey, hey, you're forgetting me!

MANNY: [*Hands on his knees, PANTING. Looks at her out of the corner of his eye.*] You should keep up then, you dozy bint....

RITA: Why am I following you? YOU should be following ME!

[*COMPERE throws out his arms in exasperation, leaves the stage shaking his head.*]

MANNY: [*Still breathless*] Yes - so why are you?

[3] Seconded to work in a local community mental health team

RITA: Because I'm afraid you'll forget me.

MANNY: [*Looks around him*]. But everywhere the paperwork reminds me you're there - it's all got your name on it.

RITA: Yes, I know - but I want to be real, I want you to touch me.

MANNY: I think that was my problem.

RITA: How?

MANNY: That I wanted you to be real enough to be able to touch you.

RITA: And you can. You know you can.

MANNY: But then I get hurt - because there are too many things in the way and I reach out to touch you and...and...

RITA: Yes?

MANNY: ...and I can't quite grasp it, there's always something else in the way. It's like trying to reach through prison bars for the key lying on the floor that will free you but it's just out of reach, out of reach by two centimetres, it's so cruel. And 'cruel' hurts.

RITA: I -

MANNY: You've seen me in those times, haven't you? When it hurts, really hurts. When I am broken?

RITA: [*Remembers*] Yes.

MANNY: ...by my wanting you, by my wanting to be you.

[*RITA pauses, doesn't know what to say*]

MANNY: I want to be with you - but I can't be you.

RITA: [*Eyes FILLING with tears*] But I never asked you to BE me. [*Pauses*] Just to walk with me.

MANNY: But Recovery makes me want to...want to...want to live you, want to see things through YOUR eyes, want to touch things through YOUR body, want to think like you do....I was trying to be emotional. And I'm not emotional. I crossed my boundaries with you. I built a bridge across the straits….

[*MAGIC MIKE, dressed in a suit, walks hurriedly on from one side of the stage. He is pursued by SERVICE MANAGER. The MANAGER and RITA see him and join the pursuit.*]

SERVICE MANAGER: But you can't close the unit down. You can't, you can't. Where will people go? What about the respite provision?

MAGIC MIKE: [*Puts his hands over his ears, continues walking hurriedly, almost running now*.] La la la lala – can't hear you, can't hear you! [*Then*]The unit wasn't fit for a twenty-first century recovery service. *The Ten High Impact Changes for Mental Health Services*[4]. Etcetera etcetera. Respite in the south of the county…. La la la lala.

MANAGER: [*Pleading*] What about people whose families are in the north of the county? There aren't even any beds here! No units, nothing. Where will people GO?

[4] Care Services Improvement Partnership/National Institute for Mental Health in England (2006)

MAGIC MIKE: Can't hear you, can't hear you!

RITA: [*Remonstrating*] You're twisting the meaning of the *Ten High Impact Changes* – that's not what it meant: close everything!

MAGIC MIKE: [*Still with his hands over his ears*] Oh yes it did! Can't hear you, can't hear you!

RITA [*To SERVICE MANAGER*]: Can't you do something?

SERVICE MANAGER: There's nothing I can do, I don't set the rules - he does [*pointing at MIKE*]; the Commissioners do. [*MAGIC MIKE exits the stage, still pursued by SD. The MANAGER and RITA halt their pursuit of him but fall into each other.*]

MANNY: [*Kicks out at something imaginary*] Oh – what's the point?

[ENTER the QUEEN]

MANNY: [*Exasperated*] Oh, no!

QUEEN: Has that horrid little man gone? Yes? Good. [*She looks about her. Her retinue collide into one another as she suddenly stops.*] Still, I'm sure that closing the unit was for the best… in the long-term [*flaps her fan in front of her face*]….Now, somewhere to sit. [*Spies a place at the rear of the stage; gestures to one of her retinue*] You, little man, fetch your Queen a chair that she may sit regally. [*The servant scurries offstage and quickly returns with a chair and places it in the area she espied. He hurriedly polishes the seat of the chair with a handkerchief he has pulled from his tunic. She sits on the chair without a murmur*.]

RITA: [*to the MANAGER then to the QUEEN*] I see you're back. What now

then? Aren't you upset that the unit was closed? Don't you think it reflects on you as MANAGER there?

QUEEN: My dear, life goes on. I am the QUEEN. [Pa*uses*] Ah. I remember: I have a meeting to attend. I don't know how long I'll be. So long! [*To her retinue*] Come on, come on, no shirking. Prepare my carriage. I must be there within the hour….

[*QUEEN exits*]

RITA: [To the MANAGER] So you're not a manager anymore?

MANNY: No. Busted back to staff nurse. Kicked back downstairs. [*Thinks*] Though it was quite an adventure while it lasted.

RITA: I hope the steps didn't hurt as you bumped down them on your backside! [*They laugh*]

[*A DALEK enters.*]

DALEK: May I remind you that you have a target to meet.

MANNY: I know, I know – six depots by lunchtime.

RITA: [*To DALEK*] And the other things? The things that service users might want to talk about? The ten essential shared capabilities[5]?

[*DALEK does not reply for it does not see nor hear RITA*.]

MANNY: Yes – what of the other things I do? Like chatting because the client

[5] Department of Health (2004)

wants to tell me their life story, like listening to a carer, like preventing relapse?

DALEK: Giving depot medication is preventing relapse.

MANNY: But not the only thing – I do other interventions as well.

DALEK: Other interventions may be recorded on ORSIC[6]. There are seven other fields on that page on which to record other interventions.

MANNY: Yes, that's fine enough. But doesn't ORSIC only record the first one?

DALEK: That is so. The system is not sufficiently sophisticated to record more than that.

MANNY: So in other words as far as the Commissioners are concerned that's all I do for three quarters of an hour at a time? One depot injection? And not including my travel time.

DALEK: The system does not acknowledge travel time. Does not compute. Does not compute. [*The DALEK spins around several times all the while saying "Does not compute, does not compute*!"]

MANNY: And so what will happen if I record as the first item on ORSIC – say – a variable such as 'monitoring mental health' as the main activity?

DALEK: You will be exterminated!! You will be exterminated!! The Commissioners set these targets. If you don't meet them they will find somebody who will. You will be EXTERMINATED!!

[*The DALEK points its probe at MANNY, who brushes it away.*]

[6] An acronym: Our [Data] Recording System Is Crap

MANNY: Go point that thing at someone else, will you. Didn't your mother tell you it's rude to point?

DALEK: We have no progenitor. Our creator is Magic Mike.

MANNY: He's a got a lot to answer for – even more than I thought.

DALEK: Magic Mike is our creator; Magic Mike is our creator.

MANNY: Okay, okay, I get the message. [*Pause*] So the Commissioners are only interested in statistics. Not people.

DALEK: People are weak. All earthlings shall be exterminated!!

MANNY: But just from bare statistics alone the Commissioners don't get to see what I do!

DALEK: The extra fields on ORSIC are available to your line manager.

MANNY: So why aren't they available to the Commissioners?

DALEK; Because they are not. You have already asked this question. You are a stupid earthling and must be exterminated!

RITA: But we're more than just statistics, more than just the recipients of depot injections. We're people, for God's sake.

MANNY: [To *RITA*] Don't bother. You're just wasting your time. It's just what they do. They're only machines. The problem is it's not us on the front line who have programmed them. The bottom line is that I have to meet their targets if I want to keep my job.

RITA: But you can't do your job if you are mainly concerned with meeting your targets.

MANNY: No – not the way I want to do it, at least. [*To the DALEK*] And what's the general point of all this?

DALEK: The Trust is preparing itself for Payment by Results[7]. If we do not do the work we do not get paid.

RITA: You mean him [*gestures* at MANNY]. You mean *he* doesn't get paid.

MANNY: [*To DALEK*] You mean I don't get paid. You're just monitoring what I do. And getting paid more than me. And I'm the one in the front line, dealing with suicidal people, at risk of violence, instigating SOVAs[8]. Who the fuck are you?

DALEK: Yes. That is a fact. I get paid more than you for monitoring you. I am not responsible for this. My role has been assessed under Agenda for Change, as has yours.

MANNY: And you come out as having a more responsible job than me who works on the front line?

DALEK: That is so.

MANNY: Well, Agenda for Change has sold us nurses down the river, hasn't it…?

[*ENTER BOB and DAVE*]

[7] Funding of NHS mental health services will be linked to activity (Fairbairn, 2007)
[8] Safeguarding of vulnerable adults

BOB: [*To MANNY*] Oh, hello, it's you; don't you get around?

MANNY: Well, you know the old place closed down?

BOB: Yeah, I heard it was on the cards. Couldn't say anything though. [T*o DAVE*] Could we?

DAVE: No, couldn't say a thing. Schtum. [*Motions a zipping movement with finger and thumb in front of his mouth.*] Souls of discretion, we were. Souls.

MANNY: [*Incredulously*] And now?

BOB: Got to move these filing cabinets. Apparently you're not going to be allowed to have anything naming a service user or a colleague on your desk.

MANNY: So I'll just keep it in the drawers of my desk then, out of the way.

DAVE: Oh, no, you can't do that. We'll be taking those as well.

MANNY: What, the drawers?

BOB: Yep. [*To DAVE*] What do they call it? 'Clean' something?

DAVE: [*To BOB then to MANNY*] The 'Clean Desk Policy'. Apparently somebody in the south of the county lost a file so all of the Trust has to tighten up. If you want something you'll have to sign it in and out of the records office and you mustn't leave it lying about.

MANNY: Oh God, is there no end to the madness this Trust can come up with?

BOB: [*To MANNY*] I tell you what, mate, it'll be far worse when it's a foundation trust[9]. I've got a couple of mates who work in FTs[10]. That's what they tell me.

DAVE: [*Jokingly, to BOB*]. Here, it's amazing you've got any mates at all, let alone a couple working in FTs.

BOB: Why, you…[*pretends to throw a punch at DAVE, who ducks*]

[*The QUEEN bustles in followed as usual by her scattered retinue. She looks askance at BOB and DAVE*.]

QUEEN: Oh, I see. You two porters again. Perhaps while you're here you can clear me an office? I like it here, so I think I shall stay. At least until something better comes along.

RITA and **MANNY**: [*Together*] And just when we thought things couldn't get any *more* desperate….

[*ENDS*]

[9] The mental health Trust remained subsumed by the larger Foundation NHS Trust [FT] for one year until the technical decision was made by the SHA to make the formerly separate local mental health NHS Trust *a part of* the much larger FT.
[10] Foundation Trust

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N12

A JESUS MEETING[1]

11/09/09

[1] Technically a 'Come to Jesus Meeting.' A term of North American (specifically southern) evangelical origin referring to a serious meeting with an individual or team. These meetings often involve ultimatums for performance improvement. (The Office Life, 2013)

DRAMATIS PERSONNAE:

NARRATOR

RITA

MAGIC MIKE

MANNY

BOB and DAVE

SOPHIE[2]

TERRI[3]

ESTATE AGENT

DALEK

DOCTOR

[The sound of alarms and sirens. Characters dashing about the stage. The DOCTOR always in the way.]

RITA: Look out, look out! There's an emergency!

MAGIC MIKE: Get Estates in, will you, sort this out!

MANNY: What's going on, what's going on? Help, help!

[*A pause*]

DAVE: [*Strolls in*] So, what's the problem here, then?

BOB: [*To DAVE*] There's an emergency, you dipstick. What does it look like?

DAVE: Well I can't see anything and I can't smell any smoke….

[2] Lead social worker in the community mental health team
[3] Community mental health team manager

BOB: [*To MANNY*] And if it's the fire panel that's faulty then I'm afraid you'll have to call in the subcontractor….

MANNY: [*Still rushing about*] [*Pleadingly*] So you can't fix it, then?

[**MAGIC MIKE** *exits*]

BOB: Nope. We're not allowed to touch it!

MANNY: But do you know how to switch off that awful sound?

BOB: Yep.

MANNY: So can you? Please.

DAVE: He told you, we're not allowed to.

BOB: Yeah, it invalidates the service contract.

[A large woman dressed as a fairy, with wings and a wand, is lowered on wires from the roof. The alarms suddenly stop.]

SOPHIE: I am the Social Work Angel.[4] How may I help?

MANNY: What's all this noise?

SOPHIE: It's a Direct Payments[5] application.

[4] My employer is a partnership between mental health care services and social care services, both under the auspices of a Foundation NHS Trust. The community mental health team in which I worked comprised both health care and social services employees.
[5] A grant of money by local Social Services in order for a qualifying person to purchase their own services rather than have those services provided for them (Gov.uk, 2013).

RITA and **MANNY:** *What?*

SOPHIE: We have the chance to apply for a Direct Payment, so that we can work towards meeting that particular target.

MANNY: Oh, of course, silly me….

[*A small, well-dressed woman* TERRI *walks on stage, followed by a strolling besuited figure, hair slicked back and carrying a takeaway latte coffee in one hand]*

TERRI: And I'm resigning as team manager.

MANNY: [*To TERRI*] Ah, what a shame - and we've only just met….

TERRI: I can't make the team perform and some of the things I am asking the team to do aren't consistent with my being a Christian. I feel I've let you all down [*Tearful*].

ESTATE AGENT: And it's the team's fault. [*Very deliberately, very calm*] I don't think it's fair that Terri gets in at two o'clock in the morning and stays until nine o'clock at night just getting the figures correct.

MANNY: For you.

ESTATE AGENT: …for me.

SOPHIE: The team *is* performing, we're just not recording it.

ESTATE AGENT: So as far as the commissioners are concerned - and I don't mean to break your crayons - your performance has not been good lately. [*Hastily, to TERRI*] Give me the performance dashboard.[6] Have you got the performance dashboard with you?

RITA: *What*? The *what*?

TERRI: No, I think I left it in the office. I'll just pop out and get it. [*TERRI exits*]

ESTATE AGENT: However without the figures in front of me I can say that when we drill down on the figures we can see that the 0.3 per cent decrease on duty referrals to the team last month is only part of the story.

MANNY: But we have too many clients on our caseloads. And you've frozen all the Care Coordinator posts until next financial year.

ESTATE AGENT: So? It's the same for everybody across the Trust.

MANNY: And that's supposed to make us feel better?

ESTATE AGENT: Well, yes, if you would only listen to [*condescendingly*] - what – I – am – say – ing. [*Pauses*] Well, some of you may have heard that an audit that I conducted in the south of the county revealed that the average number of contacts – not face-to-face contacts, mind, but also non face-to-face – that's speaking to clients on the telephone, even - averaged slightly less that one per day and that was [*contemptuously*] for an average of 45 minutes. And leaving one day for paperwork and one day for travelling between appointments –and I'm being generous here – that leaves *at least* two days each week which are unaccounted for. [*Pauses*] What the fuck do you all do all day?

[6] A performance dashboard is a performance management system. It communicates strategic objectives and enables a business to measure, monitor, and manage the key activities and processes needed to achieve its goals (Eckerson, 2011: 4)

[*TERRI returns carrying a file. Hands it to ESTATE AGENT, who for a moment peruses it.*]

ESTATE AGENT: [*Looking up from the file*] Ah, yes. A 0.7 per cent increase in completed CPA2s[7] last month. That's good. [*Artifically calm*] But a drop in CPA3s[8] over the same period – 2.8 per cent – I don't understand that. [*Pause*] I have to justify these figures to my bosses. Just as Terri has to justify them to me. [*Paus*e] And there is *absolutely* no justification for them.

[*TERRI looks down at the table. ESTATE AGENT looks ahead, into space, smiles.*]

ESTATE AGENT: I think that as a team you all need to recontextualize your priorities. [*Leans forward*] Now, can I presume that the team assumes ownership of this failure to register the recovery journey on the performance dashboard? I can understand that most people here feel there is insufficient bandwith with which to take the service forward, and that this is a continual resource contention point. Of course I understand this. But we need to modernize the way in which we deliver the service so that we as a Trust can continue to evolve vertical relationships with our stakeholders and end-users, and deliver a better turn-key product. We need to sort out the event horizon for this, and deep six the dog and pony show we are running here. Now if nobody has any more arrows to fire, I think we're finished here.

TERRI: But what you told me this morning – that again was different from the presentation that Sophie and I were given last week, which was again different from what we were told about the service reconfiguration even a month ago.

[7] An element of the Care Programme Approach, a term used "to describe the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in secondary mental health services" (Department for Work and Pensions, 2013)
[8] An element of the Care Programme Approach

ESTATE AGENT: [*Sighs as if asked something unbearably tedious.*] I think we all know that Stage 3 – which is what I am here to tell you about now – of the Trust's Recovery reconfiguration was clear from stages one and two when those started. No bells and whistles; on this project we're going for the low hanging fruit. Budgets are tight, so instead of offshoring this work parcel[9], let's water the plants in the hot house and see what grows. I'm not a chainsaw consultant, but if we can't square the circle on this then we will have to look at redeployment opportunities for all of you. I am not prepared to upweigh the spend any more. Timescales are slipping, and we need to implement a code surge. We've really got to timebox this build for before Christmas. [*He sips his latte coffee*]

[*Puzzled looks all round. DALEK enters*]

DALEK: Exterminate! Exterminate! You will perform! You will perform! Or you will be exterminated!

[MAGIC MIKE *arrives, squashed into a little motability scooter[10]. A control panel is on one arm of the steering column. The scooter is turning around and around,* MAGIC MIKE *is bashing randomly at the control panel*]

MAGIC MIKE: Stop!! Stop!! Does anybody know how to stop this bloody thing?!

[*Small heavy packages start falling from the sky, like rain. MANNY and the others dodge them.*]

MANNY: What the hell are these? [*One hits him on the head*] Ouch – that hurt!! [*Rubs his head ruefully*]

[9] Management speak for a minor project of work that can be completed from start to finish. My social services colleagues term this 'a piece of work'. Contrast with the common expression as in "a piece of work" meaning socially challenging

[10] Loosely based on the character of Davros, an evil character who built the Daleks in *Doctor Who*

ESTATE AGENT: Ah, I see the work parcels have arrived. By airdrop….

[*One package lands on* DALEK *with a metallic thud*]

DALEK: What was that? It is the enemy and will be exterminated!!

[DALEK *spins round and with its prod zaps the offending package which explodes in a flash of white sulphur.* MAGIC MIKE's *motability scooter continues erratically across the stage. At one point collides with DOCTOR*]

MAGIC MIKE: Get the hell out of my way will you? [*Bashes some more at the control panel*] Stop this thing – please stop this thing!

RITA: Hahaha! He's like a bumper car at the fairground. What an idiot!!

BOB: [*Dodges out of MAGIC MIKE's way*] Oi, mate, careful where you're going with that, ay? [*DAVE also dodges the errant scooter*]

SOPHIE: It's okay it's okay. With my magic fairy wand I will stop the parcels falling.

[SOPHIE *waves her wand, which then breaks in the middle, hanging at the hinge*]

SOPHIE: Oh. [*Smiles*] That didn't work, did it? [*Grins broadly*]

ESTATE AGENT: You know that I am going to continue to try to persuade Terri to stay.

[MAGIC MIKE *stops frantically bashing the control panel. The scooter halts suddenly*]

DALEK: [*EXITS*] Ow. Ow – exterminate, exterminate!!

MANNY: [*Arms outstretched, imploring*] Can somebody stop this crap from falling? PLEASE!!.

ESTATE AGENT: Oh, I don't think so. You already could do so much more. The statistics say so.

SOPHIE: [*To MANNY*] You should be able to do your work within your contracted hours.

MANNY: What? And you really believe that?

SOPHIE: Yes.

MANNY: Then you're obviously a psychopath.

ESTATE AGENT: And invariably they make the best managers.

RITA: And the best estate agents….

MANNY: [*Playful*] Sssshh! What if he can hear you?

RITA: But you know he can't!

TERRI: Wait! I've changed my mind! I'll be staying after all. [*Holds up some pages of paper*] And here are some boxes to tick. You can go home when you've done them. Oh, and by the way, I'm not paying overtime or giving time off in lieu to do it.

ESTATE AGENT: TERRI, dear, you've definitely made the right decision.

SOPHIE: Aw, and I thought I was going to get her job.

BOB: [*To MAGIC MIKE, who is marooned on the stage*] Here, mate, do you want a push?

DAVE: I don't know that we should, the bastard tried to run us over.

MAGIC MIKE: In my defence, that wasn't my fault.

BOB: [*To* DAVE] Forgive and forget, mate, forgive and forget. Ow! [*A package hits him on the head*]

DAVE: That's not what the union says. The union says don't trust 'em.

MANNY: [*To* TERRI] So what's changed your mind? What's suddenly different?

[BOB *and* DAVE *laboriously push* MAGIC MIKE *and his scooter towards the wings*]

BOB: [*To* MAGIC MIKE] 'ere, you 'aven't left the brake on, 'ave you, mate?

DAVE: I really don't think we should be doing this. What's this bugger ever done for us?

BOB: Oh, stop moaning, will you, you pussy, and just push….

[BOB *and* DAVE, MAGIC MIKE *and scooter all* EXIT]

TERRI: [*Nods in the direction of* ESTATE AGENT] Well he promised me it'll be different, that we will all inhabit a fairy land and live happily ever after and the moon is made of marshmallow and Recovery.

MANNY: Well, that's his version of it. The one he's trying to sell us. And you believed him?

RITA: [*To* MANNY] Yes, she believed him. Look at the way she looks at him. [TERRI *gazing at* ESTATE AGENT, *her hands clasped in front of her, sighing*]

RITA: It looks like love to me.

MANNY: More like fear I suspect.

[DALEK *returns*]

DALEK: You will do the work or you will be exterminated!

MANNY: [*Walks over to* DALEK, *rips the probe off its head and throws it into the wings with a vigorous over arm movement*] If you want it, go and get it, you infernal machine.

DALEK: Exterminate!! Exterminate!! You will be exterminated!!

MANNY: What with, dumbass? I've had enough. I'm leaving. Goodbye.

[RITA *rushes after* MANNY *as he exits*]

RITA: Don't go, don't go – stay, stay….

[*COMPERE wanders on, confused, blinded by stage lights*]

COMPERE: [*Tapping with a finger on the microphone he is holding, doesn't know who he is talking to*] Is this working? Is this working? [*Blows into the microphone*] Testing-a, testing-a, onedoothree-a. [*Blows again*] Laydeez an gennulmen….

[*Lights go out*]

[*ENDS*]

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N13

ALL STICK AND NO CARROT

24/02/10

DRAMATIS PERSONAE:

NARRATOR

RITA

MAGIC MIKE

MINI-ME[1]

MANNY

BOB and **DAVE**

ESTATE AGENT

DALEK

SOPHIE

TERRI

BUDDIST MONK

ODETTA[2]

DOCTOR

[A loud BANG off-stage.]

MANNY: [*Runs on stage from the wings, followed by RITA*] What the hell was that?

RITA: A loud bang?

MANNY: I know that. But what caused it?

MAGIC MIKE: *[ENTERS dressed in blue overalls, a welder's mask pushed back on top of his head. He holds a blow torch*] Who broke the prod off that dalek? I've just soldered it back on!

