School of Allied Health

Mental Health Service Cultures and Reform Aspirations: What is Required for Change?

Sophie Christina Ridley

0000-0002-7710-3572

This thesis is presented for the Degree of
Doctor of Philosophy
of
Curtin University

August 2022

Declaration

To the best of my knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007)—updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number HRE2017-0654.

Signature: …………………………………..
Date: ……30/08/2022………………....

Abstract

Mental health services have undergone significant policy and service reform in the last three decades. However, sustained and meaningful change has been limited. The mental health system is often described as ‘broken’ and in crisis. Although service users and families are recognised as key stakeholders in policy and service delivery, they continue to report experiences of exclusion, inadequate care, coercive practices and discrimination. Mental health service cultures are a major contributor to this lack of change. Nevertheless, there has been limited inquiry into understanding service cultures and their influence on service user, family and practitioner experiences.

This research explored how mental health service cultures mediate Australian reform aspirations and activities. An exploratory qualitative research design informed by critical theory was employed. In-depth semi-structured interviews were conducted with 21 service users, 11 family members and 19 mental health practitioners (peer workers, social workers, mental health nurses, recovery workers, psychiatrists, occupational therapists and advocates). Several participants occupied multiple identities and positions (e.g., service user *and* practitioner, practitioner *and* family member).

Reflexive thematic analysis revealed similarities in understandings of culture across the three participant groups and significant differences in how cultures were experienced. Two broad contexts shaped and sustained the existing service cultures, named cultural frames in this project. These frames reflect and reinforce the historical, social, political and economic conditions in which mental health services operate. The first cultural frame, the organisational and administrative context, outlines how neoliberalism and New Public Management permeate services and constrain practitioners’ everyday work with service users and families. The second cultural frame, histories of psychiatry and responses to mental distress, details ‘old culture’ characterised by entrenched practices, biomedical dominance and hierarchical cultures. The combined cultural conditions of the two cultural frames often lead to discourses of blame and othering being invoked in mental health services. Two cultural elements, a culture of blame and a culture of othering, were identified as by-products of the cultural frames. These elements of culture are produced and sustained by the workings of the broader cultural frames, demonstrating why they are so complex and intractable. Overall, the findings provide a comprehensive insight into the understandings, experiences and enactments of mental health service cultures from the perspectives of service users, families and practitioners.

The research findings demonstrate how mental health service cultures counteract, undermine and respond to reform and service improvement attempts. The organisational and administrative context of mental health services and old culture impede change efforts such as recovery-oriented practice. While individual practitioners may practice in recovery-oriented ways, forming patches or sites of change, the overarching culture with its entrenched historical practices coupled with the constraints of New Public Management limit sustained change efforts. These cultural frames act as substantial barriers to cultural change, to which I propose possible enablers. These findings suggest a lack of fit between policy aspirations and current service environments due to the organisational and administrative context. Consequently, I argue for reconceptualising mental health service cultures as a ‘wicked problem’ because of the multiplicity of interdependent factors complicating potential solutions.

This thesis makes two key contributions to knowledge. First, the exploration of multiple perspectives, including service user, family and practitioner experiences of mental health service cultures, is a novel contribution to the wider literature. Second, the findings demonstrate how the broader historical, social, economic, and political contexts are central to understanding mental health service cultures, including how practitioners are both constrained by and reproduce cultures in their everyday practices. Previous studies have not taken these broader contexts into account in this way.

Acknowledgements

First and foremost, I would like to acknowledge the people who participated in this research. Thank you to the service users and families for sharing your knowledge and often very difficult experiences of using mental health services with me, and to the mental health practitioners for your honesty and generosity. The opportunity to interview you all and draw on your knowledge and expertise in this research was a profound privilege and I am deeply grateful.

To Dr Christina (Tina) Fernandes, my primary supervisor, whose encouragement and support has been a mainstay since joining my supervisory team. Tina, thank you for reassuring me at so many points throughout the past 5 years. Your insights and questions continually challenged me and enabled me to improve my writing and arguments. I am very grateful to have had you as my supervisor, for your perceptive and thoughtful feedback on my thesis, and your good humour.

To Associate Professor Robyn Martin, you have taught me how to be a researcher, refused to accept anything but my absolute best, and extended me beyond what I thought was ever possible. Rob, thank you for your patience in helping me to develop my research skills, knowledge, writing and expanding my capacity to understand and grapple with complexity. It has been a great privilege learning from you for many years. Special thanks for the many hours of reading several versions of this thesis, and for your meticulous feedback, even when you moved to Melbourne.