MANNY: [*Looks at RITA*] I'm sure I don't know.

[1] The Chief Operations Officer
[2] A representative of the Organisational Development department within the Trust

RITA: Yes. I wish I could help. But….

MAGIC MIKE: [*Waves the blowtorch absently in the direction of the others*] I don't know how long the repair will last, though – that's all.

MANNY: [*Puts his hands up*] Hey, hey. Be careful there! Do you have a licence to use that thing?

MAGIC MIKE: [*Pushes the welder's mask up onto the top of his head*] I don't need a licence. I'm the Chief Executive. I *write* the licences.

MANNY: [*Thoughtful*] Hmm. I suppose so….

[*A bald-headed midget enters, also dressed in overalls and with a welder's mask on top of his head. He holds a shotgun which seems too big for him. MANNY and RITA put up their hands in a gesture of surrender*.]

MAGIC MIKE: [*To MANNY and RITA*] Oh, can I introduce you…

[*MIDGET points the shotgun in the direction of MANNY and RITA. The shotgun sways as he holds it.*]

MANNY: No, thank you. I'd rather you didn't….

MAGIC MIKE: This is Mini-Me.

RITA: Hmm. Charmed, I'm sure.

MANNY: Why's he got that shotgun?

[*MINI-ME whispers to MAGIC MIKE*]

MAGIC MIKE: [*Scoffing*] Oh, that isn't a shotgun. It fires tranquiliser darts.

MANNY: [*Thoughtful*.] Oh. Really? Same thing in my book. [*Pause*] What's it for?

[*MINI-ME waves the gun. With one eye on the captives, he whispers into the ear of MAGIC MIKE who bends down to listen*.]

MAGIC MIKE: It's to encourage you all to meet your targets.

MANNY: [*Feigns interest*] Oh, how so?

[*MINI-ME whispers to MAGIC MIKE as before*]

MAGIC MIKE: He says that if people try to escape from their responsibilities he fires a tranquilising dart at them. To stop them getting away.

MANNY: [*To RITA*] Ah, that's one way to solve the staff retention problem.…

MAGIC MIKE: But it's okay. He always aims for the thigh.

MANNY: Ah. Yes. That's all right then. [*Pause*] I take it he misses sometimes?

[*MINI-ME whispers to MAGIC MIKE, as before*]

MAGIC MIKE: He says it's friendly fire[3].

[*ENTER BOB and DAVE*]

BOB: Oi! What was that loud noise I heard earlier?

[3] A euphemism used in times of military conflict to describe armaments fired in error at one's own troops (Safire, 2008: 224)

[*MINI-ME fires his gun into the air*]

BOB: Hey, you can't do that in 'ere – 'elf an' safety!

[*MINI-ME points the gun at BOB who instantly puts his hands up. DAVE does the same*]

BOB: Hey there! Easy tiger!

[*With one hand MINI-ME takes a crumpled piece of paper from the top pocket of his overalls. Hands it to MAGIC MIKE*]

MANNY: [*To BOB*] It's all right – it only fires tranquiliser darts.

MAGIC MIKE: [*Reading from the page*] The organisation has fallen short on our targets for this most recent second quarter. In order to meet them going forward all the team managers will have a recovery plan in order to make up the shortfall by the end of the fourth quarter. As commissioners the local authority expects deficits in Section 75[4] arrangements to be clawed back. This will be achieved by such interventions as an increase in socially inclusive activities by service users, and in the use of WRAP[5] plans. I will not tolerate failure. People who fail will be terminated. I mean their contracts will be terminated. [*MAGIC MIKE high-fives MINI-ME*]

MANNY: And a happy Christmas to you, too!

[4] Since the National Health Service Act 2006 money can be pooled between health bodies and health-related local authority services, functions can be delegated and resources and management structures can be integrated. These arrangements allow commissioning for existing or new services, as well as the development of provider arrangements, to be joined-up. Previously referred to as Section 31 Health Act flexibilities. (Department of Health, 2010)
[5] Wellness Recovery Action Plan: a self-management plan for a person's mental health (Copeland and Allott, 2010)

RITA: [*To MANNY*] So they want service users to get out more? They want us to use WRAP? Even though service users might not want to? Don't we have a choice? Just because something is in government documents about Recovery doesn't mean it *is* Recovery….

[*DALEK ENTERS*]

DALEK: Exterminate! Exterminate!

BOB: Hang on! Hang on! I don't know whether to stand with my hands up in the air or just run for me life….

MANNY: Welcome to my world….

[*A white flash comes from the base of the DALEK. It stops dead*.]

MANNY: Hmm. Looks like it got too angry for its own good and blew itself up.

[*ENTER TERRI. MINI-ME gestures with the gun towards the broken DALEK. BOB and DAVE go to push it off stage*.]

DAVE: [*To BOB*] Haven't we already done this once?

BOB: It's our job. Stop complaining, will you.

DAVE: This feels like *déjà vu*.

BOB: *Déjà* what? Oh, you mean doing the same thing again?

DAVE: Well, yes, sort of…

BOB: You and your fancy fucking French or whatever it is. Just push this stupid heap of junk, will you? And if we take our time we can get overtime for it.

[*BOB and DAVE EXIT muttering, pushing DALEK*]

TERRI: So you've heard what Mini-Me said?

MANNY: Er, yes. Why did he read out his letter to us? It's addressed to you!

MAGIC MIKE: Because it's inspirational! [*Pauses*] Isn't it?

MANNY: [*Incredulous*] Fuck, no!

TERRI: [*To MANNY*] So now you can see the pressure I'm under.

MANNY: Well, now even more than ever I don't know why you want to stay around.

[*ENTER SOPHIE with ESTATE AGENT. She is dressed as a fairy; he is dressed in a suit holding a take away latte coffee*]

ESTATE AGENT: Well, can I drill down and answer that question for you?

MANNY: No thank you, because I don't believe a word you say.

SOPHIE: [*Sharp intake of breath*] Oops! I left my wand behind!

MANNY: It broke – don't you remember?

SOPHIE: Yes…but I have a spare back in my desk drawer…it doesn't work though…but it looks authoritative…. [*Chuckles*]

ESTATE AGENT: Terri's decided to remain on board because she wants to oversee the local implementation of Stage Three of the Trust's recovery services plan….

RITA: Which says…?

MANNY: [*To RITA*] Don't bother, he won't be able to hear you. He's all bullshit and no substance.

TERRI: …which is made up of two teams, Recovery and ASPA. ASPA stands for…

ESTATE AGENT: [*Butts in*] …'Assessment and Single Point of Access'. Offering support for newly-referred service user units…

RITA: [*To MANNY*] Doesn't he mean 'people'?

MANNY: [*To RITA*] Payment by Results[6] does that to you…

ESTATE AGENT: …of up to six weeks. And if any of those SUU[7]s need support for longer than that initial six week timebox then we will extend the boundaries to six months for the Recovery team to support them. Then they'll be discharged, going forward.

RITA: So whatever happened to person-centred care? And now recovery has to take up to six weeks in the first instance, then up to six months? What if people need longer? Which many people do!

[6] Under the reforms to NHS Financial Flows, instead of being commissioned through block agreements as previously, hospitals (and other providers) will be paid for the activity that they undertake (Department of Health, 2009)
[7] Pronounced 'soo' i.e., 'Service User Unit'

MANNY: [*To RITA*] People will end up being discharged when they're not ready, of course...

TERRI: People will be reviewed at six months by the Care Coordinator. And members of the new team will…

ESTATE AGENT: …come from within the existing community team.

[*A woman – ODETTA - ENTERS – or 'springs' in - dressed in a black tracksuit with two white stripes down each side and that is too small for her. The tracksuit and her white training shoes look brand new.*]

ODETTA: Hello!

[*ODETTA is ignored by the others. She springs up and down on her toes, hands on her hips bends from side to side, exaggeratedly puffing her cheeks, doing starfish jumps*.]

MANNY: So service users will stay on the caseloads of fewer care coordinators and we'll just get more and more people and less and less time to spend with them.

RITA: [*To MANNY*] Well, that's genius, that is….

SOPHIE: [*To MANNY*] You'll just have to discharge people off your caseload after six months.

MANNY: Even if they're not ready to be discharged?

ODETTA: [*Waves*] Oh, hell-oo!! [*Still ignored*. *Exercising ostentatiously throughout.*]

SOPHIE: Yes. That's just too bad. If people and their carers want to make a complaint then give them the PALS[8] phone number! [*Smiles*]

MANNY: And you really believe that?

[*SOPHIE smiles*]

ESTATE AGENT: Well, if service user units are not ready to be discharged after six months then I would have to ask questions about the recovery skills of the practitioner offering the interventions.

MANNY: You mean me?

RITA: [*Stamping her feet*] Aaagh! This makes me so angry!! Recovery isn't something you *do* to somebody – it's the way you *are* with them!!

TERRI: [*To MANNY*] Well, if they are on your caseload and you are the care coordinator then yes, that will be you.

MANNY: So - shall I leave the service now? Or wait until I'm put on a disciplinary because I don't have enough time to do everything – and *then* leave?

SOPHIE: You should have time within your contracted hours to do everything.

MANNY: Yes. So you said. I think that's your mantra.

[*A BUDDIST MONK ENTERS, dressed in orange*.]

[8] Patient Advice and Liaison Service. Deals with complaints and comments about NHS services (NHS, 2013)

BUDDIST MONK: 'Mantra'? Did somebody say 'mantra'? [*Sits down in the middle of the throng and assumes a meditative posture.*] Ommmm….

MANNY: What's *he* doing here?

ESTATE AGENT: Ah, we thought that after six people from the team reported to Occupational Health with high stress levels, we would work towards reducing levels of stress in the team, going forward.

RITA: By?

MANNY: By?

TERRI: Teaching inner peace - even though I didn't agree with his idea [*looks at ESTATE AGENT*]. Because I'm a Christian, so I already have inner peace.[9]

MANNY: Oh, really? Inner peace but no principles, it seems to me. [*Pondering*] I don't know – perhaps that's *why* you have inner peace. [*Looks at the BUDDIST MONK meditating*] Well, it seems the only inner peace he's teaching at the moment is to himself.

ESTATE AGENT: But don't you think that just to look at him makes you feel much calmer?

MANNY: No. Just bloody envious!

BUDDIST MONK: [*Open his eyes. Looks straight ahead*] We should all learn from the haiku: 'Sitting still doing nothing: the clouds still move, the grass still grows."

[9] John 14.27, *Holy Bible*

MANNY: Yes, very profound. And anyway, that's a koan not a haiku.

BUDDIST MONK: [*Bows meekly*] Thank you for the correction, brother.

MANNY: We're not related are we?

BUDDIST MONK: [*Bows*] We are all one, brother….

MANNY: Nothing is worthwhile…and knowledge chokes…..[10]

ALL: What?

[*MINI-ME whispers to MAGIC MIKE*]

MAGIC MIKE: He says he needs a toilet break. Can somebody hold the gun while he pops out? No? Here, give it to me – I'll….

[*MINI-ME hands the gun to MAGIC MIKE and EXITS one side of the stage as BOB and DAVE ENTER from the other side*.]

BOB: 'Ere, you'd better give that to me. You can't have that 'ere. 'Elf an' safety. *[Takes the gun and looks along the barrel.*] Is this thing loa-

[*Gun goes off. Plaster falls from the ceiling*.]

BOB: [*Drops the gun*] Fuck me, what happened?

DAVE: The gun was loaded and it went off!

BOB: Yeah, I know that, you knob'ead. I was being all surprised, like.

[10] The prophet of the great weariness, a character in *Thus Spoke Zarathustra* by Friedrich Nietzsche.

DAVE: Oh, sorry. [*Giggles*]

[*BUDDIST MONK gets up to leave*]

ESTATE AGENT: Hey – where are you going?

BUDDIST MONK: Somewhere quiet to meditate. This is a madhouse. There's no peace here - let alone *inner* peace.

[*BUDDIST MONK EXITS. MINI-ME ENTERS from the opposite side of the stage. Stands next to MAGIC MIKE*]

MANNY: So – what are you going to do about the high stress levels now?

ESTATE AGENT: Well, stress is an indication of weakness.

[*MINI-ME whispers to MAGIC MIKE*]

MAGIC MIKE: He says that stress will not be tolerated in this organisation.

MANNY: Then very soon you'll have nobody left to work in it. We'll all be on sick leave.

[*MINI-ME whispers to MAGIC MIKE*]

MAGIC MIKE: He says that stress is not a recognised work-related illness in the new Trust.

ODETTA: [*Waving*] Hello!!

MANNY: [*Irritated*] Yes – what do you want?

ODETTA: [*Jumping up and down on the spot as she speaks, twisting her body from side to side, hands on hips*] Hello. I'm Odetta. I'm from Organisational Development.

MANNY: And you do what exactly?

ODETTA: Oh, I'm here to get you ready to provide a 21st century Recovery service…. [*Still exercising*]

RITA: But you don't even know what Recovery is….

MANNY: But you don't even know what Recovery is….

ODETTA: [*Exercising*] But that's my brief….

[*MINI-ME whispers to MAGIC MIKE*]

MAGIC MIKE: He says she has my full backing. She's doing an important job…. [*Turns to look quizzically at MINI-ME. Mouths the words 'She has my full backing?" to him.*]

[*Odetta marches over to ESTATE AGENT. Grabs the takeaway coffee from his hand.*]

ESTATE AGENT: Hey!

ODETTA: Sorry, you can't have that – that's naughty!

ESTATE AGENT: But I was drinking that!

[*MANNY and RITA both laughing*]

ODETTA: Coffee – that's a no-no – you should be drinking water….

MANNY: Because of the caffeine?

[*ODETTA takes an object out of a tracksuit pocket. Throws it at him. He flinches*.]

ODETTA: Correct! Have a chocolate coin!

MANNY: Ouch – that hurt! A gentle underarm throw would've been nice….

ODETTA: Well – we've got to keep you on your toes!

MANNY: No you haven't…I'm already on my knees working here….

DAVE: It's better to die on your feet than live on your knees…

[*BOB gives DAVE a withering look*]

DAVE: Albert Camus said that. In his book *The Myth of Sisyphus*….

BOB: [*Shakes his head. Under his breath*] Fuckin' 'ell....

TERRI: Actually, wasn't it Emiliano Zapata who originally said that?

BOB: Wot? "Ff…."

TERRI: [*Hurriedly*] No! [*Pause*] Actually, I don't know how I know that. How do I know that?

[*ODETTA throws a coin at TERRI*]

ODETTA: Here – have a chocolate coin!

TERRI: No, thank you – I'm diabetic….

[*SOPHIE bends down to pick the coin off the floor. Unwraps it*.]

SOPHIE: Mmmm. Chocolate. *So* yummy!!

ESTATE AGENT: So – can I have my coffee back now?

ODETTA: [*Holds it away from the advancing ESTATE AGENT. Turns the cup upside down.*] Oh, it's empty!

ESTATE AGENT: Of course it is - it's a designer accessory – do you have any idea how much that cost? It was a week's salary for you. Now give it back, will you?!

ODETTA: [H*olding the cup above her head*] No, I'm sorry - you can't have it back!

ESTATE AGENT: If you don't give it back I'll suspend you!

BOB: 'Ere, you can't just go around suspending people at the drop of a hat.

ESTATE AGENT: I can do what I like – I'm the Service Manager.

MAGIC MIKE: No, you can't. The chap there is right. There's a policy to go through first – she needs to be placed on capability supervision. And anyway, *I'm* the boss around here. [*Looks pointedly at MINI-ME*]

DAVE: And then, if her performance doesn't improve under capability supervision…..

ESTATE AGENT: Then I'll get my coffee cup back?

DAVE: Ah, you see, mate, strictly speaking that isn't yer actual coffee – that's just a coffee cup. Bereft of the liquid derived from its burnt umber seeds, so it is.

ESTATE AGENT: [*Leaps up and grabs the cup from ODETTA's outstretched hand*] Ah! Got it! [*EXITS, running*]

ODETTA: [*Calling after ESTATE AGENT*] Such superb athleticism! Hey – come back for a chocolate coin! You deserve a prize!!

SOPHIE: A chocolate coin? Can I have it if he doesn't want it?

ODETTA: [*Contemptuously looks SOPHIE up and down*] Hmmm. I think you've already had enough chocolate coins to last you a fair while, young lady. Here – come with me, I'll sort you out. Let's go!!

[*ODETTA and SOPHIE EXIT. LIGHTS OUT.*]

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N14

TARGET PRACTICE

07/05/10

DRAMATIS PERSONNAE:

NARRATOR

ESTATE AGENT

ODETTA

RAY

COMPERE

MANNY

MAGIC MIKE

RITA

QUEEN

DOCTOR

A room. Sounds of cheers, though no visible signs of jubilation. ODETTA, MANNY, RITA, QUEEN, ESTATE AGENT, RAY, TERRI, SOPHIE present. The jubilant sounds suddenly stop. ODETTA has her hand on the dial of a radio cassette recorder behind her.

ESTATE AGENT

Thank you, Odetta. [*Pause*] Congratulations to Ray here, who is this month's... *Employee of the Month!....*

ODETTA

Come on! Let's be 'avin you! ‘Ave a chocolate coin! [*She throws a chocolate coin in the general direction of RAY*]

RAY

[*Aside, to MANNY*] They've got it all wrong - I haven't done it. I haven't done that many....

ESTATE AGENT

...who has managed to achieve seven direct payments for last month, which has gone a long way to us as a mental health service provider meeting our Section 75 targets! [*Gestures towards ODETTA*]

[ODETTA turns the dial on the radio cassette recorder. Sounds of jubilation. COMPERE walks on.]

COMPERE

Fear ye not, ladeezangennulmen. [*To ESTATE AGENT*] Is this a presentation? I can help....

ESTATE AGENT

[*Irritated. Dismisses him with one hand*] [*Tersely*] No, no, it's all right, I can manage this all right without your help, thank you!

COMPERE

[*Mournfully*] But I'm a 'ffessional[1] at this!" [*EXITS*]

[*ESTATE AGENT turns to ODETTA.* Makes *a rapid movement with his two arms in front of him, which cross at the wrists, stop and then part suddenly. The jubilant sounds stop accordingly.]*

ESTATE AGENT

And as a reward, please let me offer to you a bound copy of the Department of Health's latest white paper, *Setting Performance Targets as Recovery Outcomes.* [*Reaches behind him and frantically gestures to ODETTA, who hastily gives him a glossy A4 booklet.*] *Here, it's signed by the SHA Lead himself*. [*Opens the booklet to reveal the inside front page*]

[1] A term used by the UK radio talk show host Nick Abbot, who uses it to satirise those who assert they are competent when they are not

RAY

[*Aside, to MANNY*] Department for Bullshit, more like - what do I want that load of bollocks for? And, anyway, all I did was get a few magazine subscriptions for my patients.

MANNY

Yeah. But it met a target, didn't it? Look, you have to play them at their own game, just to keep your job. Just go up there and get it, will you. Don't make waves.

RAY

The only waves I'd make is while I'm drowning the stupid knob.... [*Goes up to collect the book from ESTATE AGENT. Shakes his hand as he does so. A loud burst of jubilation*. *Applause from the others. Walks back, looking dejected.*]

ESTATE AGENT

[*Surveys his audience*] And for the rest of you - during the next few weeks you will each be sent a letter telling you what your targets will be for the next financial year. [*Pause for dramatic effect*] For those of you working in the community, you will need to carry out two Carers Assessments and one Direct Payment each month.

[*MINI ME pulls at MAGIC MIKE's sleeve, who bends down to listen to MINI ME talk into MAGIC MIKE's ear*.]

MAGIC MIKE

And there will be no stacking up. [*Looks at MINI-ME quizzically*]

[*MINI ME indicates that he has something to say. MAGIC MIKE bends again to listen to MINI ME talk*.]

MAGIC MIKE

Ah. Yes. Stacking up. He means – I mean – no doing a lot in one month so that you don't have to do any the next month.

ESTATE AGENT

Yes. Two Carers Assessments and one Direct Payment each month means exactly that. Per month. Minimum. So no stacking up….

[*ESTATE AGENT receives a withering look and a shake of the head from MAGIC MIKE*]

MANNY

[*Whispers. To RITA*] At this rate *I'll* be stacking. Stacking shelves in my local supermarket, that is, after I've been sacked for not meeting my targets!

ESTATE AGENT

[*Inhales and exhales tediously*]. Quiet at the back there. PLEASE!

MANNY

[*Shouts*] And what if carers don't want an assessment? And surely after you've gone through your caseload then you haven't got any more carers to offer assessments to. Not...unless...you… [*horrified by the realisation*] discharge everybody and take on a new caseload?!

[*MINI ME pulls at MAGIC MIKE's sleeve. Bends down to listen to MINI ME talk*]

MAGIC MIKE

Carers will have assessments. Not having them is not an option.

MANNY

Do you think carers know that?

ESTATE AGENT

[*Irritated*] We know what's best. We are a Recovery service. [*Hastily*] And as for your second point....This target is intended to ensure that care coordinators have a throughput of service user units on their caseloads.

RITA

[*Shouts*] But some people need support for longer than six months!

MANNY

[*To RITA*] I don't know why you keep trying to make him listen. He can't hear you. [*Shouts at ESTATE AGENT*]

But some people need support for longer than six months!

ESTATE AGENT

Then they will have to stay on your caseload. With Payment by Results we only get paid per unit throughput, and the less time a unit stays on our books the more profit we make, and the more successful the organisation is and [*pointedly*] the longer <u>*you*</u> have a job. [*Impatient*] I would have thought that was obvious.

MANNY

Excuse me - but you're talking about people here....

ESTATE AGENT

No. I'm talking about the reality of modern healthcare.

QUEEN

And if you don't like it then, well, I can arrange your exile...

MANNY

I might well take you up on that! [*Takes a white envelope from inside his jacket. Hands it to her*.] I've been walking around with this for a few days now. But now the time is right. I can't do this any more. [*With assurance*] I'll work out my notice period. I'm leaving the Trust.

QUEEN

Oh. I see. Very well then. [*Hands the envelope to one of her retinue*] Here. Do something with this, will you? [*Lackey EXITS hurriedly, holding the envelope*]

RITA

[*To MANNY*] Are you sure about this? Can't you stay? And make a difference?

MANNY

Yes, I'm sure about it. As I said, I've been planning it for a while now. And I can't make a difference. So why bother trying to?

RITA

But you didn't tell me you wanted to go; I had no idea. [*Pause*] After all we've been through together.

MANNY

Well, all things come to an end. I'm sorry if I sound like I don't care but...well, that's modern healthcare. [*EXITS hurriedly. RITA runs after him to catch him up*]

RITA

Manny! Manny!

[*First MANNY, then RITA, collide with the DOCTOR on the way out, both times with a loud "Tsk!" The DOCTOR impedes RITA by comically moving from side to side for a few moments in the same direction as her, as if they are dancing, as she attempts to get round him*.]

RITA

[*EXITS, still running*]

Manny! Manny! Come back! Come back!