To Lyn Mahboub, you have assisted me to develop my critical thinking capacity and transformed and challenged the way I ‘think’ over the past 10 years. Thank you for agreeing to join my supervisory team when you absolutely did not have the time, yet always made space for me. Thank you for your support and mentorship; your knowledge and detailed feedback has been invaluable to my learning and the final product of this work.

Thank you to Associate Professor Angela Fielding who provided crucial supervision and wisdom during the formative stages of this project.

To Professor Donna Chung, my thesis chair, thank you for your invaluable advice, support and humour, just when I needed it. You knew exactly the sort of guidance necessary, and it has been a pleasure to learn from you. Thank you for your time and generosity, pragmatism, and for sharing your vast knowledge of social theory, and assisting me to shape this thesis into a coherent argument.

To Kerry Hawkins and Trish Tran who were Lived Experience Consultants in this research. Kerry and Trish, thank you for trusting and agreeing to work with me in this project. Your generosity, patience, questions and suggestions have been invaluable to this research and have had a profound personal and professional impact on me. It has been a privilege to learn from you both and I hope there will be opportunity to work with you again in the future.

To Associate Professor Geoff Smith, Associate Professor Theresa Williams, Consumers of Mental Health Western Australia and Mental Health Matters 2. Thank you for your insights and guidance during the early stages of this project. Thanks also for your assistance with the recruitment of participants.

To Associate Professor Suze Leitão, I am so grateful for your support and the efforts you went to in making the final year of my Candidature a little easier– thank you.

Thank you to the social work team in the School of Allied Health at Curtin University for your encouragement and support, giving me opportunities to do research and teach, and for your friendship. Special thanks to Dr Lynelle Watts, Dr Angela Barns, Dr Sue Gillieatt and Dr Barbara Blundell.

To my PhD peers and friends, Aimee Sinclair, Dr Cath Stewart, Bec Moran, Bec Field, Dr Huong Nguyen and Dr Paradee Thoresen. You have all inspired and supported me in different ways and I am so grateful to have undertaken a PhD alongside such knowledgeable and thoughtful women.

Thank you to my community of friends for being the fun, caring and kind people that you are – thank you for being interested in my thesis, and for your support and friendship at different times throughout this PhD. Special thanks to my dear friend Danielle Schalk.

To Dr Kate Dorozenko who has consistently reminded me that I could do this. Thank you Kate for your intellectual and emotional support since day one. I cherish our friendship.

Thank you to Denise White for being the best critical friend anyone could ask for. From teaching me to paint my nails as young kid in the Pilbara, to reading my PhD and helping me develop confidence in my writing in the big smoke. Thank you Neecy, your support and astute advice in the final nine months motivated me to keep going.

Thank you to my family, especially my Mum and Dad for your constant support, belief and love. You instilled in me a curiosity and joy for learning, the importance of caring for others, persistence and dedication. To my sisters, Charlotte and Eloise – thank you for being my best mates, staunchest supporters, for listening, even reading some of my work, and showing up just when I needed you.

Finally, thank you to my partner Chris for your steadfast and loving presence, and your unwavering belief in me– my gratitude for you is infinite.

I would also like to acknowledge Curtin University and the Australian government for the financial support I received as part of a Curtin University Postgraduate Scholarship and Australian Postgraduate Award. Capstone Editing provided copyediting and proofreading services according to the guidelines laid out in the university-endorsed national ‘Guidelines for Editing Research Theses’.

Acknowledgement of Country

The learning and writing for this project took place on Whadjuk Nyoongar Boodjar. I acknowledge the Whadjuk people of the Nyoongar Nation as the traditional custodians of this land and pay my deepest respects to Elders, past and present. Aboriginal sovereignty was never ceded.

Contents

List of Figures

List of Tables

List of Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers’ Advisory Council
AIHW	Australian Institute of Health and Welfare
COAGHC	Council of Australian Governments Health Council
c/s/x	consumer/survivor/ex-patient
DoH	Department of Health
DSM	Diagnostic and Statistical Manual
HREC	Human Research Ethics Committee
KPI	Key Performance Indicator
LEC	Lived Experience Consultant
LES	Lived Experience Supervisor
MHC	Mental Health Commission
MHCA	Mental Health Council of Australia
MHWAC	Mental Health Workforce Advisory Committee
NFROMHS	National Framework for Recovery-Oriented Mental Health Services
NGO	Non-government Organisation
NMHC	National Mental Health Commission
NMHP	National Mental Health Plan
NMHWP	National Mental Health Workforce Plan
NHMRC	National Health and Medical Research Council
NPM	New Public Management
RCVMHS	Royal Commission into Victoria’s Mental Health System
SSCMH	Senate Select Committee on Mental Health
UK	United Kingdom

Chapter 1: Introduction and Background

I don't know if the culture caught up with what the policy wanted it to do.