[*Lights fade. ENDS*]

N15

DISPOSAL DAY

11/09/10

DRAMATIS PERSONNAE:

NARRATOR

MANNY

JOHN

RITA

BOB and DAVE

DOCTOR

[*A room. Two chairs. MANNY sits on one chair, JOHN sits on the other one. They are facing each other. RITA standing behind MANNY, leaning on the back of his chair. MANNY holding a sheaf of papers on his lap, and a pen.*]

MANNY

John, we need to discuss your Care Plan.

JOHN

Don't you usually do that back at the office and show it to me and I sign it?

[*RITA shakes her head*]

MANNY

[*Smiles ruefully*] Well, yes, I know we've done that in the past. But as I explained to you at the time, it's because I didn't have time to do it with you first.

RITA

[*To herself, but loud enough so that MANNY can hear*] So what about 'partnership' then? [*MANNY pretends he hasn't heard*]

JOHN

So do you have time now?

MANNY

[*Embarrassed*] Well, no, not really....

JOHN

So why are you telling me you should be doing it with me, then?

MANNY

I don't know. I really don't know any more. That's why I'm leaving.

JOHN

What? Oh, you're leaving? You didn't tell me that.

MANNY

I'm sorry. I thought I had. I've told so many people that I forget who I've told and who I haven't.

JOHN

Thing is, you just get used to somebody and they move on. Why is that?

RITA

[*To MANNY*] Yes. Why is that?

MANNY

[*To both*] Oh, I don't know. You can only take so much crap for so long, I guess.

JOHN

Difference being that I have to put up with it much longer than you do, because I'm the one who's mentally ill. I can't piss off somewhere and start somewhere else. I'm stuck with this. [*Taps his head with an index finger*]

MANNY

[*Concerned*] Oh, I see. Does it make you feel angry? [*RITA shakes her head contemptuously*]

JOHN

Don't patronise me, will you? You sound like a social worker. [*Looks at RITA. Is sarcastic*] 'I think John should take the lead in this meeting. John, can you tell us, please, if you wouldn't mind, just exactly what you're feeling at this very moment.' They should go back to eating muesli and wearing their open-toed sandals and reading 'The Guardian'. The patronising twats.

MANNY

So do you think I'm patronising?

JOHN

What does that matter - you're leaving soon.

[*An awkward silence. RITA crosses the floor to stand next to JOHN]*

MANNY

[*Awkward*] Well. Anyway. First I need to ask you a couple of things.

JOHN

Like what?

MANNY

Well, you may have heard about meeting targets in health care now.

JOHN

I heard on the news that they're nonsense because people get round them. [*RITA nods*] People aren't stupid. They'll always get round things like that. [*Thinks*] I watched an episode of 'Casualty' once where the nurses just moved the patients from one part of A&E to another one, just before the time limits for each one kept running out.

MANNY

[*Uncomfortable*] Well, yes, I'm sure that happens. [*Pause*] Anyway, I've got targets of my own to meet. [*RITA shakes her head*]

JOHN

So? Why are you telling me?

MANNY

Because they are to do with Carers Assessments and Direct Payments. I have to do two Carers Assessments and one Direct Payment a month.

JOHN

[*Sarcastic*] Lucky you.

MANNY

[*Looking down*] Yes, aren't I just?

JOHN

I know what a Carer is, and I don't have one, but what's a Direct Payment?

MANNY

A Direct Payment is like when the local council give you money to buy things that will help you improve your mental health. [*As an afterthought*] And help your recovery.

JOHN

And do I have to pay it back? I can't really afford to. I'm on benefits.

MANNY

No. You don't have to pay it back.

JOHN

You mean it's like free money? To buy stuff with?

MANNY

Well...yes...it's sort of like that....

JOHN

Hey, sign me up for that, then!

MANNY

But there are some limits on what the money can pay for. And we'll have to adjust your care plan to include it.

JOHN

But you're good at that. That's your department.

RITA

[*To MANNY*] What about working in partnership?

MANNY

[*Quickly to RITA*] I don't have time. [*Continues, to JOHN*] And once you're discharged you won't be able to get the payment any more.

JOHN

Why's that?

MANNY

Because in order to receive a Direct Payment you have to have a Care Coordinator in the community mental health team. And after I've discharged you because you're recovered then obviously I won't be working with you any more.

JOHN

So don't discharge me then! [*Places a hand to his forehead in an exaggerated fashion*] Oh, I'm hearing voices telling me to kill myself. You can't discharge me! [*Laughs. Looks up at MANNY*]

MANNY

I'm sorry. I can't help that. Those are the rules.

JOHN

[*Sarcastic*] Great rules whoever thought those up! Doesn't really make sense to me.

MANNY

[*Uncomfortable*] Anyway. The Carers Assessment.

JOHN

I told you, I don't have a Carer.

MANNY

No family? Not even a next of kin?

JOHN

No. I have a brother in Australia, though.

RITA

[*To MANNY*] What? You're not going to go all the way out there to do a Carers Assessment, are you, just to meet a target?

MANNY

[*To RITA*] Be quiet, will you, and let me concentrate. [*To JOHN*] What - there's no-one?

JOHN

No. I told you.

MANNY

[*Thinks to himself*] Do you have a cat?

JOHN

No. Why?

MANNY

Well. The cat could be your main carer.

JOHN

Eh?

MANNY

Well. It'd be looking after you.

JOHN

What? It's a cat, for God's sake. I would be looking after it! [*To RITA*] What is this bloke on about?

MANNY

What about a dog? A hamster? A gerbil? Surely there's something? I need it to meet my target.

JOHN

I'm sorry, mate. I'd like to help you. You sound desperate.

MANNY

That's because I am. My job's at stake.

JOHN

But you're leaving anyway.

MANNY

I know. But I'll be leaving even sooner if I don't meet my targets.

[*Enter BOB and DAVE*]

BOB

'ere - let's 'ave them chairs, then.

MANNY

What do you mean? Can't you see we're using them?

BOB

Sorry, mate. They've got to go. Didn't you know they're having a clean up?
Today is Disposal Day!

DAVE

Got a great ring to it, that,
hasn't it? Alliterative. 'Disposal Day'!

MANNY

Well, yes, I heard something, but I wasn't quite prepared for this....

BOB

Didn't you get the email?

MANNY

[*Sharp intake of breath*] What email?

BOB

Well, if you'd read the email….

MANNY

Bu I didn't read any email! Honestly, you get so many emails that you don't have time to read them all - and then you miss something you should've known because you haven't read the email. And it's your own fault because it's written down so you should have read it. Crazy.

BOB

Well, I'm sorry, mate...but I've got a job to do.....

MANNY

Well so have I - but I can't do it because they keep moving the goalposts...

DAVE

...or the chairs.... [*Chuckles*]

JOHN

What? And has even the good stuff got to be chucked out?

BOB

Yep. Everything what isn't anti-ligature. Or what doesn't have the new Trust logo on it.

JOHN

That's mad. You people are throwing good stuff away and then chucking money at me. You're more bonkers than I am.

[*A pause*]

MANNY

[*To JOHN*]

But, John, they're different departments. The NHS are throwing away the good furniture. And it's the Local Authority who are 'chucking money at you', as you put it.

JOHN

It's the same difference to me, mate. It's all public money, isn't it?

BOB

Come on, then. Let's 'ave them chairs.

[*MANNY and JOHN stand up as BOB and DAVE pick up a chair each and start to leave*]

BOB

[*To DAVE*] 'Ere, I reckon if we went to the local auction house we'd get a few bob for these. Or stick 'em on Ebay[1] or somefin'.

DAVE

Yeah. But you know we're not supposed to. Everything's got to go in the skip.

BOB

Well, they ain't gonna check, are they? They couldn't wipe their arses with the right end of a toilet roll, that lot.

[*BOB and DAVE EXIT holding chairs*]

[1] A popular online auction and shopping site (http://www.ebay.co.uk/)

MANNY

[*To JOHN*] Well, I suppose we'll have to finish this off some other time, won't we?

JOHN

[*Slightly confused. Distractedly offers his hand to MANNY for him to shake*] Er…yeah…okay, then, mate.

MANNY

[*Shakes JOHN's hand*]. Yes. See you. Good luck. Thanks. [*To RITA*] And you - I'll see you. [*They embrace*] I won't forget you, you know.

RITA

[*Pulls away from the embrace*] Don't. Don't forget me. [*Pause. Offers her hand for him to shake*] Goodbye. Have a nice life....

[*Rita looks away. MANNY is about to release her hand as the lights fade to the music of 'Drophere' by Dzihan & Kamien featuring Madita.*[2]]

[*ENDS*]

[2] Dzihan & Kamien (2003).

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CHAPTER FOUR

COMMENTARY ON THE NARRATIVES

Throughout this series of narratives the character of the Doctor is ever-present on the stage but does not directly appear in my narratives. It is my depiction of the traditional unease that exists between doctors and nurses, whereby nurses tend to see doctors as obstructive and oppressive (Fagin and Garelick, 2004[1]). By representing the traditional unease in this way I wish the audience to challenge this conception and the Doctor's position within the dominant paradigm (Medicine). This stage obstruction is only directly indicated once in my narratives (N12); however I take the traditional antipathy as given and already in the consciousness of most nurses, and therefore at the discretion of a director as to how to illustrate it.

The part of my personal journey represented by my narratives contained in this thesis began when I found myself 'acting up' as manager of the rehabilitation unit in which I had already worked for four years as a staff nurse. In the first of these narratives (N1) I tried to convey my own disorientation and my fear at my new position, and the sense of responsibility that I felt about proceeding with the Recovery project that the Unit Manager who was substantively in post had started.

The jeers and heckles from the audience were intended to represent my self-doubts. When the narrative was performed in a drama studio at the University the jeers and heckles from the assembled audience came across as

[1] The Fagin and Garelick (2004) paper is dismissive of the notion that there is a justifiable antipathy between the two professions; however it is worth considering that both authors are medical doctors and therefore writing from a position of privilege and power.

enormously discomfiting to me. It was interesting that while on paper they only represented my own fears and self-doubts, to hear them being hurled at me in the studio caused those self-doubts and fears to be more real, as though they now became doubts and fears about my own competence to continue to steer Recovery. Nurses experience shame associated with thoughts of incompetence (Dartington, 1993: 29). This is reinforced by the emphasis on competence placed upon nurses as a condition of registration (Nursing and Midwifery Council, 2008).

This terror subsequently became more apparent to me at AN's[2] portrayal of a shrieking, agonized Recovery frustrated at my lack of grasp of who she is and what I wanted from her. Although AN's physical representation of the character was improvised, her enactment coincidentally prompted childhood memories of my mother's mental illness, and so it was immensely traumatic for me to have the character of the Woman interpreted in this way. As I stood behind a lectern trying to make a rational, logical, inspiring speech, I felt immensely troubled by what was occurring in my mind as I spoke, as I attempted to present a particular image and exemplar to others. My reflection upon this now is that this scene depicted my own psychological struggles and how that impacted upon my professional performativity.[3] I did not know how to manage my own anxiety, nor that of the Woman's. At the time I had temporarily rediscovered my Christian faith, hence the Manager's weak (and somewhat desperate) resort to prayer

[2] Chapter Two, p. 84
[3] I refer specifically to Judith Butler's notion that identity is performed and reiterative. At the same time as it is reiterative it iterates the identity of the other (Butler, 1993)

and evangelism (the t-shirt that declared JESUS LOVES THIS GUY) in order to calm the Woman as it had calmed him. I liked this image of the Manager ripping open his suit to reveal his superhero – and comic! - abilities because ironically he is – I am – far from that. In a way mine was an attempt to prevent the Woman's anguish from touching me. As a manager Recovery suddenly took on a vital, ardent significance that demanded my attention. It was a challenging, emotional aspect because I find emotions very difficult to process. I had invested my hopes for political change, and my ambitions for radical meaning for the lives of both nurses and service users, in Recovery.

The Manager's ill-fitting suit was intended to represent how his new role and the expectations that came with it were equally ill-fitting; and for the Woman to only wear a flimsy shift was in order to convey her vulnerability.

Narrative N1 also introduced the character of the Compère. I have to admit that this character mystified me as to why he is present throughout many of my narrative texts, as his character did not feel to be only a dramaturgical device used to hold scenes together. However his character arose because his character *flowed* from my being onto the page. He offered a sense of tawdry showmanship, as was indicated by a drama student's representation of him at the Drama Workshop on 04/02/09 as drunken and bumbling. Perhaps the Compère represents somebody who has seen better days, such as the NHS Trust I first worked in before it was subsumed by a Foundation NHS Trust. Therefore he inhabits the later narratives as a sort of Dickensian revenant of

what the NHS once was. Or perhaps constant tinkering with the NHS since its inception have driven him to alcoholism and misery.

In N2 the Woman's emotions had changed from agony to anger. This was a cipher for how I felt my relationship to Recovery had changed since I began to consolidate my role as a manager. I had started to feel that Recovery was an organizational project, and that it was my function as a manager to steer that undertaking. I imagined that the Woman (i.e., Recovery) felt anger and impatience towards me because the ideals that I had as a staff nurse – the everydayness of my clinical practice – were starting to be supplanted by political considerations in line with organisational goals. Hence the Manager's comfort at being in the presence of the Service Manager; and hence the Woman's rage that I was basking in the sunshine, comfort and warmth of political power and influence rather than affecting people's lives directly as I had done as a staff nurse. Again this narrative is riven with self-doubt and unease, which I found myself describing spontaneously and immediately as I composed the narrative. In an academic supervision at this time CJ told me encouragingly that I was now in a position to directly influence the political strategy of the organisation; but I felt unnerved by this thought, as I already had a particular preconception of how large organisations such as the NHS Trust which employed me would function. (Such a preconception may be helpful or not, of course.) My preconceptions are indicated in Chapter One.

I had started to become caught up in attempting to position myself politically

within the organisation. The post of Manager that I had 'acted up' into was advertised as a short-term secondment of three months and although I applied and was interviewed for it – and had already been 'acting up' in post for six months – I was unsuccessful. The Service Manager's words in the narrative are the actual words that she used when she advised me of the decision. Therefore I also wonder whether the Woman (Recovery) felt angry at me because I hadn't presented the case for Recovery sufficiently at interview. She may simply have chosen to direct her free-floating anger at the organisation's stunted implementation of Recovery at me because I was familiar to her and she could anticipate my response to her rage. I was disappointed at the interview result because I experienced the successful candidate as being unemotional and systematic in her own clinical practice. I found Narrative N2 particularly difficult to write because I had an emotional response to the Service Manager's decision from interview, as the following narrative (N3) shows; but I felt that it was most appropriate for me not to betray my emotion because it did not correspond to my self-image as a practitioner. I was afflicted by the macho-posturing culture of mental health nursing (Clarke, 2008).

N3 was equally a very difficult narrative to write, because of the emotion that I felt but did not wish to betray. The emotion was not merely disappointment but also my greatest fear that I am held to be not good enough. On reflection the experience described in N2 and N3: *A Full Moon* had an immense personal significance for me, as my emotional response to events led me to experience an episode of depression. During a camping trip on the weekend following the

result of the interview I awoke with a start and took a walk in the dark silence outside the tent, and I had a feeling that I was being followed by demons that disappeared each time I looked around. It was a frightening experience, and lasted only minutes, yet it clearly indicated the way in which an experience from my practice could affect me so profoundly, and could invoke my dread and my worst fears. When I sat down to inquire into this narrative I found that reflexivity did not resolve the emotions but made them more powerful by highlighting their significance. Ironically it was this unease which had caused me to isolate the experience in the first place and to narrativize it.

In the midst of this trauma and dread, within several days of being notified of the initial interview decision I was offered the post I had applied for because the successful candidate had withdrawn. However this only served to re-energize my fear that I was not good enough to ever be first choice.

Subsequently, my reflexive study of N4: *The Commissioner's Visit* indicated that my dread diffused into ridicule and cynicism. I felt that I had found a purpose for my narratives: catharsis. Narrative N4 was based upon an impromptu visit by a representative of the Commissioners in the PCT, who was accompanied by a balding man dressed in a dark suit, white shirt and dark tie, and wearing glasses, who explained that he was a health and safety specialist, and who assiduously took down notes in a paper notebook as we followed the commissioner about the unit. The commissioner had very much a military bearing (hence her characterisation), as though efficiency were her watchword,

and I felt that she savaged with military brevity the clinical environment in which I worked (hence her name 'Mauling' in the narrative). I enjoyed writing this narrative, and its comedy was well-received in the monthly supervision group; which of course I found to be encouraging, as I had not hitherto introduced comedy into my narratives. I found the visit itself to be disrespectful of the efforts I and my team were undertaking to work according to the goals of Recovery that had been set for us. It seemed to me that the Commissioner was critical of the clinical environment, as this is what she and the health and safety specialist focussed upon, with no mention of Recovery. I wrote my narrative of the experience in order to resist the criticism that I felt personally as a result of the Commissioner's visit, by representing the visit with vitriol and humour, in fact projecting “the deranged as normal” (Smith,1989:10). I wanted to use fiction and farce to “allow space to raise hard-hitting and very specific criticisms” (Pratt and Kirby, 2003: 19) of the preoccupation of the commissioners of mental health services with the technicalities of the clinical environment rather than with the aims of Recovery. I found writing the narrative to be cathartic because I would not have made such observations at the time of the incident, constrained as I was by my expectations of myself and of others.

At this point in my narrative journey for the first time I felt a distance between what I experienced in my clinical practice and the way in which I depicted those experiences. I no longer felt emotionally involved (as I had prior to N4) with my narrative texts. This strategy was perhaps a means of managing my emotions or even of disowning them. It was during a later phase of my transformative

journey that I identified from the literature that I had achieved a *cynical distance* from the organisation. According to Fleming and Spicer (2003) this is a common strategy by employees working in organizations. It is

- a psychological defence mechanism that protects the individual's core self from the what they perceive to be the powerful influence of the organization;
- a means by which workers can remove themselves ('dis-identify') from the roles that they perform in the organization; and
- a means of covertly questioning organizational practices.

Cynicism typically however does not effect organizational change, as the cynic may have plenty to say but fewer solutions to offer (Fleming and Spicer, 2003). This illusion – or "enlightened false consciousness" (Sloterdijk, 1987: 5) - is embodied in various apparently autonomous practices such as discretionary service behaviour, for example in adopting ways of behaving that are not necessarily approved or scripted by the organisation (Blancero and Johnson, 1997). It is also embodied by shallow-feeling such as a lack of emotional commitment to work tasks, and by working at the margins of practice (Fleming and Spicer, 2003). The cynic perhaps thinks that such practices are subversive but in fact they do not change the way the organization works.

The cynicism of my narratives quickly became my *jouissance*.[4] Cynicism is a way of reconciling the individual to the unhappiness of their situation (Fleming

[4] In Lacanian psychoanalysis the term *jouissance* goes beyond its approximate English translation of 'enjoyment' because it relates to "transgressive violations, the breaching of boundaries and breaking of barriers" (Stanford Encyclopedia of Philosophy, 2013)

and Spicer, 2003). Yet cynicism goes beyond simply being a reconciliation to unhappiness, because it *makes someone feel good.* By reference to it the individual does not appear (especially to themselves) to be a fantasist but is instead a hardened realist who has special insight into the way things 'really' are. Cynicism enables the cynic to bear the harshness of reality; the cynic is unlikely to withdraw from their cynicism for fear of returning to the depression and despair that cynicism deflects them from (Zizek, 2008). Cynicism infused all my narratives from this point on, although this was unconscious. My *jouissance* expressed itself as playfulness and *flow*. This deflected me from my desire to achieve mental health Recovery in my practice, because my struggle to realise my desire had become too psychologically painful for me.

At this point the Strategic Health Authority [SHA] decided that the failing NHS trust that employed me should become allied to (or subsumed into) a local – and very successful - Foundation NHS Trust. As a manager I attended a meeting at which the new Chief Executive Officer [CEO] introduced himself to the organization and described his aims and goals for the takeover. At the meeting he also lauded himself and his relationship with the SHA, and his friendship with the departing CEO. I was reminded of Mark Anthony's disingenuous peroration at the funeral of Julius Caesar: "I come not to bury Caesar but to praise him" (Shakespeare, 1992: Act III, Scene II).

The new CEO came across not as an equal to the one who had euphemistically 'stepped down' from his post, but rather as a more composed and organised

older brother. In the meeting in which he introduced himself to all the Trust's managers, he emphasised several times that he was himself a nurse, as though to gain our confidence and commitment – that is, that he was just like us. In my narratives the new CEO took on the character of a Superhero, class two (i.e., a hero but not a saviour; or a self-styled superhero). The rumour in the organisation was that he had been 'parachuted in' by the Strategic Health Authority in order to save the ailing NHS Trust we worked for. Hence his entrance into the narrative – I imagined an SAS-style mock-heroic entrance, as I remembered the televised SAS assault on the Iranian Embassy in London in 1980. At this point I also introduced the characters of the two maintenance workers with whom I regularly interacted in my practice due to their frequent presence on the unit for various reasons. I grew up watching comedy double acts – Laurel and Hardy, Abbot and Costello, Little and Large, Cannon and Ball – so to make the two Estates workers a 'turn', as AP later described them, seemed only natural to me in contributing to my *jouissance*. The Magic Man – as I termed the new CEO - continued to represent the grating sense I felt of the new organisation's preoccupation with vanity and appearance. The emphasis upon the containment and minimization of risk, which appeared to me to be very clearly contrary to the notion in Recovery whereby positive risk-taking is encouraged as a means of the person re-testing reality (Watkins, 2007; Felton and Stacey, 2008; McCulloch and Ford, 2009; Currie, 2010), surprised and frustrated me for that reason. The two estates workers, Bob and Dave, suddenly appeared to have an increased technical significance within the organisation as operatives who were to carry out physical adjustments to the building in order to

decrease or remove physical risk.

The anti-ligature survey (as mentioned in Narrative N5) was indeed a piece of work that as a manager I had to review four times, as each time the brief changed slightly and the organization demanded a broader inclusion of risks. In the narrative even the service user was nonplussed by the organization's obsession with risk management. In this scene the Manager’s frustration is conveyed by his wistful threat of suicide; that is to say, if one wishes to harm oneself then one will find a means to do so, no matter what arrangements have been made to minimize or remove that risk within the immediate clinical environment. This is not an argument for not managing risk; rather it is an appeal for risk management to be tempered against the goals of Recovery.

Subsequently as a manager I found that I began to find myself concerned with budgets, risk management, costings and reports, to the extent that I had lost sight of the vision of Recovery that I had as a staff nurse. This distance is represented in N6: *An Invisible Woman* when the Manager can hear the Woman but not see her; that is, he has stopped seeing (or noticing) her – but he has not lost her entirely. The period of this narrative was a difficult time for me, because the technical requirements of my day-to-day role as manager of Twelvetrees increased in significance. I also wanted the narrative to convey the cacophony of the technical-rational *impasse* in which I had found myself, and yet I continued to crave Recovery's sensuousness. In *An Invisible Woman* the CEO appeared in another incarnation, this time as Death, in response to a rumour

that had swept the staff-side representatives (of which I was one) in the organization that he had met with the executive board of the former Trust and very clearly spelled-out to them what a Foundation NHS Trust required of its board. The CEO was subsequently to adopt many disguises and incarnations in my narratives, which perhaps indicated that I found it difficult to position him, or which perhaps reflected the inconstancy of the manner in which I related to the organization.

An Invisible Woman was also significant because of my introduction of the character of The Queen. The idea for her character came about when I attended a performance of my son's school play,[5] the plot of which contained the character of a queen bee. I was also reminded of my fondness for the capricious and despotic cartoon Queen in *Alice's Adventures in Wonderland*.[6] Therefore it was a short leap of my imagination to create the character for my narratives.[7]

I remained as Deputy Manager, still 'acting up'; but was not resentful of my demoted role, as I always believed that the Unit Manager was the true inspiration for the practice of Recovery by the team. However, I found that the Unit Manager's subsequent comings and goings to promote Recovery in the remainder of the organisation to be disheartening and stressful, because I felt that she neglected Recovery in Twelvetrees. Indeed, she announced her return

[5] Wootton (2003
[6] (Walt Disney, 1951)
[7] Magical realism lends itself to reflexive examination of the influences upon a text which have been drawn from the narrator's experience and imagination (Langdon, 2011).

to the unit by circulating an email amongst the team (each team member had their own email account) stating that the service would return to the ideals of Recovery that she had established before her secondment, and which I – in my 'acting up' post– had maintained.[8]

Following this initial email, the Unit Manager subsequently sent a personal letter to each team member at their home address. More than one team member was enraged at this, not only because the letter now stated that in her opinion the ideals of Recovery had slipped during her time on secondment, but also because it felt like an invasion of privacy. This imperiousness seemed to set the Unit Manager against the team; and I was also enraged that the letter seemed to suggest a thinly-veiled criticism that as acting manager I had not nurtured the Recovery vision. Therefore I found that my depiction of the Unit Manager's vagaries as the Queen in my narratives to be cathartic.

Hence my cynicism and anger grew, and this largely informed the bitter chaos of N7: *A Glamorous Assistant*. The notion of an irascible and choleric magic show arose from a clinical supervision that I requested from a senior colleague elsewhere in the organization, during which she compared the expectation of us as practitioners facilitating Recovery to be like a magician performing the so-called 'tablecloth trick', whereby objects representing existing mental health services placed upon a tablecloth remained undisturbed when the tablecloth is

[8] This felt like damnation by faint praise, so that I became resentful that she did not indicate in her letter to the team how difficult my task had been in her absence.

whipped away from underneath them. She explained that the tablecloth being suddenly removed represented the impact of Recovery upon those services; and that it was her belief that despite Recovery mental health services expected to go on as before. I liked this analogy, as to me it represented the stasis that established mental health services relied upon, and suggested that nothing (not even Recovery and its 'tawdry magic') would disturb it. For me Narrative N7 was significant in that it conveyed my own anger and frustration, and the belief that had started to take root within me that Recovery was merely a glamorous appendage to the sleight of hand and trickery of public mental health services.

Further frustration and anger surfaced in narrative N8: *Livin' in the Grotto (A risk to Christmas)* after I was struck by certain incongruities contained in a new policy that the Trust had issued on how employees were to ensure regular observations of service users. The title of this narrative arose from the Elvis Presley song entitled *Livin' in the Ghetto*, which was equally a tale of hardship and struggle. Possibly I imagined that an authentic Recovery within the organisation had become marginalised just as a ghetto is. I set the narrative in Toytown (a children's BBCtv series which ran throughout much of the Twentieth Century) because the new organisational policy in question seemed to me to be infantile and fatuous. It was the first major policy that the Foundation NHS Trust had issued to its new child organisation, and the way in which the policy was constructed and implemented (i.e., without consultation) angered me. My cynicism had started to know no bounds, and my depiction of the CEO as a somewhat absent-minded Santa Claus was a deliberate subversion of the

notion of bountifulness and seasonal goodwill of the time of year in which the narrative arose.[9]

Also relevant to Narrative N8 was another secondment of the Unit Manager to the local community mental health team. I wanted Narrative N8 to encapsulate the way in which in the absence of an assured leadership the team was disagreeing amongst ourselves as to in what way the service should be focussed on Recovery (the arguing of the elves; the anxiety of the Chief Elf; the insouciance of the Queen; the unquestioning task-orientation of Bob and Dave; the distraction of the CEO in wanting to appear bountiful rather than to facilitate Recovery in the organization). *Livin' in the Grotto* in fact continues the precedent set in N5, of the character Magic Mike representing specific (and real-life) examples of the way in which my wanting to work as a practitioner according to principles of Recovery was compromised by the organisation's focus upon matters of technical-rationality. I had started to feel ghettoised – no longer basking in the sunshine and optimism of Recovery as I had been in Narrative N2: *Eclipse*. By this time the Service Director to whom I was responsible, and as depicted in N2 and N5, had left the organisation, ostensibly due to the new management team brought in by the Foundation Trust. This was also an immense disappointment to me because I had enjoyed working with her, and I felt that she had a felt sense of what Recovery is, rather than did her replacement who came across as being concerned with reports and statistics.

[9] Another subversion was the idea that the organization could in fact wholly remove the experience of 'Christmas' due to a preoccupation with reducing or removing risk.

Of note in narrative N8 is John's (service user) comment that he would drown himself in the bath because he was unable to garrotte himself with a shower hose after it had been removed in order to remove the ligature risk. In fact this was a real comment by a service user following a discussion about the same incident. I greatly appreciated the service user's sarcasm, which was brief yet apposite. Narrative N8 is significant for the absence of Rita; I intended this narrative to show the absurdity of organizational policy and hoped that it would be self-evident without the presence of Rita to point the absurdity out.

What also arises for the series of narratives so far is that I had very firmly established a narrative trajectory – a way of accounting for my practice – that necessarily projected into future such accounts. My cynicism was an accounting for my clinical experience that gave me the comforting feeling that I could uniquely see the 'truth' (i.e., the absurdity) of what was 'really' taking place. This is not to say that I was not being reflexive – for I was being so – and I was nagged by the suggestion of the Slovenian philosopher Slavoj Zizek (2008) that cynicism is an indication (a masking) of depression. However I began to fear for the objectivity of the narrative trajectory that I was on, because although my narratives may have complicated my clinical practice by interpreting experiences in a way consistent with the unfolding narrative trajectory I had established, they were nevertheless comforting. Through writing them I could laugh at the organization by positing its concerns as folly and indeed idiotic. However I also began to wonder whether my *jouissance* had become the centre

and the *raison d'etre* of my practice, rather than care. Perhaps at this point I was already clinically depressed, but my narratives helped me feel better, enabled me to feel superior (because as a practitioner I 'knew better' than the organisation what Recovery actually *is*, i.e., its 'felt' sense). The excoriating nature of my narratives helped me cope with the norms that were promulgated by the organisation but which I experienced as being discordant with my own. Soon after writing Narrative N8 the Unit Manager again returned to her substantive post in Twelvetrees, but I resigned my 'acting-up" post of Deputy Manager because I found that a repeated absence of communication from her made my own position untenable. For this reason I characterized her in my narratives as being imperious.

This prompted narrative N9: *The Wall*, because I felt that my decision to resign was the logical conclusion to my working relationship with the Unit Manager even though she had told me upon her return that she would like me to remain 'acting-up' until the Deputy Manager post could be advertised as a permanent one. Narrative N9 was also significant for me because of a nurse colleague's *schadenfreude* at what he considered the naiveté of my elevation to manager of Twelvetrees and the indignity of my subsequent fall. I suspected that he was bitter that despite his own professional experience he had never been promoted to any senior positions he had applied for. He is represented as the character 'Ray' in my narratives. 'Ray' is also representative of the nurses whom I have met or worked alongside during my career who appear to luxuriate in the

lucrative NHS pension they will have when they retire.[10]

This narrative was also informed by a play I had recently seen at a local theatre, preluded by two dancers who threw themselves with abandonment about the floor to the accompaniment of loud electronic music. I found the dancers exciting and emotionally expressive, in particular of anger and dereliction. It seemed natural for me to convey my own sense of anger and *abandonment* in a physical way within the narrative. To this end I set the dancers to the music of *Omen* by The Prodigy, which was contemporaneous with the real events this narrative depicts. The lyrics to this song gave my narrative its title.

The writing's on the wall
It won't go away
It's an omen.

The song described my own feelings of despondency. At the same time I found that the physicality of the dancers tempered the gleeful cynicism that I first identified through reflexive study of N4, *The Commissioner's Visit,* and added the dimension of a vigorous and physical drama to the unfolding narrative. I chose the song *The End* by The Doors to conclude the narrative because I know this song from the finale of the anti-Viet Nam war movie *Apocalypse Now.*

As far as the study was concerned it felt like it was indeed the climax of my data-collection period because not only had I resigned from my management

[10] Such largesse no longer exists in the current NHS due to changes to the pension scheme (Thurley, 2012)

post but the Foundation NHS Trust took the decision to close Twelvetrees. It appeared to the team that this was primarily an economic decision, due to the high running costs of the fabric of the building (as the frequent presence of the two estates workers illustrated), and also the budget of £250,000 which was allocated to our service annually. We were advised by the Foundation NHS Trust that the closure was due to our failure to offer a Recovery service, which nonplussed us all.[11] I was subsequently seconded to a local community mental health team as a community mental health nurse. This prompted the narrative N11: *A New Job*. After writing N11 I wrote N10: *A Secret Meeting*, as a means to create a link between the closure of Twelvetrees and my new role, and in order to show by the Commissioner's and Magic Mike's deafness to Rita that it was not a decision that involved her (i.e., Recovery). Although Narrative N10: *A Secret Meeting* was entirely imagined by me, I was pleased to have written it, because it seemed like a successful dramaturgical device that advanced the narrative plot.[12] My secondment to the community mental health team gave me a new motivation to continue my study and to collect further data. I now had the feeling that I wasn't quite finished yet. N11 saw the naming of the character of the Manager as Manny, as though my redeployment indicated a new start and an acknowledgement that Manny was now free of the constraints of management.

However my desire for grotesquery continued, and in Narrative N11 I introduced

[11] My reflection on this was that we were not providing the type of Recovery service that the organisation required; that is, according to its own definition of what Recovery is.
[12] Notwithstanding that the team suspected subterfuge by the organization in the closure of the unit without consultation.

a sidekick for Magic Mike, named Mini-Me after the loathsome Doctor Evil's spiteful and unpleasant assistant in the *Austin Powers* comedies (Entertainment in Video, 2005).[13] This characterisation coincided with the increased visibility of the new Trust's most senior director in the large open plan space in which all the community teams were housed. He was a short, dark man with a continual scowl on his face as though he had swallowed a wasp.

Likewise the introduction into my narratives at this point of the robotic and uncompassionate Dalek, was to represent the perceived emphasis upon statistical targets rather than on service users in the new organisation. Hence the Estate Agent's incoherent management speak in N12: *A Jesus Meeting*; and his repeated reference to performance dashboards and audits, as though assuming that what he said made sense to practitioners subject to his direction. The manner of the local service manager upon whom the character of the Estate Agent was based was exaggerated in my narratives. My characterisation of him arose because my new colleagues remarked that he always dressed as they have seen male estate agents attired and that he was never observed drinking from the cup of take away coffee he would often clasp in his left hand.

This means of play and of creative flow was a delightful conduit for my imagination and my frustration. It became my fantasy world, in which I could

[13] This narrative embodied an adventurous cynicism that the Foundation Trust led by its CEO was in fact attempting to dominate the world. No doubt this enabled me and also my colleagues to accept that we were not being dominated because we were weak but because the parent organisation was wicked and amoral compared to our own beneficence and sense of moral duty.

play out my imaginings and ridicule powerful figures and situations present in my practice, and satirise them, even exposing their surreality and pretence.[14] I felt a continual resentment against the organisation for what I perceived to be its autocratic manner, for example by directing community practitioners to clear their diary for a minimum of thirty minutes (often longer) at the end of every day in order to record on a computer our community visits against a series of intervention codes. Naturally the codes were self-limiting, as they in no way took cognisance of the complexity of a nurses' interaction with a service user. As N12 reveals, many nurses did not include travel-time in their daily recording, so for that reason the audit results with which the Service Manager lambasted the team were in fact wildly inaccurate in any case.

Narrative N13: *All Stick and no Carrot*, reveals how the organisation had based its support of staff on a projection of similarly erroneous data, and as a result made a half-hearted and rhetorical effort to relieve the stress and anxiety evident within the team. This narrative was informed by my learning from an Occupational Health nurse whom I had consulted due to my own work-related stress that her department had seen a steady increase in the number of such referrals from the community mental health teams including the team in which I worked. At this point in my narrative journey I also introduced the character of Odetta to represent Organisational Development, in that whilst she may have good intentions in developing the organisation and also employees she was not concerned with Recovery and in fact was simply annoying. Her habit of throwing

[14] However this does not make for a happy ending, as I will go on to show.

chocolate coins to – at – people in reward for a correct answer was a real behaviour by a member of the Organisational Development team in the Trust who facilitated a Twelvetrees team away day. I still recall the shock and bemusement with which the team regarded this behaviour at the time.

This strategy of strained *bonhomie* and chivvying lent a schizoid (Obholzer and Zagier Roberts, 1994) quality to the organisation, in that it appeared to be in denial of its own anxiety to justify its continued existence to the Foundation NHS Trusts regulator Monitor and to the Department of Health. The Trust was also concerned over its profitability, which is a concern that afflicts Foundation NHS Trusts due to the nature of their structure (Pollock, 2005). The character of Odetta introduced in Narrative N13 was based on the character of Miss Hackett, a fitness coach in *Running Riot*, a farce written by Derek Benfield (1988), and which I was reading at the time and enjoyed immensely.

The letter read out by Mini-Me in N13 was not originally intended for all practitioners in the community teams to know, but it had been forwarded to them by email by a disgruntled manager of one of the teams. Once again it seemed to expose the organisation's own anxieties, and the organisation’s attempt to make practitioners responsible for those anxieties. At the behest of the commissioning body, practitioners were given the target of arranging a minimum of two direct payments to service users each per month; these varied from a manicure to a season ticket to watch a Premier League football team. It seemed that the organisation did not care about the money thrown at a target

so long as that target was achieved.

In narrative N14: T*arget Practice*, and Narrative N15: *Disposal Day*, I chose to alter the format of my narratives in order to make them look more like play scripts. I felt that this indicated clearly that my performance turn was now complete. Narrative N14: *Target Practice*, represented my desperation as a practitioner to achieve the target for Direct Payments I had been set by my employer. I experienced a bad conscience about having to achieve this target, because it seemed anathema to what I imagined Recovery to be about (that is, *not* technical achievement); a point that Rita (as the personification of Recovery) makes within the narrative itself. Also of note to me was service users' surprise that they were actually being *encouraged* to spend public money on themselves (as John evidences in the narrative itself).

My perception of the Employee of the Month scheme that the organisation operated, and which opened *Target Practice*, was that it was a cosmetic exercise intended to inspire and enthuse employees to further efforts (Tate and White, 2005). I personally distrusted this initiative, as it appeared to indicate to me an increasing tension between the cynicism arising from my employment and the autonomy I felt I craved as a practitioner. Crawford *et. al*. (2008) observe that in contemporary health care practitioners only become visible when they meet the requirements of the organisation, and it is my belief that organisational schemes such as Employee of the Month achieve this.

In *Target Practice* Ray accepts his Employee of the Month award because although he is cynical about the organisation and in a consciously cynical manner has gone along with its discipline of him, he believes by dint of his cynicism that he is unaffected by it (a common misconception of the cynic). Another irony is that he accepts the award even though he knows that his character is undeserving of such reward.

Furthermore it is possible that the organisation itself gives out such awards in the belief (itself cynical) that to permit an element of cynicism in its corporate life can be seen as being enlightened (Fleming and Spicer, 2003). Narrative N14 was informed by my insight that I experienced the conditions of my employment as a mental health nurse as being awash with cynicism.[15]

The final narrative that depicts my journey, N15: *Disposal Day* is an alliterative title that was used in an organisational email advertising an amnesty on items within the Trust that were to be removed and destroyed, because usually there was a charge for the service to the relevant budget. This term seemed particularly apposite, however, as by this time I had decided to leave the organisation and move house to another part of the UK. I felt that I was 'disposing' of my clinical experience, and – most importantly – I felt 'disposable' to the organisation. The title of this narrative also seemed to neatly sum up how I now 'disposed' of the ideals of Recovery that I once had, because I felt they had been crushed out of me by the organisation.

[15] Contemporary social reality is itself infused with cynicism (Zizek, 2008)

For example Manny's interaction with John in this narrative is intended to illustrate my own increasing frustration at the priority of my practice becoming the meeting of targets, and that only once the targets were met could I then undertake therapeutic interventions. Hence Manny's increasing desperation (and Rita's escalating disdain) at finding a reason for a Direct Payment to be made to John. Team members who exceeded the monthly target were publicly lauded by the Service Manager, and results were written on a white board in full view of the entire team. In this way I started to feel as though the work environment I inhabited with colleagues was being engineered to resemble a sales culture. In Narrative N15, Bob and Dave remove the chairs on which Manny and John sit, and this is the final straw for Manny. I intended for this act to be symbolic of the way in which I felt the organisation had removed its support for facilitating Recovery. I felt like I was trying to implement Recovery in my practice *in spite* of the organisation, and not supported by it.

As indicated by the text, Narrative N15: *Disposal Day* ends with another song, *Drophere* by Dzihan and Kamien (featuring Madita). I still find this song immensely beautiful and sad, and it encapsulated how I felt when ending this part of my narrative journey. I imagined Rita singing Madita’s lines, and the lyric “One day means someday means nothing” was especially poignant, for I now perceived mental health Recovery as the promise of something to come rather than something that is.

In the end Manny and Rita never 'got it together' as would have befitted a happy ending. Instead they reluctantly agreed to part as friends. I felt that there was a genuine affection between myself and Recovery – but as so often in many stories of relationships, 'life' gets in the way.

The following chapter comprises a longer – and concluding - conversation between Manny and Rita, and continues the strategy of personification used throughout all my narratives.

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CHAPTER FIVE

NOT YOU, BUT ME:

A MONOLOGUE WITH TWO VOICES

MANNY

It's not you, it’s me.

RITA

People usually say that when they're ending a relationship.[1] [*Pause*] Are you finishing with me?

MANNY

No. I'm just saying...

RITA

What?

MANNY

...I'm just saying that...I know people say that when they're ending something...and that might be how it seems now...but... what I'm trying to say is...people say it hoping that the other person won't feel so bad about themselves if you blame yourself but it's never just you, it's always...the other person too.[2]

RITA

So you're saying it's me as well? What have I done? I haven't done anything. The only way to change another person in relation to you is by changing yourself.[3]

MANNY

[*Hastily*] No , no – that's not what I meant!

[1] Young (2010)
[2] Young (2010)
[3] Firestone (2010)

RITA

What then?

MANNY

Oh, I don't know. I don't know what I meant. I don't know anything any more.

[*Pause*]

RITA

I just feel so... dirty. [*Sobs*]

MANNY

Oh, I'm sorry. [*Holds out a hand in a half-hearted attempt to soothe her*]

RITA

[*Between sobs*] Oh, it's nothing you've done. I don't think you could have helped it. [*Pauses*] This thing is so...*male*.

MANNY

How so?

RITA

Oh; the focus on objective measurement, targets, *their* priorities. The masculine is to favour "reason over intention, justice over care, outcomes over process."[4] I feel sullied. Used.

MANNY

I want to blame myself. But I also know that I can't be held at fault for the way you feel. For what's happened to you. But I still feel responsible, nevertheless.

[4] Johns (2010a: 20)

RITA

[*Looks at him*] Well, that's very sweet of you but...I don't blame you at all, not really. [*Pauses*] There are some things that are bigger than both of us.

MANNY

Well, yes. I found that out. I thought I could change the world, but...

RITA

You have to change yourself first. You have to fully experience what you are before you can know the full range of change that is possible.[5]

MANNY

Ah. The paradoxical theory of change[6]?

RITA

[*Smiling*] Yes. The more you try to change the more you stay the same.

MANNY

So are you saying I wasn't ready for change?

RITA

Maybe not professional change. But perhaps...

MANNY

Yes?

RITA

Perhaps personal and professional change are the same thing. At the same time. Or one has to happen before the other. I don't know.

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[5] Mann (2010: 62)

[6] Change is usually thought of as taking place in a linear and a wilful manner: that is, as desire-decision-intention-change (Harris, 1996). However change meets resistance for the ego always prefers safety.

MANNY

But..well...I started from the right place...which is where I was. But I wasn't 'me'. Not the 'me' I am now.

RITA

That's inevitable! Everyone changes over time. Everyone has new experiences, sees things differently, tells the same story in a different way. Like anyone, your story only matters at the time you tell it. You're not immune to that, you know.

MANNY

But when...you know, 'we' began...I was a different 'me' then. I didn't like myself.

RITA

I thought that when we first met – you know, when you were giving that unbearably pompous speech.

MANNY

You mean N1, the first narrative?

RITA

Yes, then. I wondered who you were because you really couldn't cope with me. In all my passion and my rawness. [*Pause*] I don't think a lot of people can.

MANNY

What do you mean?

RITA

People from...your side of the fence.

MANNY

As opposed to?

RITA

People on mine. [*Smiles*]

MANNY

[*Thoughtful*] Hmm. That rings a bell.

RITA

How?

MANNY

You're saying what a mental health advocate said to me once – years ago now – while I was in training as a mental health nurse and I met her at a conference. She said that as long as I'm a nurse I'm always on one particular side of the fence. I think she meant the side that supports the existing system. And I suppose she was right. If I don't think it directly then I'm always at least unconsciously projecting the interests of whoever provides my employment. Not to do so is to do myself out of a job, which is obviously self-defeating.

RITA

To be a nurse is to allow yourself to be disciplined, that is to think in particular way, to be colonised. Otherwise you're not a nurse. You're something else.

MANNY

It's to put up with the psychological noise[7] that comes from Clinical Governance, NMC regulations, organisational policies, targets, the subtle coercion of service users[8]. I ended up telling service users what I – or rather my employer – wanted them to hear. I'd just stopped *listening* to service users. Sometimes it's so busy in my head that I can't think straight enough to practice authentically any more.

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[7] The way in which a person may experience a message they receive from others (West and Turner, 2011: 13). The 'noise' may be caused by, for example, prejudices or too much/too little communication (Kaul, 2004)

8 Interpersonal strategies such as persuasion, encouragement, and manipulation (Lutzen, 1998)

RITA

'Authentic'?

MANNY

I mean, just being your ‘real’ self; not being what other people expect you to be. That's what I mean.

[*Pause*]

RITA

Is that a dig at me?

MANNY

No! Why do you think that?