—Service user

This thesis explores how mental health service cultures mediate Australian reform aspirations and activities. The introductory quotation from a participant in this research is an example of the way culture and cultural change are understood and articulated in the context of mental health services. There is a strong view that cultural change is needed in mental health services; however, at the same time, culture is a concept that "can cover everything and consequently nothing" (Alvesson, 2002, p. 3). This duality was a key challenge of this thesis. What does culture mean in this context? How do definitions and experiences of culture differ between stakeholders? What would cultural change look and feel like for those using and working in mental health services?

Mental health services have undergone significant policy and service reform in the past three decades. However, the lives and service delivery experiences of service users and their families remain largely unchanged (J. Crowe, 2017; Habibis, 2005; Mendoza et al., 2013; Productivity Commission, 2020b; M. Wright et al., 2017). Some positive changes have occurred as a result of reform (Mendoza et al., 2013; Whiteford, McKeon et al., 2014), and Australia is described as a world leader in articulating national policies and goals (Australian Health Ministers' Conference, 2009a; National Mental Health Commission [NMHC], 2014a). Despite this, policy aspirations fail to translate into large-scale and coordinated improvements in mental health services on the ground (Mendoza et al., 2013; NMHC, 2014a; Rosenberg & Hickie, 2013; G. P. Smith & Williams, 2016).

Mental health service cultures have been identified as a key barrier to realising policy and implementing approaches such as recovery-oriented practice (Mendoza et al., 2013; Piat et al., 2021; Royal Commission into Victoria's Mental Health System [RCVMHS], 2021d). Additionally, mental health service cultures have been described as enabling discrimination and poor practice (M. Wright et al., 2017). Despite widespread calls for cultural change, and many references to culture in national and local policies, there has been limited focused inquiry into understanding service cultures and their influence on service user, family and practitioner experiences.

I adopt a critical realist ontology and social constructionist epistemology to explore how service cultures in the Australian mental health sector mediate reform aspirations (see Chapter 3). As I argue throughout this thesis, service cultures require exploration from multiple subject positions. Therefore, service user, family and practitioner perspectives are explored to understand how cultures operate and function in mental health services. The broader purpose of this thesis is to enhance understanding of why mental health service reform has remained stagnant and uncover possible pathways towards sustained and meaningful improvement.

In this opening chapter, I provide the research background and context. I describe the organisational context of mental health services and the theoretical frameworks that guided the project. Key concepts and terminology are explained, followed by an overview of the recent service and policy reform in the Australian mental health sector. I outline my motivations for the research, guiding commitments and provide an overview of the thesis structure.

The Organisational Context

Mental health services are delivered in a range of organisations. These include private hospitals, mental health practitioners in private practices, large public hospitals and clinical community services that employ many people, and smaller non-government services. The structure of these organisations varies considerably, as can the day-to-day practices and procedures of those who work within them. These organisations have a common focus on delivering mental health support and treatment to service users. This study focuses broadly on mental health service organisations encapsulating public inpatient and community services, non-government community-based services and private services.

Contemporary mental health service organisations developed from a history in which psychiatric institutions operated separately from the general health sector until the 1980s. One of the twentieth century's most significant changes to mental health organisations was deinstitutionalisation—an ideological shift from institutional containment to therapeutic approaches (Sawyer, 2005). This shift resulted in the closure of most standalone psychiatric institutions and the dispersal of psychiatric authority to a range of entities (Gerrand, 2005; Gooding, 2016). Additionally, deinstitutionalisation involved a transfer of resources from psychiatric hospitals to community organisations (Alakus & Petrakis, 2020).

Changes in the division of labour followed as deinstitutionalisation meant that responsibility for the care extended from nurses and psychiatrists within institutions to include allied health practitioners and community mental health teams (Sawyer, 2005). With deinstitutionalisation, the administration of mental health organisations was transferred to the general health sector (Gerrand, 2005). This background to mental health service organisations is integral to a comprehensive understanding of mental health service cultures, including how different stakeholders experience culture. The next section provides an overview of the unique position of mental health organisations by situating them in healthcare bureaucracies. I then outline the influence of neoliberalism and New Public Management (NPM) on healthcare bureaucracies and consequent changes.