RITA

Well - I too was 'thrown'[9] into a world of mental health services that was already there. And it wasn’t going to change just for me. So I was accommodated. I was fitted in. And now *I* struggle to retain authenticity.

MANNY

So there is a true Recovery? Not the version accommodated within Clinical Governance?

RITA

Of course. All you have to do is go back to the original writers about Recovery such as Deegan[10] and Anthony[11].

[9] Chapter One, p. 2
[10] Deegan (1998, 1996)
[11] Anthony (1993)

MANNY

How do you mean?

RITA

It seemed so simple then. Recovery was not to become “mainstream”.[12] It was not to become “normal.”[13] Yet sometimes it seems to me that’s exactly what’s happened!

MANNY

Yes. I can understand why that might be frustrating for you.

RITA

Don't forget: I come from a long tradition. I didn't just happen. The idea of me has been around at least since the Enlightenment,[14] perhaps longer. [*Pause*] And when we met I was loud and angry because after being ignored for so many years, suddenly here was my chance. They seemed to want to take me seriously. But they just wanted me to fit in with what they already had. And now I feel like I’m being pimped out.

MANNY

[*Shocked*] What?

RITA

They use me. They circulate me amongst themselves and put my name to things – they prefix everything with the word ‘Recovery’, and then turn me over to the next service, because once they’ve associated me with themselves they carry on as before, even reifying their institutions and their practices – their discourses – in my name, because the word 'Recovery' is attached and so they seem even more legitimate than ever.

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[12] Deegan (1996: 92)
[13] Deegan (1996: 92)
[14] Roberts and Wolfson (2004)

MANNY

Yes, my narratives show that prefixing everything with the word 'Recovery' didn't change where the power and the authority resides. Priorities remained the same they'd always been. The organisation needed to ensure its continued survival. The Estate Agent was concerned for the community mental health team to achieve targets set by the commissioners. Bob and Dave had to ensure the day to day material functioning of Twelvetrees. The Queen was concerned with her personal development….

RITA

And you? What was *your* priority?

MANNY

Change. I ached for change.

RITA

So what happened?

MANNY

Well - my narratives show the ways in which these priorities constrained my practice. For example, I experienced the Estate Agent's ruthless managerialism as oppressive, Bob and Dave's functionalism as obstructive, and the Queen's rush to ambition and professional development - which included study and occasional redeployment to manage other mental health teams - as inconsistent and demoralising.

RITA

Demoralising? In what way?

MANNY

Well, the effect that the Queen's physical absence had upon my own commitment to realising Recovery in my practice, and the consequent lack of

team and service cohesiveness are indicated in my narratives. She just wasn't there. Leadership is "the ability to define a vision and guide individuals and groups toward that vision while maintaining group-promoting teamwork, commitment, and effectiveness."[15] The Queen's mercurialness impacted adversely upon the cohesiveness of the team and upon the way in which we as a team hypostatized[16] the Recovery vision.

RITA

Even when you were in charge?

MANNY

Yes. Even then. It always felt like I was only waiting for her to come back.

RITA

So you babysat her Recovery vision while she was away?

MANNY

Yes. And we never knew when she would be back. But why did they want you? What was the purpose of *The Journey to Recovery* document[17]?

RITA

The government couldn't resist the groundswell of service user agitation about mental health services. They had to do something. [*Smiles*] You can't have any section of society questioning things, you know. The government had to act quickly before the questioning got out of hand. Before there really *was* change.....

[15] Knodel (2009: 2)
[16] The process by which particles in a liquid settle as sediment (Chambers Dictionary, 2011), become corporeal. In philosophy, hypostatization is an elevation to substance (Schmid, 200: 368)
[17] Department of Health (2001)

MANNY

You can't think this was what they were actually thinking, do you?

RITA

Of course not. It may have been well-intentioned and innocent at the start, but that's the way it goes when something big gets hold of something smaller and weaker. There arises a tension between liberal notions of social justice and governmental requirements for social control, for keeping a handle on things.[18]

MANNY

And that's what's bigger than both of us?

RITA

Exactly. I wish it wasn't. But that's the fact. [*Pause*] So have I disappointed you?

MANNY

[*Surprised*] What? You? Oh, no, no. I've disappointed myself.

RITA

You shouldn't be so hard on yourself, you know.

MANNY

But I feel like I've failed in...everything. I thought that when Recovery transformed mental health services I would transform as a practitioner along with them. And my narratives would show this transformation as it happened. [*Pause*] But mental health services *didn't* transform.

RITA

[*Smiling*] But they have a new name now. And there are fewer of them.…

[18] Fay (1987)

MANNY

Yes. But you know that's not what I meant….

RITA

I know…..So have you?

MANNY

What?

RITA

Transformed?

MANNY

Yes. But not in the way I wanted or expected to.

RITA

So what are you blaming yourself for? The fact that services didn't change? Is that *your* fault?! [*Incredulous*] That's a bit self-important, isn't it?

MANNY

[*Thoughtful*] Yes, put like that it does sound a bit silly. Blaming myself for global mental health services not changing.

RITA

Or at least *your* little bit.

MANNY

[*Smiles*] Yes. At least my little bit of the NHS.

RITA

So how have you changed?

MANNY

If you mean by leaving the NHS, becoming mentally unwell and ending up in psychotherapy, then, yes, I've changed.

RITA

[*Laughing indulgently*] No, silly. That's not what I meant. I mean, are you *different* now compared to how you were? As a practitioner?

MANNY

Yes. I'm starting to find out now why I am like I am, why with hindsight my project of realising Recovery in my practice was doomed right from the start. Perhaps if I'd done things differently….

RITA

But it's always easy to say in hindsight that things might have been better. How can you know that?

MANNY

Yes. And most importantly I'm starting to understand why I 'see' things as I do. And it gives one a kind of peacefulness, because then one feels a part of the organic process of reality. There is a solace in allowing mundanity to just be, rather than trying to force it to be something special. [*Smiles*] I hold *you* at least partly responsible for that.

RITA

How? What for?

MANNY

When public mental health services saw you, and how you threatened them, of course they would have to manage the anxiety that arose from the questions brought up by that encounter with you. Recovery signifies a massive paradigm shift; and obviously that's going to be an enormous threat to those in power.

RITA

So what did they do?

MANNY

Who? The Recovery writers?

RITA

[*Smiles*] No. Those in power.

MANNY

They appropriated you.

RITA

How do you mean?

MANNY

It's when one group, usually a dominant one, takes something from another culture or another set of ideas by another group, usually a politically weaker one, and assimilate those ideas into their own. But - what is more sinister – they then use those ideas to justify and reinforce their own dominance. This weakens the identity or the viability of that other group.[19] People no longer 'own' those ideas - they become the possession of the dominant group. And sometimes people from the weaker political group are forced to abandon them – their own ideas!

RITA

And you think that's what's happened with Recovery?

MANNY

Yes. Who owns it now? Who drives it forward? Who says 'this' or 'that' is

[19] Brunk and Young (2009)

Recovery? It's not service users! It's not people who have actually experienced recovery from mental ill-health who direct services. So you see: nothing has meaningfully or significantly changed!

RITA

But there are service user representatives. Lots of them. Even direct employment of mental health service users.

MANNY

It can seem like tokenism. Service users are used to make things seem like they are changing, whereas they aren't.[20] And in this way Recovery slots neatly into the political discourse of consumerism. Consumers think they have power – are even encouraged to think that way - but consumerism is cyclical in that it only ever creates enough so that the desire for satisfaction remains. Consumption *creates* expectations.[21] Recovery is used by mental health services to increase expectations of those services, so justifying the continued existence of those services and a continued dependency upon them. Mental health services are now suddenly an object of consumption, because mental health service users have become 'consumers', with expectations and a desire for satisfaction, and in that way Recovery has become a part of the consumerist cycle. Consumerism is an illusion. Recovery is not; but by associating it with an illusion then Recovery becomes illusive – and elusive. If mental health service users who are posited as 'consumers' - because the idea fits within the existing dominant discourse - were fulfilled then why would they want mental health services?

RITA

So they appropriated me for their own ends? In order to maintain their own power? And that's why I feel dirty?

[20] Trivedi (2010)
[21] Miles (1998)

MANNY

Yes. Rhetoric hides a vacuum and by definition a vacuum cannot be filled. A vacuum only has one law: that it remains a vacuum. Recovery in its original form was never going to happen. I've always thought that Recovery is like trying to turn a tanker on a five pence coin. Davidson *et. al*.[22] said that Recovery would take at least a generation to effect change. But that's just apologism; if Recovery was going to change things radically it already would have. Wham! [*Loudly hits the heel of his right wrist against the palm of his left hand*.] [*Sadly*] But, then, who wants chaos? Anarchy? Overthrow?

RITA

Perhaps you wanted too much.

MANNY

Perhaps I did.

RITA

So Ray was right then?

MANNY

[*Jokingly*] Ssh! Keep your voice down – if he heard you say that he would be puffed up for life!

RITA

[*Jokingly in a whisper*] He said he'd seen it all before and would again and that nothing changes.

MANNY

Yes. He liked his *schadenfreude*. And I'm *still* trying not to say that he was right. But I think I'm losing that particular battle.

[22] Davidson *et. al*. (2006: 645)

RITA

Isn't he retired now?

MANNY

Yes. And he's also got a better pension than I'm going to get, as well. Sometimes it seems better just to keep your head down and work through the madness until retirement. Academics talk about 'commitment'[23] in nursing but the only thing that he was ever committed to was his bloody pension!

[*They laugh*]

RITA

We laugh at nurses like Ray – but does that make *you* morally superior? Because you 'suffered' for your commitment to Recovery? Was your suffering noble? Or even heroic?

MANNY

In a supervision session CJ told me that I'm an anti-hero. You know, someone who is an ordinary person who lacks the traditional qualities of a hero.[24] In literature the hero in narrative is held to be someone who exhibits virtuous traits of moral goodness, nobility and fortitude.[25] The anti hero staggers through a world which is bereft of values, meaning or certainties;[26] just as I found myself picking my way through the smoking ruins of my dream of Recovery.

RITA

[*Laughing*] So you're *not* the hero you thought you were?

MANNY

[23] Van Zwol (2009)
[24] Baldick (2008)
[25] Miller (2000)
[26] Abrams and Harpham (2012: 14)

People are always heroes of their own tales. Joseph Campbell[27] says that the narrative tale - the hero's journey - is a monomyth in that it is known across time and across cultures, and always tells the story of how somebody has survived trying circumstances and is ready for new experiences.

RITA

[*Teasing*] Like you!

MANNY

Yes. He argues that the heroic narrative isn't always full of the sort of hyperbole that exaggerates the narrator's moral virtuousness, for example. *The Hero's Journey* is a kind of heroic anti-heroism, if you will. [*Smiles*]

RITA

[*Still teasing*] So you *are* a hero?!

MANNY

Of my own story, yes. But to CJ and other people, I'm not. I'm an anti-hero. They won't know what I went through to get here.

RITA

And the curious reader?

MANNY

They will know. They will read into the narrative text I've written. It will resonate with them. I want the curious reader to every so often look up from the text and say to themselves, "Yes. That's what *I* feel." They too can be heroic. They too can survive the madness of their existence.

[27] Campbell (2008)

RITA

Perhaps for them life isn't 'mad', as you call it.

MANNY

Lucky them. But for me it was. I want my narratives to confound expectations of what the Recovery narrative is 'supposed' to look like.

RITA

How do you mean?

MANNY

The Recovery narrative as it has become is much like the usual – masculine – dominant narrative of mental health care: admission – treatment – discharge. And on either side of that is the requirement to function socially – the requirement to be a good citizen. And that is always defined by the regime.[28]Sometimes I think that Recovery in its appropriated form is a means to ensure good - productive - citizenship, and all that entails. Mental health care has always been associated with social control.[29]

RITA

Hmm. 'The Recovery narrative'. I like that phrase. There are two different forms of narrative going on here. A linear one; and a personal one. Don't your own narratives correspond to the dominant narrative mode? They have a beginning, a middle and an end? They're linear?

MANNY

Their magic realism cuts across linear - and privileged[30] - expectations of narrative. They zig zag. And the magic realism, the farce, the madness, the flow, the *play* – that's what subverts the dominant form! Narratives like mine

[28] Strauss (1959)
[29] Scull (2006)
[30] Langdon (2011)

which purposely seek to be transgressive propose “a return to an awareness of the bizarre nature of the mundane”.[31] [*Pause*] And the fact that we're talking now....

RITA

[*Impatient*] Means what?

MANNY

The fact that we're talking now means *there is still something else*. Something else to happen. To come.

RITA

New experiences?

MANNY

Yes! For you - and for me. I've moved on. I've accepted you for what you are.

RITA

[*Curtseys sarcastically, with an exaggerated West Country burr*] Why, thank you, kind sir. Will that be all?

MANNY

Very funny.

RITA

[*Wondering*] So where does that leave me?

MANNY

That leaves you where you are. I now know that it's not for me to fight your battles. Or even to think of doing it. I'm not a knight in shining armour, fighting for your honour.

[31] Kinceloe (1997: 72)

RITA

[*Protesting*] And I'm no damsel in distress!

MANNY

No. You never were! But...

RITA

[*Impatient*] What?

MANNY

That's how I saw you, for good or ill.

RITA

[*Incredulous*] What? As needing rescue?

MANNY

Yes. I always sensed that your distress came from you being so radical - so grass-roots, so earthy, yet so passionate! But I couldn't feel your distress because I was so wrapped up in my own. But I didn't know that at the time. [*Pause*] And then came the domestication. You had to fit in somewhere. Mental health services couldn't change everything just because of you.

RITA

[*Defiant*] Well they should have!

MANNY

But think what that would have meant! Overturning everything! Things rely on the stability of mental health services as much as the other way around. The idea that mental illness is a particular social construction that depends on other forms of social construction. Each maintains and reifies the other. Judith Butler calls this interpellation – the idea that one calls another into being – a particular

form of being – just by hailing – acknowledging - them.[32]

RITA

So mental health service users confer that identity upon themselves by repeatedly interpellating mental health services?

MANNY

Yes.

RITA

So sane people only exist because there are mad people?

MANNY

Yes! So you see there is a continued need for mental health services to be there to *be* interpellated. [*Pause*] Yes. And not just by service users.

RITA

So what did you want from me?

MANNY

The Marxist historian Walter Benjamin said,

> In every era the attempt must be made anew to wrest tradition away from a conformism that is about to overpower it. The Messiah comes not only as the redeemer; he comes as the subduer of Antichrist.[33]

RITA

So that's how you saw me?

MANNY

[32] Interpellation proposes "a social scene in which the subject is hailed, the subject turns around, and the subject then accepts the terms by which he or she is hailed." Butler (1997a: 106)
[33] Benjamin (2009: 247)

As the Messiah, yes. As the subduer of the big bad mental health system.

RITA

Of which you are a part.... As a mental health nurse....

MANNY

Of which I am a part, yes.

RITA

[*Incredulous*] So you'd be doing yourself out of a job, then....

MANNY

Yes. As mad as it seems. But I was that desperate for justice.

RITA

So why are you a nurse?

MANNY

It’s a narcissistic pursuit.

RITA

A what?

MANNY

To make my mother better, because she was seriously mentally unwell when I was a child. And I couldn't help her then.

RITA

And so this is your narrative? Your narrative is about your narcissistic pursuit?

MANNY

It's the backdrop to it all, yes. It's why I am a mental health nurse. The narcissistic pursuit is only ever “a magical effort to overcome unsurpassable interpersonal obstacles and to reach impossible goals.”[34] You think that by achieving it it'll bring omnipotence or omniscience.[35] But that was never going to happen. She is recovered now, and has been for many years. I no longer need to. Not that I could have, anyway.

RITA

So really it was your own stuff?

MANNY

Isn't everything?

RITA

How do you mean?

MANNY

I mean all one’s thoughts and feelings and emotions - and ideas - about anything are generated by one’s psychological schema. Which one may - or may not - be aware of.

RITA

So are you saying that the things - the constraints - that prevent me from being radical - for truly making a change - are all in my mind?

MANNY

..No -

RITA

[34] Ronningstam (2005: 166)
[35] Moore (1999: 42)

[*Angrily*] Well, quite frankly, that's insulting!

MANNY

No. No. No. No. Let me finish....

RITA

[*Anger subsiding*] Go on then.

MANNY

Users of mental health services can't be truly radical because of the taken-for-grantedness of mental health services – of reality.

RITA

You mean 'false consciousness'?

MANNY

Yes. The systematic self-misunderstandings on the part of people about their needs, about what will make them happy, and about the nature of their social relations. These self-misunderstandings are usually shared by a whole group of people who have the same position in society or even by a whole community….These self-misunderstandings are attempts to satisfy important needs and desires of the people who hold them…[36] This is even at the psychological level in terms of wish-fulfilment.[37]

[*Pause*]

MANNY

But it's the way you manage the constraints. There are some that exist outside of us. Some are internal, generated by ourselves. But some you can't argue with.

[36] Fay (1987: 98)
[37] Fay (1987: 98)

RITA

Like removing the shower hoses[38] in case somebody wanted to use one to hang themselves from! So that John couldn't have a shower even though he wanted one and he said he was going to drown himself in the bath instead....

MANNY

Yes. And when the Trust said that for health and safety reasons Bob and Dave had to cut the rubber seals around the UPVC windows to no more than six inches in length,[39] because if they were any longer then somebody might remove the entire seal and garrotte themselves. And then every time afterwards whenever you closed the door the glass fell out because there was nothing to hold it in....

[*They laugh*]

MANNY

So, you see, some constraints are outside of you, which proves that the madness *does* exist.

RITA

They're just tensions. It's you who perceives them as constraints. You've got to work around them. Be creative.

MANNY

But I *resent* having to navigate obstacles that somebody else has put in my way. You surely can't tell me that removing the shower hoses, weakening the glass in the doors, required me to make *creative* solutions! It wasn't my fault they were there! I had nothing to do with it!

[38] Narrative N8: *Livin' in the Grotto*
[39] Narrative N8: *Livin' in the Grotto*

RITA

Ah. happy times....

MANNY

[*Startled*] Pardon?

RITA

[*Taps him playfully on the arm*] I'm teasing you, silly. I know they weren't *that* happy.... Not for you, anyway.

MANNY

No, they weren't. I think now that they were what they were. But I also know it didn't feel like it at the time.

RITA

Yes. "I can smile about it now - but at the time it was terrible."[40]

[*They laugh*]

RITA

At least you *can* laugh about it.

MANNY

Yes. Now.

[*Pause*]

RITA

You mentioned 'internal' constraints....

[40] The Smiths (1985)

MANNY

Yes. I'll use The Influences Grid[41] for that.

RITA

What forces influenced your decision making and actions? That thing?

MANNY

Yes. Here. *[Reaches into his jacket pocket, takes out several pieces of folded paper, opens them in turn and then hands one to RITA. He places the others back into his jacket pocket.*]

RITA

[*Smiles*] Ah. So you just happened to have...

Conforming to normal/practical habit? The weight of tradition	Negative attitudes and prejudice? Racism?	Expectations from others; knowledge to act in certain ways?
Limited skills/discomfort/confidence to act in new ways	**What forces have influenced my decision making and actions?**	Fear of sanction? The weight of authority
Emotional entanglement/ over-identification		Misplaced concern - loyalty to colleagues versus loyalty to patient? Anxious about ensuring conflict?
Need to be valued? Deeper psyche factors?		Knowledge to act in suspicious ways? The weight of theory
Wrapped up in self-concern? Pity? Stressed? Guilt? Frustration? Other feelings?	Time/priorities?	Expectations from self about 'how I should act' Doing what was felt to be right?

Figure 5.1 The influences grid (Johns, 2010b: 38)

MANNY

A copy of the grid on me, yes.

[41] Figure 5.1

RITA

[*Smiling*] How fortunate.

MANNY

Yes. Well - it's my narrative. They are my rules.

RITA

[*Laughing*] I suppose so....

[*Pause*]

RITA

[*Looking at the paper she has been handed*] So what do you want me to do with this?

MANNY

Read it - ask me about it.

RITA

But why do you want to use it?

MANNY

Well, I could argue about it - the grid I mean. I mean, it looks like it could be mostly anecdotal. It's based around the things that must matter most to the author of the grid. Perhaps it'll only mean something to another nurse. But that doesn't matter because Johns *is* a nurse. Like I am.

RITA

Its part of a cue isn't it? From his Model of Structured Reflection?

MANNY

Yes. The cue about what factors influenced me. [*Pauses*] By the way - I'm impressed.

RITA

What about?

MANNY

That you know. You've obviously been paying attention.

RITA

To?

MANNY

To me. To what I've been saying.

RITA

[*Angry*] Don't patronise me.

MANNY

[*Embarrassed*] Oh. Yes. Sorry.

RITA

I've been a part of this - your - journey. All along. Don't forget that!

MANNY

I know. I know.

RITA

[*Dismissive*] Idiot….

MANNY

[*Still embarrassed*] Yes. Look. I said I'm sorry. I spoke out of turn. Okay?!

RITA

[*Reluctantly*] ...Okay.

MANNY

Good. Can we move on, please?

RITA

[*Laughing*] You should listen to yourself. You are *so* pompous!

MANNY

I *can* hear myself! It's called reflection, dammit!

[*Pause*]

MANNY

Anyway. The grid....

RITA

[*Impatient*] What do you mean, "Anyway. The grid..."?

MANNY

Can we get back to it, please?

RITA

Your relationship to me *has* changed, hasn't it? It feels like you don't care about it anymore. [*Points an index finger back and forth between herself and MANNY*] About us.

MANNY

Yes! I care! Okay?!

RITA

[*Pauses. Sighs*] Anyway. How do you want me to do this?

MANNY

How do you mean?

RITA

I mean, do you just want to put your own stuff onto the grid or do you want to talk about each cue separately?

MANNY

Ah. I see. [*Pauses*] Yes. That.

RITA

What?

MANNY

Ask me about the cues separately. Please.

RITA

[*Dubiously*] Okay. First one. [*Looks down at the paper. Pauses. Looks back up at MANNY*] Do you want me to go from left to right across the grid or from right to left?

MANNY

[*Irritated*] it doesn't matter. Whatever.

RITA

[*Smiling*] Okay. First one. "Conforming to normal/practical habit? The weight of tradition."

MANNY

Ah. Yes. Tradition. One of the three constraints that Fay[42] says afflicts us all. The other two are force and embodiment. Tradition and force are embodied in mental health services. They weren't going to change. Not just for you. They'd been around for too long. There were too many interests involved for mental health services to suddenly abandon the space to Recovery. It's just the way things are. It's what people are used to.

RITA

But just because something is what people are used to doesn't mean it shouldn't change.

MANNY

[*Wistful*] Ah. Spoken like a true revolutionary! [*Pauses*] Tell that to the Department of Health.

RITA

Well, why were they interested in me, then?[43]

MANNY

If you read the foreword to the *Journey to Recovery* document by the Health Minister at the time, one word sticks out for me: "modernising".[44]

RITA

So? All that means is that the government wanted a modern mental health service. What's wrong with that?

MANNY

Even service users sometimes think that the term ''recovery' is used by services as a disguise to cover up service cuts or to discharge people before they are

[42] Fay (1987)
[43] Department of Health (2001)
[44] Department of Health (2001: 1)

ready from community mental health teams that are under-stretched and underfunded.[45]

RITA

Yes. Good point.

MANNY

And Roberts and Wolfson[46] pointed out that Recovery fits 'cleverly' into existing Clinical Governance. I think they really meant that Recovery can be used to make things look like they've changed whereas existing structures didn't have to change *at all* in order to accommodate it. They didn't say it outright, but I like to think that's what they meant. Look at how well Recovery integrates with the target culture, the consumerist discourse, the expert patient programme. Even privatisation of the NHS by the back door.[47] Recovery is simply co-opted in order to legitimate all these existing discourses! [*Pause*] It corresponds with political accommodation theory….

RITA

What's that?

MANNY

The idea that the state – or the hegemony, in order to preserve its cohesiveness – its authority and power - adopts ideas and beliefs and even practices which appear in opposition to it, in order to ensure homogeneity and therefore its continued survival, its safety. There should never be too much of one thing, or too much of another. So the one thing which appeared separate and even threatening to the *status quo* loses that radical difference by becoming a part of the homogonous.[48] And isn't that what's happened to Recovery - accommodation? [*Pause*] And another thing....

[45] Fieldhouse (2008: 499)
[46] Roberts and Woolfson (2004)
[47] Pollock (2005); Klein (2006, 2010)
[48] Lijphart (1975)

RITA

What?

MANNY

Well, the *Journey* document kind of headed revolution off at the pass. The government got hold of Recovery before it could do any damage.

RITA

"Do any damage"?

MANNY

Force any changes. You know, make a difference. Stick the word 'Recovery' in front of existing services and, well, everyone's happy. Nothing changes and yet everyone's happy. The government because nothing has changed. Service users because they're involved. And everybody else because it looks different.

RITA

[*Scornful*] You are *so* cynical.

MANNY

Tell me - show me - that it's any different than I've just said.

RITA

[*Hesitates*] I...er...what about consumer consultants? Because of Recovery service users are now directly involved in planning services.

MANNY

No. What they are involved in is finding Value for Money, and value for Money is

about improving quality[49] yet reducing costs.[50] Consumer consultants will think they're making a contribution to planning and implementing services but it's actually a clever sleight of hand by the government, who are always looking for ways to make cuts. It's like saying, 'we'll close down specialised day services and you can all go to the local library instead.' Because that is classed as the outcome of involving people in community services. Never mind that if you're mentally unwell you get stressed out of your box trying to keep up with the teaching in evening classes. And then service planners glad-hand each other at the success of their latest wheeze. I can almost hear them saying it: "We'll do it, and nobody will suspect a thing of what we're up to. Good old Recovery!" Of course, the government isn't so transparent about it as to actually say that. And that's what's so bloody depressing: everyone knows but *nobody says what is actually going on.* We're all being mugged.

RITA

[*Laughing*] You sound like Ray!

MANNY

Is that meant to be an insult?

RITA

I don't know. What do you think?

MANNY

He isn't wrong. I wish he was. He'd seen it before, and he'll see it again. Nothing changes.

RITA

You sound like the Prophet of the Great Weariness.

[49] Naylor and Bell (2010)
[50] Klein (2010)

MANNY

From Nietzsche?

RITA

Yes. “It is all one. Nothing is worthwhile. Knowledge chokes.”[51]

MANNY

So what's the point of anything?

RITA

But you've – I've – got to keep on *hoping*.

MANNY

Yes. And hope is central to Recovery.[52] That’s just as well, really….

[*Pause*]

MANNY

[*Smiles*] I think we should move on. What's the next cue in the Grid?

RITA

"Negative attitudes and prejudice."

MANNY

Hmm. Well, I suppose that if you're going to start off as an unreconstructed Marxist as I did and see yourself - as a nurse - immediately set against your employer - then that's pretty negative. And to see Recovery as a sort of vehicle for revolutionary overthrow of the *status quo* in mental health services. [*Pauses*] What can I say?

[51] Nietzsche (2003)
[52] Slade (2009)

RITA

You can say, “What on earth was I thinking?” You see, *that’s* naïve.

MANNY

My thesis was – I was - doomed from the start.

RITA

You weren't really very earthed at all, were you?

MANNY

Yes. I didn't see you as you. I saw you as I wanted you see you.

RITA

And you saw yourself as you wanted to. And not as you were.

MANNY

I didn’t know myself. I had no idea who I was.

RITA

You did that through self-inquiry into your narratives. Reflexivity showed you.

MANNY

Yes. Reflexivity got me to a point where, like Seamus Heaney in his poem *Exposure*[53] described his own sudden realisation, I wondered, “How did I get like this?” This thesis became more a reflexive study of ‘how did I get like this?' than a narrative which describes my surfing the crest of a Recovery wave.

RITA

Yes! Welcome to my world....

[53] Appendix 4

MANNY

How do you mean?

RITA

Well, I'm more bothered about the mundanity of my everyday existence than any lofty ideas of transformation.

MANNY

But so am I. Now.

RITA

But that's because of the reflexive self-inquiry into your narratives.

MANNY

Yes

[*Pause*]

RITA

[*Gently*] So the next cue: "Expectations from others; knowledge to act in certain ways." What did you expect from yourself? What did others expect from you? And how did that play out?

MANNY

I have to get my head around this bit. I thought I knew what my expectations of myself were as a person. And Recovery is about individual narratives of recovery.[54] And as a practitioner I am supposed to hold somebody's hope whilst they are too unwell to bear it themselves.[55] So in Recovery the relationship

[54] Shepherd *et. al*. (2008)
[55] Wolfson *et. al.* (2009)

between the practitioner and the service user is central, facilitative, helping.[56] But how well does that fit in with contemporary mental health services? How well can I do that when all I am concerned about is achieving the organisational targets I am set, in case I get the sack for not achieving them, an anxiety that my later narratives show? How can I do that when my employer doesn't care a wet slap about how I *feel* having to do it? Many health care organisations which employ individuals to deliver services to others pay scant attention to the personal psychological issues of those employees that may affect the delivery of that service.[57]

RITA

But you had – you have - a choice. Do their stuff or do your own.

MANNY

A choice?! I didn't feel I had a choice: if I didn't make the target then I'd lose my job. It was as simple as that. The Estate Agent made that very clear when he met with the entire community team.[58] I was running scared - and that's no way to support or care for other people.

RITA

So it became an ethical issue for you?

MANNY

Yes. I was like an actor, permitted to improvise but subject to the drive of the script. I could “shape my show” but that not the conditions or direction under which I performed.[59]

RITA

But your expectations?

[56] Borg and Kristiansen (2004)
[57] Thomas (2006)
[58] Narrative N12: *A Jesus Meeting*
[59] Crawford *et. al*. (2008: 1061)

MANNY

Yes. I know what the expectations of my role as a nurse are, at least those that are written by the NMC and in Clinical Governance. But I still have to *interpret* them using my own pre-existing psychological schema. And if that pre-existing schema[60] is already messed up – as I later found out - then, well, you have a problem. If you're left to interpret things yourself then you're more likely to interpret them cautiously and out of the anxiety it causes from not knowing what they are.[61] And as a result practice is even *more* constrained. I mean, as a nurse you have to know Clinical Governance - like the Clinical Governance on Recovery, for example - but nurses are already equivocal about Clinical Governance, because our contribution isn't valued.[62] And nurses are still regarded as being a subordinate occupational group in UK health care so that we're also going to feel excluded from matters of Clinical Governance.[63] The *Report by the Chief Nursing* Officer[64]on Recovery felt like it was an *imposition* upon practice.[65] I and my colleagues wondered who this Chief Nursing Officer was, because we had never even heard of them before. So we wondered what right had *they* to teach nurses how to suck eggs? And obviously they were a government appointee to start with, so it seemed like they were simply a mouthpiece of the government.

RITA

But somebody has to tell nurses what Recovery is about.

MANNY

[60] Commonly understood as being a personal mental structure and psychologically interpretative framework (Holland, 1992)
[61] Knights and Wilmott (2002)
[62] The Health Foundation (2011: 44)
[63] The Health Foundation (2011: 44)
[64] Chief Nursing Officer (2006)
[65] Barker and Buchanan-Barker (2005)

So why couldn't service users tell us about Recovery? In fact, two did.[66] My point is that it came from Government. *That's* what makes you wonder what is being said and why. *That's* what made it feel like interference. It felt like just another statutory regulation. Nurses already feel overloaded by policy so that we can't focus on the quality of the care we deliver.[67] And Recovery is not just another policy!

RITA

Yes! It's certainly more than that!

MANNY

So you see it's not just me who struggles with Clinical Governance! Even health care organisations regard what is required of them in the name of Clinical Governance as an added source of corporate anxiety.[68]

RITA

Whew! [*Looks down at the piece of paper, then up at MANNY*] I'm bored with this.

MANNY

How do you mean?

RITA

It's a bit long. It's ending up as being a monologue from you. But remember, I'm a part all this too.

MANNY

So just ask me the important bits.

RITA

[66] p 41
[67] The Health Foundation (2011: 44)
[68] Samanta and Samanta (2011)

Like what? How can I possibly know what they are? This is your stuff!

MANNY

[*Irritated*] Give me that back, then.... [*Takes the piece of paper from RITA's grasp. It tears*]

RITA

[*Sarcastic*] Hey! Steady on there, tiger!

MANNY

Give me the rest of it! [*Takes the remaining paper from **RITA**. Looks at both torn pieces*] It's torn!

RITA

[*Calmly*] I know. That's because you grabbed it from me.

MANNY

[*Remembers himself*] Oh. Yes. Sorry. I'm sorry.

RITA

Sometimes I think I don't know you anymore.

MANNY

[*To himself*] You don't.

RITA

[*Shocked*] What?

MANNY

[*Ignoring her question*] Listen. Look. [*Tapping the paper*] This cue here. About emotional entanglement and over-identification. And also the bit about being wrapped up in self-concern, stress, guilt. And my need to feel valued.

RITA

[*Wonderingly*] When I met you, you weren't good on emotion. I scared you, didn't I?

MANNY

Yes. In the first narrative. In N1. I wrote you in thinking of Pina Bausch's dance performance in the play *Café Müller,* from the movie *Talk to Her*.[69]

RITA

I was your mother, wasn't I? In that first scene?

MANNY

Yes. That was the first - and my main - emotional entanglement. And an immediate over-identification with you. With Recovery as change, as overthrow, as transformational. And when I started to realise through reflection that it wasn't going the way I hoped for - I think that was when I turned to cynicism.

RITA

So your hopes for me - for Recovery - was another narcissistic pursuit?

MANNY

[*Discomfited*] Yes.

RITA

Something that if it magically happened would somehow make you feel powerful and omniscient.

MANNY

Yes.

RITA

[69] 20th Century Fox Home Entertainment (2002)

And your cynicism - your *jouissance* - covered up that disappointment?

MANNY

[*Facetious*] Yes. Oh my God - it's like you were there!

RITA

[*Laughing*] But I was! I was!

MANNY

But the *jouissance* didn't last.

RITA

Because?

MANNY

Because of reflexivity. I started going back on things - as a necessary part of self-inquiry – which removed my false consciousness and forced me to confront my unhappy consciousness. Perhaps that was my 'true' consciousness.

RITA

Your what?

MANNY

Unhappy consciousness. The pleasure - and relief (what in the psychoanalytic tradition is called soothing[70]) - that I derived from subverting the certainties of others in my narratives became a problem when through reflexivity this very subversion that produced my joy - that made me feel better – made me look at my own part in it. I realised that I was a part of the reality I despised; part of the madness. Judith Butler wrote:

"The sadistic pleasure which looking at another gives, becomes in the 'mode of unhappiness' an unpleasant looking at oneself. […] The self which upheld its identity by seducing others to a

[70] Kalsched (1996)

state of contradiction, suddenly sees itself as one of the others; seeing itself from a distance not only leads to an unhappy consciousness, but also causes the pleasure of the sceptic to turn to pain.'[71]

RITA

So…

MANNY

I thought that through my narratives I was being subversive by describing the norms of the public mental health organisation that employed me, and using farce to ridicule, examine and ultimately deconstruct their taken-for-grantedness. One of the functions of cynicism is to steep the cynic in the self-congratulatory belief that it is only they who can see the 'truth' or the reality of a situation. I idealised my narratives as being percipient and subversive, and the consolation that this gave me was moral superiority, nobility and heroism because I persuaded myself that only I could see and depict the reality of mental health nursing that other nurses cannot. My narratives were a consolation because they helped me to feel better about my situation when the reality was that my cynicism masked depression.[72]

RITA

[*Confused*] I don't understand - how do you mean, you were depressed? In what way? About your practice? Or clinically?

MANNY

I thought I was 'just' depressed about my practice, because I felt so frustrated that I couldn't realise desirable practice. But reflexivity further deepened *that* insight and I realised that I was actually clinically depressed.

RITA

[71] Butler (1997b: 45)
[72] Zizek (2007)

I thought so. Sometimes you were quite low.

MANNY

But I was laughing at it. And I kept laughing at it. Not at myself, but at everybody else. It was a deflection, a denial that I would have kept up were it not for reflexive self-inquiry into my narratives.

RITA

So you thought you were 'just' subverting the norms that you found were constraining you?

MANNY

Yes. But there can be no subversion of norms in nursing, because nursing itself is *defined* by those norms – in particular norms of Clinical Governance. One can work on the margins, which is vaguely subversive, though the discipline of the organisation reaches into even these margins - like defining the interventions that a practitioner must use. When I met with a service user I thought in terms of the intervention codes that I could put in to the data recording system when I got back to base. These were organisational targets yet they became mine and they started to govern my personality.

RITA

What do you mean, "govern your personality"? Do you mean your practice?

MANNY

It means using an employee's personality – their sense of responsibility and commitment – to make them "self-initiate" - behave - in a way that is advantageous to the organisation, without the employee realising it.[73]

RITA

[73] Villadsen (2007)

How can you not know what is happening to you?

MANNY

False consciousness. What started to be foremost in my mind was how to stay in a job by doing what the organisation wanted – *not* in the first instance how to support a service user's Recovery. That became secondary.

RITA

So your clinical practice started to be fired by your anxiety?

MANNY

Yes. Exactly.

RITA

It sounds very bleak to talk about it - even now.

MANNY

I'd painted myself into a corner. I could no longer be this 'pure' and incorruptible Recovery nurse I thought I could be - this Recovery revolutionary I'd idealised in my head - who was untouched by what was going on around me, because going back on my narratives showed me the impossibility of that. I *was* influenced by the environment I ridiculed. I *was* necessarily part of a metanarrative, because all nurses are defined by it - we cannot operate without it - and it was awful to realise that. Going back to my background in Chapter One – there is no way in a million years that I would have chosen such a thrall and yet remained authentic. Yet there I was. [*Pause*] Butler[74] talks of the melancholia that arises from knowing there is a part of you that you can never know, because the only way of knowing your identity is to define it within the norms of the culture you inhabit, so that there is always a part of you that you don't have the language to know. Perhaps the natural state for a nurse is

[74] Butler (1993)

melancholic. [*Smiles*] In the Butlerian sense.

RITA

But doesn't Butler argue that it's the same for everyone?

MANNY

Yes. She says the way that you can subvert the norms of power is to refuse to use the language.[75] I've heard nurses complain that their managers seem to forget they were nurses once – those that were. But it's because your priorities are different. If you refuse to use the terms of power - those you are given, those you inherit - in an attempt to alter the identity of 'nurse', you'd very soon end up out of the profession. As a manager I had to stop being – or thinking like – a nurse who was in practice because I had the organisation's norms to action. CJ kept telling me in my academic supervisions about this thesis that as a manager I had a chance to change things.

RITA

So why didn't you?

MANNY

It was a different form of psychological noise than being in practice. It was all performance dashboards and key performance indicators and budgetting. But it has the same effect – I couldn't focus. It was like living in a perpetual blur. Reflection may have given me clarity about my situation, but reflexivity just made me see the hopelessness of my predicament. It traumatised me! Perhaps nursing is only ever an accommodation of sorts. An acceptance that you can only do the best you can with the resources that are available, and within the discourses that define and delimit you. It's a form of bricoleurship[76], in that practice is only ever a form of making best and making do. Perhaps that's all

[75] Butler (1999)

[76] The bricoleur uses whatever is at hand to manage the task in which they are engaged of creating an end-product. This concept will be familiar to nurses, for whom it encapsulates the reality of nursing practice. (Gobbi, 2005: 119)

that nursing can ever be. I thought I could change the world. And I thought Recovery could, too.

RITA

But haven't I done the best I could have hoped for?

MANNY

Yes. I think you have.

[*Pause*]

MANNY

But even as a manager I felt burdened by a continual anxiety to comply with the regular Key Performance Indicator – 'KPI - audits. Recovery outcomes were generated, and these became KPIs against which the service offered by Twelvetrees was measured. But this was counter-intuitive because the recovery outcomes were generated from within the version of Recovery that had been accommodated! So they were generic and therefore bore no resemblance to individual narratives of Recovery as they were lived by service users. [*Pause*] But in fact these KPIs, whilst they seemed to be Recovery-orientated, gave the statistical measurements required by the Commissioners for budget-planning and projection. These figures didn't gauge the success of a service. I felt that I wasn't doing it for the service users. The statistics measured a particular version of Recovery and whether Twelvetrees was economically viable in terms of that version. As it turned out, it wasn't. Within a year, Twelvetrees was closed.

RITA

So - hard economic facts. They who pay the piper...

MANNY

...Call the tune. Yes. *That's* the reality. *That's* the metanarrative. And that's what caused everyone's anxiety: and why the organisation was continually concerned

about its continued survival. [*Smiles*] Which is okay if you're on the executive board of the organisation.

RITA

How so? And what's so amusing?

MANNY

The irony was that in the end the organisation was swallowed by a bigger fish. By a shark which had the approved version of Recovery already in its services, whilst the old NHS Trust that employed me was still grappling with the idea. [*Pause*] I think the grappling with the concept was more honest than the declaration that the idea had been pinned down and that was what Recovery was. Mind you, it might have been more honest but it certainly wasn't more economic….

RITA

[*Sighs impatiently*] But that didn't mean that just because the officially-sanctioned version of Recovery was in place that it was actually Recovery.

MANNY

No. I think they tried to force you into the shape of a space they already had for you. [*Pause*] Not just for you, though – for anything, really, that might threaten them. They just out-manoeuvred you, because they were already in a position of power. When you push a square peg into a round hole you lose all the edges in order to get a fit.

RITA

And that's what happened to me...?

MANNY

So – you see, there was nothing joined-up. It felt like everything was working against everything else. And I was actually a part of that...madness. I was

contributing to the chaos as much as I was resisting it.

RITA

By doing what?

MANNY

I don't know. Perhaps by not doing anything about the chaos. Which was as good as going along with it all.

RITA

But what *could* you have done?

MANNY

[*Sighs deeply*] I don't know. I really don't know.

RITA

[*Thoughtful*] That's a strange word, 'chaos'.

MANNY

It's "anti-narrative", because it describes "time without sequence, telling without mediation, and speaking about oneself without being fully able to reflect on oneself."[77] And anti-narrative is attractive to me because it disregards officially accepted forms of storytelling. That's what I did. Because of my denial. Because of my melancholy. I want to resist any rules or authority that is externally-imposed. It's a psychological need I have.

[*Pause*]

RITA

So I can see that there is a similarity between your own story and that of the

[77] Frank (1989: 86)

tension between Recovery as narrative and Recovery as prescribed outcomes.

MANNY

Yes. Recovery *is* an anti-narrative. It cuts across the linear structure of mental health services. Mental health services can't take account of service users' 'river narratives' - when it's going to flood, when a new tributary may branch off. Lived experience of Recovery is by nature all over the place. By definition Recovery isn't systematic – it isn't a ladder – or an escalator - of change like the Recovery Star[78] represents. And for that reason Recovery doesn't fit in with mental health systems that are already in place unless it is accommodated.

RITA

So why did you want this?

MANNY

[*Smiling*] Ah. My usual suspects: revolution, overthrow, paradigm change, etcetera. [*Sadly*] And I feel quite ashamed of it now.

RITA

From what you said earlier – don't you mean you wanted social justice?

MANNY

Yes. Not only for service users, but also for practitioners as well. I mean, can you *really* have one without the other? How can practitioners facilitate empowerment in Recovery when they feel disempowered by the very system in which they practice?

RITA

And now you feel ashamed of how you felt? What's the difference between that and guilt?

[78] Figure 5.2

MANNY

Guilt is feeling sorry for doing something. Shame is feeling sorry for being me.[79]

RITA

[*Chuckles*] But still….

MANNY

It's the word that most closely describes what I feel. I'm embarrassed that I didn't realise desirable practice. I'm ashamed that I wasn't a tough and macho mental health nurse.[80] I'm ashamed that I showed my emotions in my research because the dominant research paradigm is a positivist one.[81] I fear that I'll be rejected for not playing the research game, such as by focussing on research that supports existing research hierarchies and which will also attract large amounts of funding.[82]

RITA

But there's enough literature about the importance of vulnerability and emotionality in nursing and research[83] to show that even if you were rejected – and you probably wouldn't be –there *is* a place in nursing for these things, because it is *lived experience*. Service users don't have an exclusive right to that, you know. And arguably as a practitioner you can't understand the lived experience of a service user unless it is similar to your own. [*Pauses*] And perhaps there is an assumption that the narratives of practitioners are linear and ordered. There is a continuous tension between professional and researcher narratives and personal narratives which convey the humanity of the researcher.[84]

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[79] Brown (2012)
[80] Clarke (2008)
[81] Gilbert (2001)
[82] Lucas (2006)
[83] Gilbert (2001)
[84] Ellis *et. al.* (2011)

MANNY

Perhaps.

RITA

And is there an assumption even in officially-sanctioned versions of Recovery that practitioners are always there, are constant, skilful, competent, *professional*?

MANNY

But nurses can't - I'm not - all those things all the time. You can't be. You're human. Nurses have traumatic thoughts about their practice.[85] We can feel ashamed that we don't have the same social respect or economic rewards that Medicine has.[86] It's not unexpected that nurses should feel bad about things sometimes.[87]

RITA

So, back to the Influences Grid.[88] And your expectations of yourself.

MANNY

But I keep thinking that I wanted Recovery for the wrong reasons.

RITA

Is there such a thing as a 'right' reason for wanting Recovery?

MANNY

Something in me thinks that wanting Recovery because it helps people is the 'right' reason.

---

[85] Dartington (1993: 29)
[86] McIntosh (2005)
[87] McIntosh (2005)
[88] Figure 5.1

RITA

But *you* wanted Recovery, and Recovery helps people – so the reasons why you wanted it don't matter. And besides you're a mental health nurse so you *had* to want it. You had no choice, because it was part of Clinical Governance.

MANNY

[*Hesitant*] Yes....