Healthcare Bureaucracies

The bureaucratic structure is an important consideration of the health and mental health organisational context. Max Weber's (1922/1962) theory of bureaucracies provides a useful framework for understanding healthcare organisations. Weber's concept of the ideal type of bureaucracy was characterised by a division of labour, hierarchical management structures with fixed rules for decision-making and clear communication channels (Cockerham, 2015). For Weber (1922/1962), bureaucratic organisations were the most efficient form of legal-rational organisation for managing complex human activity, such as that occurring in healthcare systems. Weber also identified numerous limitations of bureaucracies, including an inherent tendency towards dehumanisation due to the impersonal nature of organisational processes and rules. He warned of bureaucracies becoming an iron cage where workers' autonomy and activities were hampered by rigid and inflexible processes (Cockerham, 2015). Despite these limitations, bureaucracies remain the most common organisational form conceived to manage complex work (Cockerham, 2015).

Healthcare services have adapted bureaucratic forms of organisation (Germov, 2005) because healthcare requires flexible and often timely, non-bureaucratic responses (Cockerham, 2015). Unlike Weber's traditional bureaucracy consisting of a single hierarchical form of organisation, a dual level of bureaucratic rules and professional authority coexists in healthcare organisations (Andreasson et al., 2018; Cockerham, 2015).

Healthcare organisations have been referred to as professional bureaucracies, consisting of medical professionals with a high level of authority, control and autonomy in decision-making due to the specialist and complex nature of their training and knowledge (Andreasson et al., 2018; Dickinson, Bismark et al., 2016; Dickinson, Snelling et al., 2017; Germov, 2013; Kitchener, 2002; Mintzberg, 1979; Reay et al., 2016).

Willis's (1989, 2006) influential work referred to this situation as medical dominance. It was characterised by the authority of the practice of medicine over the work of other healthcare disciplines and its consequent privileged position in Western societies. Medical dominance in the professional bureaucracy is enshrined through health legislation, policies and procedures. Historically, medical practitioners' clinical autonomy in decision-making largely shaped resource allocation and expenditure, creating difficulties for hospital administration and government to control health expenditure or evaluate the effectiveness and quality of the health care provided (Coburn, 2006; Germov, 2013). Medical professionals' authority meant that managers or senior officials had to negotiate procedures and policies with professionals rather than impose them top-down, as often occurs in single-structure bureaucratic organisations (Andreasson et al., 2018). This dual authority represents an ongoing tension in healthcare bureaucracies.

Similarly, the medical discipline of psychiatry has occupied a privileged medical viewpoint in mental health policy and service delivery (Pilgrim & Rogers, 2009). For example, globally, psychiatrists have the authority to detain people and force medication and physical treatments (Bracken & Thomas, 2005; Samson, 1995). Since the twentieth century, psychiatry's interest in applying medical science to mental distress (see 'Key Concepts and Terminology') has aligned closely with the increasing social acceptance of the role of technical expertise, which assumed knowledge lies exclusively with medical professionals (Bracken & Thomas, 2005). Psychiatrists' expertise is viewed as superior to that of other mental health professionals. The law deems psychiatrists to possess medical expertise and the responsibility to diagnose and treat mental distress (Samson, 1995). I now describe how the organisational context of health and mental health services changed towards the end of the twentieth century.

Neoliberalism and NPM

The coexisting dual power structure of professional bureaucracies changed at the end of the twentieth century when neoliberal economic and social policy was imposed on healthcare organisations. NPM, a form of neoliberal governance (Bessant et al., 2020), entailed a shift from government-run monolithic service provision to market-oriented approaches, the privatisation of services and competitive tendering for government-funded contracts (Henderson, 2005; O'Flynn, 2007). Governmental implementation of NPM strategies and processes across all policy portfolios created new and increased forms of regulation of health professionals. This regulation consists of formal measures aimed at optimising accountability. For example, quality assurance, auditing, risk assessment and risk management were introduced to mental health services (Sawyer, 2008). This shift to NPM was partly a response to the perceived deficiencies of public sector bureaucratic administration (O'Flynn, 2007; Stoker, 2006). Healthcare organisations have absorbed NPM and continue operating as a dual bureaucracy (Cockerham, 2015; Stoker, 2006).

A key effect of NPM on professional bureaucracies was the reduction in medical professionals' autonomy and control within healthcare organisations and subsequent changes in how they work. The increasing authority held by administrators and managers meant that dominant professional groups' influence and power were undermined (Hujala et al., 2014; Liff & Andersson, 2013) to ensure organisations operated according to the aims of administrators and governments (Coburn, 2006). Shifts away from valuing professional knowledge and expertise occurred and were replaced with explicit and measurable standards aligned with fiscal and management strategies (Bury & Taylor, 2008; Hujala et al., 2014).