RITA

And now you're recovering, aren't you?

MANNY

How do you mean?

RITA

You've acknowledged your own mental health vulnerabilites. Because of the stuff that came up for you during this thesis.

MANNY

Reflexivity, you mean? Yes. That was the worst bit. It's like Lawson[89] said: "to remain in the self-denying chaos generated by the *paradoxes* of reflexivity is not merely uncomfortable, but unsustainable." That's how it felt. Unsustainable. The reflexive researcher is forced to question what they hold to be truthful,[90] because the act of going back on what one assumes to be truth forces it to be problematized.

RITA

So was *that* 'the self-denying chaos' you experienced?

MANNY

[89] Lawson (1985: 125)
[90] Lawson (1985: 17)

Yes. Perhaps some researchers can hold it together when they are confronted with ‘the self-denying chaos’. But I wasn't able to, for a long time.

RITA

And reflexivity peeled away the mask of identity that concealed your depression?

MANNY

Yes.

RITA

So now you're making a meaningful life for yourself in spite of any limits those vulnerabilities might impose.

MANNY

[*Still hesitant*] Yes....

RITA

Which is the definition[91] of Recovery!

MANNY

[*Realising*] Ah. I see. Yes. I suppose so.

RITA

Remember, I've seen it happen to you!

MANNY

But usually *I’m* the Socratic questioner....

RITA

[91] Deegan (1988)

Well, I'm turning the tables. [*Laughing*] As you say – it's what I'm about!

MANNY

I feel I've come to terms with the cumulative trauma[92] I experienced in my infancy, and which has influenced my adulthood. You know, trauma being "a deeply distressing or disturbing experience," that is.[93] That's the dictionary definition, anyway. I'm learning through psychotherapy that so much of the way I 'see' things is a re-enactment of trauma, or even the fear of original trauma being re-enacted.

RITA

[*Smiles*] Wasn't there that narrative about the Commissioner's Visit? You mentioned to me recently what you thought was behind your selection of the experience as a narrative and also why you found it so difficult to process as an experience?

MANNY

Oh, yes, that one. I can still remember really enjoying writing it. I was overtaken by *flow*. I think now that perhaps that particular narrative had the most to hide by my turning to *jouissance*.

RITA

How?

MANNY

Well, the practice experience was actually a visit by a commissioner together with a health and safety consultant.

[92] Kalsched (1996: 1) states that the infant may experience cumulative trauma from unmet dependency needs as a result of his/her mother's mental illness.
[93] Chambers Dictionary (2011)

RITA

So there were actually two central characters?

MANNY

Yes. But for brevity – or perhaps some other reason – perhaps in an attempt to evade the re-trauma – I don't know - I rolled them into one.

RITA

But you didn't know that at the time.

MANNY

No. But looking back on it something just clicked.

RITA

And you didn’t know what that was until reflexivity....

MANNY

Yes. I realised that I chose to narrativize that particular experience because it was a re-enactment of a trauma.

RITA

And the trauma itself?

MANNY

I remembered an incident from my childhood. When I was aged eleven I had a tree house in some woods with a couple of friends. I had noticed that some of the toys we kept there had started going missing. Then one day I went to the tree house with my younger brother and when I got there, there was a boy and a girl – she was the boy's sister, because I recognised them both from school – up in the tree house taking our toys and putting them into a plastic carrier bag.

RITA

So what did you do?

MANNY

I didn't do anything. I just watched them. I was frozen. Just rooted to the spot.

RITA

[*Surprised*] Oh. You didn't say - do - anything?

MANNY

No. I even smiled at them as they climbed out of the tree and left.

RITA

Oh....

MANNY

It was a horrible experience. You don't know what to do – like whether to say anything or not – so you just stand there, feeling like an idiot. And I've felt ashamed of it ever since.

RITA

And this was what you felt when the commissioner visited along with the health and safety consultant?

MANNY

Yes. It was the brother and sister all over again. Though I wasn't aware of it at the time. And again I just froze; even though the Commissioner and the health and safety consultant were very critical of the unit I suppose I just froze because what could I do that would have changed anything? Through psychotherapy I've learned that 'freezing' is a dissociation from the feelings that arise from a primitive trauma.[94]

[94] Kalsched (1996)

RITA

So how much of what I saw you go through is genuine trauma or were merely re-enactments of past trauma?

MANNY

Thinking about it now, I think most of the experiences I narrativized – and others that I didn't - were re-enactments of previous traumas. It didn't mean that the moments themselves were not emotional and infused with psychic pain. It just means that I wasn't aware of them as re-enactments that reprised emotions and feelings associated with previous traumas. The way in which I accounted for my experiences from practice was profoundly and unconsciously affected by my personal psychology. This study called into question my performativity of the role 'nurse'....

RITA

Hang on! 'Performativity'?

MANNY

Judith Butler[95] attributes identity to an individual's ability to *perform* it, and regards the performance of identity as a dynamic and political one since our very bodies do not exist outside the culture we inhabit.

RITA

So you have an identity and in order to maintain it you have to keep 'performing' it?

MANNY

Yes. And by performing their own, other people maintain yours at the same time.

[95] Butler (1997)

RITA

It sounds very precarious.

MANNY

It is, as I found out. I found myself with an identity crisis because reflexivity revealed to me that I could no longer allow myself to perform the identity 'nurse' in the way I had grown accustomed, because in fact t simply wasn't authentic for me. I experienced a crisis of self-representation. John Updike said that "celebrity is a mask that eats into the face."[96] I think 'nurse' is a mask just like it, and does the same thing. Reflexivity forced me to remove the mask 'nurse' and suddenly – who was I? Something hideous and ugly. I didn't know myself any more….

[*Pause*]

RITA

So how can anyone believe what you say? I know what happened is as you say it did because I was there, I witnessed it. But what about anybody else?

MANNY

[*Sighs heavily*] I've always thought that I'm at a disadvantage. After AP recommended to me[97] that I write commentaries for each narrative so that they would make sense to people like her who aren't nurses - and I did - she left the narrative group soon after. And I can't use the commentaries here in the present study for reasons of space!

RITA

So is there another way? What about coherence? Validity?

[96] Updike (1989: 252)
[97] Chapter Two, p. 91

MANNY

Coherence? I don't know. Part of me thinks, Do I have to *prove* coherence? *I* know it happened'!

RITA

But things didn't happen *exactly* the way they're described in your narratives, did they? The characters? The personification? The magic realism?

MANNY

No. The narratives obviously weren't the simple and naive stories which correspond to Johns' First Dialogic Movement. As my narratives were refined by each successive dialogical layer, I found that reflexivity and discipline gave not only coherence and order to them, but also a deeper significance. My narratives felt chaotic when I wrote them; however the Six Dialogical Movements model enabled the narratives to capture my lived experience of chaos, and located them in a literary and structured form.

RITA

So is the curious reader more likely to believe the simple naive story than the emerging text?

MANNY

I suppose that depends on how committed they are to reading and reflecting upon the text.

RITA

But how do they *know*? How does the curious reader *know* that what you have written is coherent, is valid?

MANNY

They can read my commentaries.

RITA

But you've just said - you don't have that luxury in the present study.

MANNY

Well - According to Wilber[98] validity is “truthfulness, trustworthiness, sincerity…” Validity is accuracy in capturing what really happened.[99] Anyway I don't really like the term 'validity' because it implies somebody else's rules that I have to conform to.

RITA

And what’s wrong with that? If you want to be taken seriously….

MANNY

They’re somebody else’s rules, that’s what’s wrong.

RITA

You still haven't answered my question. How does the curious reader know?

MANNY

Well, I agree with Lather[100] that since it isn't possible for any research to be free of any ideological interests at all, you may as well be explicit about what your influences are. Which I have done.[101] Also that there is no cosy notion of objectivity and trustworthiness which guarantees the probity of research.[102]

RITA

Go on. You still haven't answered my question!

MANNY

Coherence ensures that a narrative text is trustworthy and enables it to be

[98] Wilber (2001: 14)
[99] Pitney and Parker (2009: 62)
[100] Lather (1986)
[101] Chapter One
[102] Lather (1986)

subject to the scrutiny of academic and social peers alike.[103] Rules and guidelines don't necessarily ensure coherence.[104] What ensures coherence is that *it makes sense to the reader*. There could be any number of rules of injunction or engagement but what is in fact paramount is that a narrative will "enable the reader to deeply grasp the experience and interpretation" of the narrator's lived reality.[105] So my narratives are more than academic enterprises, and are adventures in 'seeing' as nurses 'see'. I wanted to open a dialogical space. I started out wanting to tell nurses what to think and ended by asking nurses to just think….

RITA

But *how* does it make sense to the reader? What is it about your narratives that resonates with them? How do you know?

MANNY

To my mind, validity - or coherence or whatever - is fundamentally a question of to what extent the reader (or audience) trusts what is placed before them. Truth is a common understanding that exists in communities.[106] This means that for nursing research to be valid it has to correspond to the common understanding that nurses have.

RITA

[*Frustrated*] So - *how* do you get somebody to believe you?

MANNY

In a way, perhaps that doesn't matter, because only the practitioner is in a position to say what their truth is, and that can't be disputed because every paradigm has its own definition and rules for truth.[107] Usually, the dominant

[103] Johns (2010c)
[104] Johns (2010c: 262)
[105] McIlveen (2008: 4)
[106] Johns (2010c: 267)
[107] Johns (2009: 22)

paradigm gets to say what truth is, and everybody else is expected to conform to that.

RITA

So are you saying you don't care if somebody believes whether your narratives are true or not?

MANNY

Yes, of course I care! But if the curious reader were to look at my background, and my methodology, and read my narratives - and if they are committed to hearing my story - then they can make up their own mind. Coherence arises when the curious reader closes the hermeneutic circle my narratives have opened up for them.[108]

RITA

Hmm. Don't you kind of have to think out of the box here? I mean, what exactly are you saying?

MANNY

But that's the problem. Everyone's used to thinking in one particular way. The way that's taken-for-granted, that seems natural, that is owned by the dominant paradigm and proliferates everywhere. But that's exactly why *that* reality doesn't seem 'natural' to me.

RITA

But how will it make sense to the curious reader who isn't a nurse?

MANNY

My dialogue with the literature and with peers according to Movements Three and Four of the Dialogical Movements model, and the subsequent co-creation

[108] Johns (2010c: 272)

of meanings, show that my narratives resonate with the experiences of members of my own and other professional groups, like those teaching in education, who are likely to experience the same kind of organisational forces as constraining of their own practice.[109] *That's* shared meanings; *that's* coherence....

RITA

I suppose so….

[*Pause*]

MANNY

Of the several notions of post-structuralist validity that are proposed by Lather,[110] rhizomatic validity resonates most with me. The metaphor relates to the rhizomes or roots of trees, which grow underground, out of view, criss-crossing and traversing, transgressing the linear growth of the tree above ground. For Lather this form of validity "undermines stability, subverts and unsettles from within... [it] is a nominalist counter-logic: it...situates itself in the interstices of the no longer and the not yet."[111] This form of validity gets everywhere, it inhabits every nook and cranny of one's existence. The phrase 'the no longer and the not yet' seems to encapsulate the place I reached at the end of this study. What I thought I knew about nursing - about myself - was 'no longer', and a true sense of my self was 'not yet', was incipient.

RITA

[Looks puzzled] And you are telling me this because…?

MANNY

Because it's the way in which my study is coherent...and valid.

[109] Machin and Vignoles (2005); Gerwitz and Crubb (2009); Youdell (2010); Brown and Carraso (2013)
[110] Lather (2007)
[111] Lather (2007: 124)

RITA

But you don't have to prove that to me. [*Sarcastic*] Like I said – I was there!

MANNY

But I've still got to demonstrate that.

RITA

Who to?

MANNY

Examiners. Academics.

RITA

Oh, Pah! [*Waves an arm dismissively*] Academia is full of big egos![112]

MANNY

[*Laughing*] In what way?

RITA

There are tons of people in academia with big Egos. After all, it's pretty cool to be called "doctor."[113]

MANNY

[*Smiles*] Yes. [*Sighs.*] But I've got something from this thesis that I wasn't expecting.

RITA

What's that?

[112] Karp (2009: 32)
[113] Karp (2009: 2)

MANNY

It's forced me to face up to a few things about myself, not just as a nurse.

RITA

So what about me now?

MANNY

You?! There is a kind of peace about working in private health care as I do now. I've always been much more bothered by the psychological noise that is continually and persistently transmitted down to nurses by the hegemony. Almost as though being in the NHS you have to take all the latest Clinical Governance stuff much more seriously than in the private sector where you just have to make sure you work according to Company policies.

RITA

So is there Recovery in your new employer?

MANNY

Ah. There's no such thing. The unit I work in is a Company pilot for Reablement.

RITA

What's that?

MANNY

It's about "maximising independence". It talks about "Services for people with poor physical and mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living."[114]

RITA

Oh my God. It sounds like mental health care has gone backwards by fifteen

[114] Care Services Efficiency Delivery Programme (2007)

years. Such as the use of the word “accommodate” - when Recovery is about moving forward despite any limits that your illness may impose.[115]

MANNY

Yes; it doesn't sound as ambitious as Recovery. But perhaps that means it’s more realistic, achievable. Though to use the term “daily living” is immediately limiting because somebody else – probably in authority - has said what those 'activities of daily living' are against which 'independence' is measured. Recovery never made any such claim. Until things like the Recovery Star, and KPIs. Those are imposed outcomes. Just because they are written down on a document somewhere doesn’t mean that anybody who is recovering from a period of mental ill-health aspires to them. Recovery is about lived experience and not objective accomplishment.

RITA

I *am* individual!

MANNY

Well, is it who you are now? It seems that Recovery has been defined by the hegemony, which says this or that is an indication of somebody's [*mockingly holds up his hands and gestures quotation marks with his fingers*] ‘Recovery’. And because it’s the hegemony – remember, governance by consent – the version of Recovery that is projected appears to be the ‘natural’ one. [*Pauses. Thinks*] Hang on! [*Excitedly*] Here! Here! [*Pulls a small, plain hardback book from the inside pocket of his jacket*] Let me show you what I mean.

RITA

What?

[115] Deegan (1988)

MANNY

[*Opens the book and reads from it*] It's my diary. Two entries - several years apart but illustrative of what Recovery had become in the organisation.

RITA

[*Sarcastic*] Go on. Knock yourself out.

MANNY

[*Still excited*] Well – you know the Recovery Star[116]?

RITA

[*Sighs*] Yes….

MANNY

And how there is a progression on each leg of the star on which the service user advances as they exercise or regain more and more skills? A linear progression?

RITA

Yes. So what? We've already established that Recovery is not linear….

MANNY

[*Still excited*] Well, listen to this. [*Starts to read from the plain little book*]

RITA

[*Irritated*] What?

MANNY

Hang on! [*Flicks through the pages of the book*] Ah. Here it is! Listen to this!

[116] Figure 5.2

RITA

[*Smiling*] I'm listening….

MANNY

[*Looks up from the book*] Well, I have to explain a little bit of the background first.

RITA

[*Irritated*] Go on….

MANNY

Well, in 2008 I approached the Unit Manager…

RITA

The Queen?

MANNY

[*Smiles*] Yes – her. [*Continues*] …With the idea of the team implementing the Recovery Star, because it seemed to me a good way of measuring Recovery outcomes, which I knew is why the Trust kept auditing us for Key Performance Indicators.

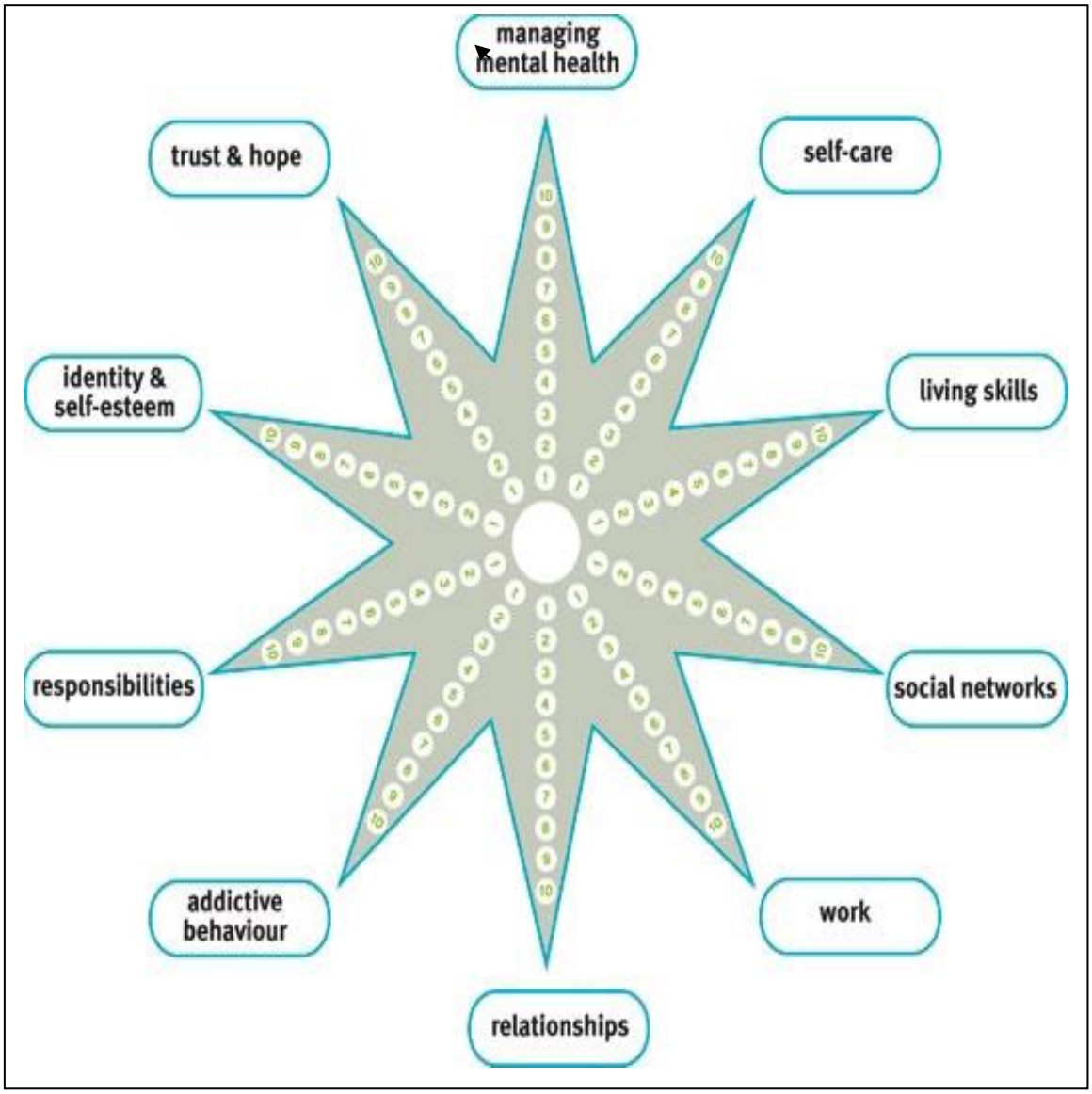

Figure 5.2: The Recovery Star (Mental Health Providers Forum and Triangle Consulting, 2008)

RITA

Okay….

MANNY

This is my diary entry for that day:

Thursday 14th February 2008: I've come across the Recovery Star on the internet. It offers a model for Recovery, and I don't like calling Recovery a model because then it's something fixed; but it identifies things about Recovery which are measurable. I showed it to C who said that she's already come across it and rejected it because it is too specific and rigid and "not what we want." She said that Recovery is not something that can be defined by a few things that people do. I'm disappointed because although I'm not in favour of outcome measurements I understand that that's what NHS Trusts need these days to plan services and attract money, and I think the Recovery Star can do that.

RITA

So? And?

MANNY

Well; it was interesting that shortly before I left my employment with the Foundation NHS Trust two years later I attended a training course on mental health Recovery which featured the same Recovery Star model that the Unit manager had rejected earlier for being inflexible and proscriptive! This is my journal entry from then [*reads*]:

Tuesday 9th March 2010: I'm about to leave the Trust but they've still insisted that I go on a training course about Recovery! Man, I was a bit weirded-out when the group was presented with the Recovery Star and asked to plot the recovery of some imagined service users on it! There were two facilitators and the male one thought it was a double act but the woman very quickly showed him she wasn't having that. They presented scenarios of people with different states of mental health and asked the group to say whether the person is Recovered or not by referring to the Recovery Star. Wow. I remember showing this to C two *years* ago, and her rejecting it because it was too definitive or something. C has been managing one of the CMHTs for the past two years, and the unit has been closed for a year; and the new Trust is audit-crazy. What goes around comes around.

Two years later that same manager was one of the managers now implementing the Recovery Star!!

RITA

[*Smiles*] Perhaps it's a much more refined model now....

MANNY

You don't really believe that, do you?

RITA

Well, the Recovery Star is a best fit tool, specifically - and I quote -

designed as an outcomes tool, providing quantifiable information for the service user, key worker, and service provider to visually and numerically track change over a period of time.[117]

[*Pauses*] Hmmm.

MANNY

What?

RITA

I'm not sure I like the sound of that. It kind of suits everybody, when I thought that Recovery is about service users, and everyone is different.

MANNY

Yes. My issue with the Recovery Star is that it is an example of proscription and generalization rather than one that takes account of individual Recovery narratives. It's basically saying what Recovery is and the course it will take. It states what criteria indicate Recovery and what recovery should be measured against. If you achieve all the outcomes set by the model then you're recovered. Even if you don't feel like you have. Recovery has become a technical-rational achievement.

RITA

Don't knock it. It works for some people. Some service users are happy with it.[118]

MANNY

Well, I'm not saying that service users aren't involved more than they ever were. But I struggle with Recovery as it is being implemented by the metanarrative. I see how 'consumer consultants' are used, and how easily that can be related to

[117] Mason (2012)
[118] Donnelly et. al. (2011)

the consumerist discourse. I remember the wide-eyed surprise of service users to whom I offered free manicures and Premier league football season-tickets because these met targets for Direct Payments that were imposed by the commissioners of mental health services. And I wonder, where is the incentive *to* recover? To hold down a job and pay taxes, for example? There are still, it seems, many more advantages to receiving mental health services than not to – and that hasn't changed since the era of Talcott Parsons and the social advantages of the sick role! I mean, where's the progress? This makes me think that it's not actually in the interests of the hegemony - or of some service users themselves - for users of mental health services *to* recover. Being a user of mental health services is now as much a career[119] as it ever was, even if that's being a career 'expert' on services, or a 'consumer consultant'. And as a mental health nurse I have a necessary part in ensuring this *status quo*.

RITA

So are you on the steering group for this...

MANNY

...Reablement?

RITA

...Reablement thing. Project, pilot - call it what you will....

MANNY

[*Smiling*] No. Despite – or because of - my experience of Recovery, I thought it unwise to volunteer for the project steering group.

RITA

And nobody asked you?

[119] Goffman (1959)

MANNY

No.

RITA

You should have put yourself forward for it, then.

MANNY

Why? I'd already looked at it: the whole thing is inscrutable. At the end of every month colourful graphs and bar charts are produced which can only be interpreted by someone with a trained eye. In some way Recovery's just the same now. Figures and charts that only clinicians can make sense of. The psychic pain of trying to change the system but realising you can't and of knowing that you yourself are one of the things holding it up – it's just too much. I think not even the clinicians really understand it. It seems like it's done for the benefit of commissioners. [*Pauses*] It's like the French say....

RITA

Plus ça change, plus c'est la même chose.

MANNY

Yes. "The more things change..."

[*RITA and MANNY together*] "...the more they stay the same...." [*They laugh*]

RITA

[*Serious*] And the new knowledge? From your thesis?

MANNY

Oh. That....

RITA

After all, you can't have completely wasted the past six years.

MANNY

My narratives indicate what obstructs service change in public mental health care and why. They illustrate the norms and values that affect individual practice both vertically (that is, from the organisation and the government), and horizontally (that is, from colleagues and managers), and how an individual practitioner experiences these as obstructive to delivering the service they are directed to.

RITA

But what's so new about that?

MANNY

I could be defeatist and say that the new knowledge is not to bother trying to do what I did, because it won't work. But then I'd have to moderate that.

RITA

How?

MANNY

Well, I guess... I *could* say don't do it the way I did it. Unless you change first. Change on the inside, I mean. As a person. After all, you can admit to everything in your background chapter – you know, all the things that influence you – but that's no use if you leave it there and let it tie you up in knots anyway.

RITA

So what has your thesis contributed to existing knowledge?

MANNY

It's highlighted the factors which constrain practice.

RITA

Practice in general or just your own?

MANNY

Well i have my own stuff to contend with - as i've shown....

RITA

Stuff like...?

MANNY

The re-enactments of my primitive traumas; the dissociation....

RITA

So there were factors which constrained you and factors which are general....

MANNY

Yes. Like the general processes. My thesis exposes the tension between the rhetoric of Recovery and the reality. The tensions between the organisation, the structure of mental health nursing practice - which don't forget necessarily takes place within the context of the organisation - and one's experience of the organisation – the tension between all these things and the ideals of Recovery.

RITA

[*Hurtfully*] But Recovery isn't an 'ideal' - it's reality, it's everyday, it's people's lives!

MANNY

Yes, i know that's how it should be, how i want it to be. But in comparison to organisational life - for practitioners *that's* what's real, *that's* what's everyday. And *that's* why Recovery is an ideal. Because real – authentic - Recovery is so far removed from what the organisation is trying to do. The influence of authority, tradition and embodiment means that the narratives of service users

are at odds with the dominant – domesticated – version of the Recovery narrative.

RITA

But Recovery 'fits' with things - like the consumerist discourse, like the expert patient, like clinical governance - you've said so yourself.

MANNY

I don't think Recovery really 'fits' with anything. And that's what attracted me to it.

RITA

[*Laughing*] it's like you, in that sense! You think you don't fit anywhere either!

MANNY

[*Thoughtfully*] Yes. And like me it is *forced* to 'fit' with existing discourses. Recovery is accommodated within and by those existing discourses. And that's how it's constrained. Mine is a privileged account but only insofar as it was me who experienced it. It provides a starting point for other practitioners to account for their own transformative journeys of becoming.

RITA

Yes. But where do your narratives fit?

MANNY

My narratives indicate that professional transformation for a nurse is not possible without that nurse truly accepting who they are as a person. This has implications for health care organisations which employ individuals to deliver services to others, but pay little attention to personal psychological issues of those employees that may influence the delivery of that service.[120]

[120] Thomas (2006)

RITA

And reflexivity?

MANNY

I found that 'the self-denying chaos of the paradoxes of reflexivity' in fact psychologically traumatised me. So it was just as well that I'm a mental health nurse and have been able to navigate the chaos. I don't know how I would have otherwise managed the psychological issues which arose for me during the course of my thesis.

RITA

But that's what reflexive self-inquiry is for! Is there another way?

MANNY

I don't know. Right now I think public mental health services will never change, certainly if you leave it to the system to reform itself.

RITA

Too many vested interests, norms; too many reified social discourses, do you mean?

MANNY

Yes. What Johns[121] in another context described as "the reality wall" that the reflective practitioner can come up against when they see their true situation and what actually constrains their practice.

RITA

And the strengths and limitations?

[121] Johns (2010b:41)

MANNY

I consistently found it difficult to stand back far enough from the study. This is required by the second dialogical layer[122]; I was unable to detach my emotions from the processes of collecting data, constructing narratives, and of reflexive self-inquiry. My background chapter indicates my emotional and psychological investment in the transformative process of becoming the practitioner I want to be. Instead of that, due to the very identification of organisational processes and rhetoric I found myself enmeshed in a web of discourses. Over the course of my data collection, definitions of Recovery changed, the goalposts were moved, the sands shifted. As a practitioner I found it difficult to remain upright in these shifting sands, and with each new statement of service rhetoric that was issued by the Department of Health, Recovery seemed to drift further out to sea.

RITA

[*Smiles*] So is this thesis your message in a bottle? [*Pause*] Did you feel like you were drifting out to sea along with your ideals of Recovery?

MANNY

In a way, yes…But qualitative research is an embodied process to the extent that researchers may invariably find themselves emotionally affected by the research[123], so this affectedness is to some extent unavoidable. In other words, I was a part of what I was seeing. But it was a while before I realised that. The

[122] Fig 2.3
[123] Dickson-Swift et. al., 2009

thesis - in particular the narratives - was a living, breathing, creative thing, often with an energy of their own. A strength of the thesis is that it is a graphic revelation of the conditions in which I practised as a mental health nurse. This provides a dialogical space for the reader (or in the case of a staged performance, the audience member) to dwell with the text or the representation.

RITA

But it was just you.

MANNY

Yes, I know. The thesis is a single case study, and therefore as such there can be no claim to generalisability. However as they dwell with my narratives the curious reader will find resonance within it.

[*Pause*]

And I didn't conform to the traditional swagger and sway of mental health nursing.[124] That was difficult, because for that reason I felt vulnerable throughout. Not normal.

RITA

Is that a strength or a limitation?

[124] Clarke, 2008: Simpson, 2008; Watkins, 2008

MANNY

I don't know - but it is something with which the curious reader is to dwell. I didn't become what I wanted - I am still transforming into something else, someone other than I wanted when I set out. And hence my focus was on my personal experience as captured by my narratives, rather than a deconstruction of the constraining processes that I identified in my narratives.

RITA

Perhaps that's for somebody else to do.

MANNY

Yes.

RITA

But you weren't published? You didn't go to any conferences.

MANNY

Yes. That's a limitation. I think it was just because I found self-inquiry constantly traumatic, and I didn't want to publicise that. But...my narratives can be used towards social action. Towards building a better clinical world.

RITA

That's ambitious! Who would be interested in them except for other nurses?

MANNY

I'd like to think that my depiction of some of the processes and discourses which constrained my practice would resonate with other practitioners from other disciplines. I've approached a local theatre group to see what they think about perhaps staging them.

RITA

So what now?

MANNY

How do you mean?

RITA

What's next for you?

MANNY

Well. You know I'm in psychotherapy now.

RITA

Yes. I know. You're recovering….

MANNY

I started psychotherapy with the aim of achieving – or 'recovering' – a coherent self, which I lost through reflexivity. The psychotherapeutic approach favoured by my psychotherapist is Psychosynthesis.

RITA

Which is?

MANNY

The founder of Psychosynthesis, Roberto Assagioli, described it as: first and foremost a dynamic, even a dramatic conception of our psychological life, which it portrays as a constant interplay and conflict between many different and contrasting forces and a unifying centre that ever tends to control, harmonize and use them.[125] There's an element of serendipity here, because Psychosynthesis lets me use the narrative strategies I developed during the course of this thesis for psychotherapeutic insight.

RITA

How does that work?

MANNY

Well, the same narrative format as I developed in this thesis enables me to capture the 'constant interplay and conflict between many different and contrasting forces' that's essential to Psychosynthesis. And this narrativization of what Assagioli described as the client's rich inner resources[126] is in keeping with the processes of Psychosynthesis.

RITA

So is that your next adventure?

MANNY

Yes. I think so. I've already started it. And you?

RITA

Well, you know, more rhetoric, more hope. And perhaps one day….

MANNY

Yes. That'd be wonderful.

[125] Assagioli (2000: 26)
[126] de Coster, 2010

RITA

But when? That’s all….

MANNY

I once I thought it would be with you...

RITA

So did I for a while. I thought we were good together.

MANNY

But it wasn't to be.

RITA

No.

MANNY

So you see?

RITA

What?

MANNY

I've talked you round, haven't I?

RITA

To what?

MANNY

It's not you, it's me who is at fault. As I said.

RITA

[*Laughs*] Very clever! [*Serious*] No, I don't think it was either of us. [*Pause*] I think it was – both of us.

MANNY

It was the reality wall. It was too high, and too far to go around.

RITA

Perhaps you've made a few chips in the brickwork. But the stone is very thick.

MANNY

As Heidegger said, you've only got those tools available to you that are ready-to-hand.[127] To journey inward – to recover – is to find new tools.

RITA

So what has been the point?

MANNY

You mean what other practitioners can learn from this thesis and how they can take it further?

RITA

Yes.

MANNY

Well. The thesis opens up a space where the practitioner can dialogue with possibility. Other practitioners can learn what the pitfalls of narrative self-inquiry are. These include the chaos which can arise from reflexivity.
Through the process of narrative self-inquiry practitioners can identify factors which constrain practice, and act upon them, and they can uncover the tension

[127] Parsons (2010)

between the reality of practice and desirable practice. Personal practitioner narratives are authentic and important. The thesis illustrates the link between narrative and cognition – that is, the way we think about things. Then we can be agents of change, and not victims of it. I'd like to see other practitioners working in other units write their own narratives of becoming the Recovery practitioner they desire, of personal or professional transformation. But Recovery has perhaps faded from those early, halcyon days but, then, doesn't everything - the nursing process, primary nursing, named nursing; why do these things seem to continually fail? My thesis can start to provide an insight into that.

RITA

And where does your thesis fit in with the wider scholarly debate about reflection?

MANNY

Well, I think it shows that reflection isn't enough on its own. Although reflexivity is built into the MSR, reflexivity is important if you're going to change who you are.

RITA

How do you mean?

MANNY

People talk about 'critical' reflection as though there are times when reflection isn't 'critical'. Reflection is always transforms perspective.[128]

RITA

But you've seen it. You've seen reflection being used uncritically.

[128] Mezirow (1981)

MANNY

Yes. When organisations want their practitioners to meet certain organisational behaviours – or policies – so they provide a reflective framework for achieving that. The irony is that if reflection is used properly then the employee can't help but use it as a critical tool – a tool that is critical of the way the organisation wants them to do things. Reflection is emancipating (Johns, 2009). The organisation shoots itself in the foot because reflection doesn't change what you do but it changes who you are.

RITA

Which shows that that they don't understand reflection.

MANNY

Yes. Organisations like that…their approach to reflection and reflective practice is instrumental. My thesis shows what is possible with reflection through the practitioner's own experience. My thesis – the emphasis on narrative – shows what is possible through imagination and ways of representation. It enables practitioners to write, to represent their worlds in ways which flow.

RITA

But nothing about your practice changed....

MANNY

I changed. My thesis shows why change is not possible. But that also opens up a space for change to take place. What Heidegger calls *lichtung*: literally, the clearing in the woods.[129] It's almost as though there is too much else going on, so many discourses in which the practitioner becomes enmeshed – organisational, professional, personal – that the practitioner must struggle with their own agenda, which necessarily settles at the bottom of the pile. But throughout the Six Dialogical Movements, the practitioner is increasingly paying

[129] Wikipedia, 2013

attention to practice – from the first moment of writing in a journal, to being able to put the completed reflexive narrative before for the curious reader – or the audience – to peruse, to view. My narrative illuminates the Third Dialogical Movement – what has influenced me – it opens up a dialogue between emerging issues and existing knowledge, and which ultimately takes the form of narrative representation

RITA

Yes. To know the road ahead, you must ask those who are coming back….[130]

[*LIGHTS OUT. SCENE ENDS*]

[130] Chinese proverb

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AFTERWORD

In Chapter Four I remarked that I was uncertain about the significance of the character of the Compère. Whilst I initially struggled with a colleague's portrayal of the character as an old soak (see Chapter Two), something about his portrayal has stuck with me. In writing this final chapter, I have started to imagine that the character of the Compère is a failed actor, whose talent and discipline was insufficient to propel him into the footlights as was his dream. He still maintains a presence in the theatre, his only and fondest love, but he still harbours a resentment that it did not give him what he desired. He moves unsteadily between scenes, uncertainly connecting them one with another, not even sure of their connection, and cannot understand (or does not care) that he is merely politely tolerated by an audience who pity him.

Looking back, I was a different person when I wrote the character of the Compère. As for acting, so for nursing.

For that character was me.

Appendix 1

The Simple Story

It was lunchtime. That morning I'd been out to couple of service users in the community, one to arrange with him a time to sound the Council Cleaners in to clean his flat (this was a favour for his Social Worker, who argued that the state of his flat was a health hazard and therefore down to me to arrange) and another with whom I filled in a CPA [Care Planning Approach] risk assessment. I felt that I had spent too long with him, as I had some depot injections to give before lunchtime.

Fortunately I was able to reschedule the depot injections – I seem to spend much of my time on the telephone these days, mostly apologizing for being late.

I was sitting at my desk starting to input data onto the antiquated DOS-based computer recording system we have to use, and trying to eat my lunch in between key strokes. I sit opposite R, a social worker, and try not to laugh so much, because I find him so funny. He says he is taking anti-depressants for his stress and he says they relax him a lot.

Suddenly I hear a shout. It is ABJ calling for attention. Today he is wearing a pink striped shirt, pink tie and grey suit. He holds up his arms as he calls for attention.

"I want everyone to clear their diaries for three o'clock this afternoon, he says. "I want to meet with you all, and no exceptions please." Then he just walks away.

We all look at each other, bewildered as to what the meeting might be about. I have a couple of depot injections to do, then at three o'clock I'm back for the meeting.

We all cram into the meeting room. Only two days ago we'd had somebody from health and safety come round and tell us that there can be up to thirty people in a room that size. But the team is forty strong, and we all fit in there, although its a very tight squeeze and obviously against fire regulations. Nurses, social workers, administrators, managers – are all in there.

ABJ says that he is getting pressure from his bosses to meet targets. He tells us that if we don't meet them – or can't meet them – then "perhaps" we should work somewhere else. I don't know about my colleagues, but I interpret that as a threat. He carries on for a little while and then closes the meeting. It lasts for half an hour, and we all come out of it thinking that it's just more of the same.

APPENDIX 2

Journal Entry

Tuesday 23 March 2010

Suddenly unexpectedly at lunchtime today CBA told us all clear our diaries for the afternoon because we were having an important meeting later. None of us knew what it was, but we all squeezed into the meeting room (contrary to fire regulations) – all sixty of us in the team. Then he laid down the law about how we had to meet our targets otherwise we should leave.

We were all bewildered. It didn't seem fair. I've asked around and most of us think this target business is all nonsense, but I suppose if the commissioners want it done then we have to do it otherwise they pull the plug. Simple as. I am angry about it all on two counts. Firstly because I think the targets are silly; I'm going to get stressed trying to meet them (when I'm already stressed, as Occupational Health will testify); and i object to be being threatened.

I wish I could have piped up to say that's not what Recovery is about – but so what, what difference would that make. They're hell-bent on their version of Recovery as they see it. I'm despondent.

Appendix 3

Response to a significant experience using the Model of Structured Reflection

CUE	RESPONSE
(1) Bring the mind home	Centring the self
(2) Focus on a description that seems significant in some way	The community mental health team was called to a meeting with the Service Manager
(3) What issues seem significant to pay attention to?	The Service Manager told the team about the importance of meeting targets which were used as outcomes by the commissioners
(4) How were others feeling and what made them feel that way?	Other members of the team were nonplussed about the purpose of the meeting. However they feared it was something negative because of the critical spirit that was promulgated by managers
(5) How was I feeling and what made me feel that way?	I felt trepidation about the meeting. I had not had positive or productive personal encounters with the Service Manager. He regarded my role as cast in stone, even though it was a new role within the team, and that therefore I must achieve the objects of my role.
(6) What was I trying to achieve and did I respond effectively?	I was trying to realise mental health Recovery in my practice, by focussing upon the personal narratives of service users. I found it difficult in the meeting to articulate this in the meeting
(7) What were the consequences of my actions on the patient, others and myself?	The Service Manager remained with the notion that the organisational representation of Recovery which he was promulgating was the correct one. My colleagues remained under the same impression because the Service Manager's model of Recovery was uncontested. My passivity caused me to feel bad about myself because I had not advocated for colleagues and for service users
(8) What factors influenced the way I was feeling, thinking or responding?	I felt intimidated by the Service Manager and by my fear that colleagues within the team would not understand what I meant, making me look ridiculous in their sight and unsupported
(9) What knowledge did or might have informed me?	I had already started to learn the importance of service user narratives in Recovery, and the tension between this and the use of technical-rational measurable outcomes used to define Recovery
(10) To what extent did I act for the best and in tune with my values?	I feel that I failed to advocate for myself, my colleagues and for service users. I failed to advocate for my own perception of Recovery. My values were to keep out of trouble and not to draw attention to myself, because I had been advised that my role was an 'experimental' one and thereby potentially temporary
(11) How does this situation connect with previous experiences?	I am fearful of confrontation with authority especially within a public setting. I was uncertain of my own perceptions of Recovery and readily felt intimidated.
(12) How might I reframe the situation and respond more effectively given this situation again?	The meeting was impromptu which placed all the community mental health team at an immediate disadvantage. I feel that I would respond more effectively by overcoming my fear and becoming more certain of my perceptions of Recovery.
(13) What would be the consequences of alternative actions for the patient, others and myself?	I would like to think that the Service Manager would have agreed with my ideas about Recovery and represented those to the executive board. However the culture of the organisation was such that organisational strategy was to meet the requirements of the commissioners, because 'they who pay the piper call the tune.'
(14) What factors might constrain me from responding differently?	I have a psychological fear of authority. When feeling under stress I find it difficult to control my stammer, which influences the efficacy of how can communicate my ideas. I feared for my job if I were to indicate that I am opposed to organisational strategy over the matter. There was a culture of bullying and intimidation in the organisation.
(15) How do I NOW feel about this experience?	I felt that I let myself down, let my colleagues down, let down service users and their carers, and failed to advocate an authentic notion of Recovery. I NOW feel better prepared for such an experience.
(16) Am I more able to support myself and others better as a consequence?	Because of my acknowledgement of my feelings, and my isolation of the factors, I feel better able to support myself and others in the event of a similar experience.
(17) What insights do I draw towards self-realization?	That I need to overcome or to understand my psychological fear of authority and of confrontation. That I need to fully ground myself in an authentic notion of Recovery, so that I have an evidence base from which to argue it. The Service Manager used a language – a sort of management speak - with which I am unfamiliar as a practitioner. My insight is that (i) he is so used to speaking in this way that he considers it to be the norm; (ii) it is a deliberate attempt to obfuscate matters of everyday practice. His is a discourse of power and suggests that if the discourse is to be engaged with there is an expectation that it must be met on its own terms.

Fig a3: Response to a significant experience using the Model of Structured Reflection

Appendix 4

Using the Six Dialogical Layers Model

1	Dialogue with self (written in a journal or spoken) as a 'naive' or spontaneous story (that reflects dialogue with persons and self within the story itself)	Upon my return home after the incident I recalled it and imagined what I really wanted to have said the meeting.
2	Dialogue with the story (written in a reflective journal) as an objective and disciplined process (using a model of reflection) to produce a text	See Appendix 1. What arose was a narrative text that was prosaic
3	Dialogue between the text and other sources of knowing in order to frame understandings emerging from the text within the wider community of knowing (theoretical framing)	I was confused by the meeting, and in particular by the Service Manager's use of management speak. I did an Internet search for the term 'management speak' using the Google search engine, and this was how I came up with the term 'Jesus Meeting' and realised that this is what the meeting was. I had watched the BBC TV series entitled The Office, in which a fictional manager, David Brent (played Ricky Gervais), is played to comic effect. I could not resist the urge to satirize the Service Manager's management style, which appeared to have echoes of David Brent's management style. I hoped that by satirizing the Service Manager's management style would give an effect equal to or similar to that of the erstwhile David Brent. Similarly I accessed resources on targets used in service planning and delivery in order to emphasise the Service Manager's management-speak.
4	Dialogue between the text's author and a guide(s) to develop and deepen insights	I posted the narrative online in the narrative group and received comments on my narrative,such as that practitioners of other disciplines also experience the target culture, and also experience a language of power that it is expected they will comply with. This assured me that it is not only I who as a practitioner feel burdened by the practice culture I inhabit.
5	Dialogue within the emerging text to deepen insights and weave the narrative into a coherent and reflexive pattern of form that adequately plots the unfolding journey	Although the character of Rita was technically absent from this narrative, I could easily imagine her contempt for the Service-Manager's 'Brent-speak'. I could imagine her thinking that her concern as the personification of Recovery is that of people's lives (that is, individual narratives), and not that of targets and statistics. I might have used her my narrative of the meeting, although I was sure that I would constantly have to quieten her! Instead I wanted the text to speak for itself, as a part of my unfolding journey of despondency about the way in which Recovery had been appropriated and assimilated by hegemonic forces.
6	Dialogue between the narrative and the curious narrative reader responding to the invitation to dialogue	The invitation for the curious reader to dialogue with the text is twofold: (i) in the reading of the text, and (ii) in the dramaturgy of the staged scene.

Fig a4: Using the Six Dialogical Layers Model

Appendix 5

Exposure

by

Seamus Heaney

It is December in Wicklow:
Alders dripping, birches
Inheriting the last light,
The ash tree cold to look at.

A comet that was lost
Should be visible at sunset,
Those million tons of light
Like a glimmer of haws and rose-hips,

And I sometimes see a falling star.
If I could come on meteorite!
Instead I walk through damp leaves,
Husks, the spent flukes of autumn,

Imagining a hero
On some muddy compound,
His gift like a slingstone
Whirled for the desperate.

How did I end up like this?
I often think of my friends'
Beautiful prismatic counselling
And the anvil brains of some who hate me

As I sit weighing and weighing
My responsible tristia.
For what? For the ear? For the people?
For what is said behind-backs?

Rain comes down through the alders,
Its low conductive voices
Mutter about let-downs and erosions
And yet each drop recalls

The diamond absolutes.
I am neither internee nor informer;
An inner émigré, grown long-haired
And thoughtful; a wood-kerne

Escaped from the massacre,
Taking protective colouring
From bole and bark, feeling
Every wind that blows;

Who, blowing up these sparks
For their meagre heat, have missed
The once-in-a-lifetime portent,
The comet's pulsing rose.