Mental health and healthcare bureaucracies have dual organisational structures involving administrators and professionals (Cockerham, 2015; Germov, 2005). This organisational structure authorises professionals to exercise autonomous judgement when working with service users and families. At the same time, professionals must follow a rationally based management approach focused on efficiency, formal rules and regulations (Cockerham, 2015) and prioritisation of budgets and performance (Hujala et al., 2014; Kitchener & Thomas, 2016). This ongoing tension creates competing and contradictory expectations for professionals by limiting the type of interventions and responses available (Freeman et al., 2009).

Therefore, to examine mental health service cultures, a key consideration is the organisational context of mental health services. The complexity of the organisational context stems from the increasing authority of administrators under NPM, hierarchies of authority based on professional qualifications and position within the organisation, and the tension between professional judgement about mental health service delivery and efficiency and cost.

Theoretical Frameworks

A critical theoretical orientation was employed to understand how mental distress is understood and debated in contemporary environments and to conceptualise organisations and organisational culture. This section begins with an overview of critical theory, followed by a discussion outlining how I employed a critical orientation. Finally, the framework employed to understand culture is described.

Critical theory is “a socio-philosophical school of thought that is part of the tradition of the Enlightenment” (Scherer, 2009, p. 30). Critical theory embraces multiple theoretical perspectives and interpretations (Denzin, 2017; Ife, 1999; Morley, 2003). It can be traced to the Western Marxism of the Frankfurt School, which produced a multidisciplinary critical analysis of modern capitalism (Alvesson, 1987; Briskman et al., 2009; Scherer, 2009) by scholars such as Herbert Marcuse, Jürgen Habermas, Theodor Adorno, Erich Fromm and Max Horkheimer (Antonio, 1981; Briskman et al., 2009; Paradis et al., 2020). Critical theorising is concerned with examining how power dynamics operate to understand the processes by which inequalities are reproduced and to identify how changes to power dynamics can lead to a more just society (Alvesson & Deetz, 2000; Antonio, 1981; Hodgson & Watts, 2017; Sherer, 2009).

An important feature of critical theory is the intent and focus on not just explaining and understanding oppressive social conditions but adopting an orientation towards developing a humane and just society (Sherer, 2009). Hill Collins (2019) refers to this as the “sweet spot” between critical analysis and social action (p. 3). Research informed by critical theory seeks to challenge and question rather than conform to that which is established, disrupt rather than reproduce cultural traditions and conventions, and illuminate tensions in what appears to be consensus (Alvesson & Deetz, 2000).

Importantly, critical theory has several limitations. First, it is inherently modernist and can be hegemonic, ironically pronouncing a view of what a ‘better’ future involves (Alvesson & Deetz, 2000; Paradis et al., 2020). Critical theory can exaggerate the importance of consciousness in radical change processes (Alvesson & Willmott, 2012) and assume limited awareness in the people it aims to 'empower' (Alvesson & Deetz, 2000). Second, feminist critiques highlight the apparent gender blindness of critical theory (Sherer, 2009). Third, critical theory has been critiqued as elitist (Alvesson & Deetz, 2000) because its complex and dense philosophical concepts make it inaccessible (Healy, 2012; Ife, 1999).

During the twentieth century, critical theory expanded to include feminist, antiracist, anticolonialist, Queer, Mad and critical disability theories and positionalities (Paradis et al., 2020). A critical orientation in this project meant engaging closely with social movements such as the consumer/survivor/ex-patient (c/s/x) movement (Macfarlane, 2009; Whitaker et al., 2021). This expansion is consistent with the influence of components of postmodern thinking, including attention to difference and challenges to core assumptions on which modernist social theory, including critical theory, depends, such as power, progress, reason and identity (Briskman et al., 2009; Healy, 2012).

A Critical Orientation to Mental Distress

Adopting a critical approach recognises the "iterative relationship between the personal and political dimensions of life" (Sewpaul et al., 2015, p. 54) and the complex interplay between agency and structure. Emancipatory research ideas were adopted to ensure a focus on potentially discriminatory, disabling and inequitable environments of mental health services and society rather than individual deficits and differences or normative concepts (Barnes, 2003; Boxall & Beresford, 2013; Oliver, 1992). Many service users and families continue to experience harm and discrimination by and within mental health services (NMHC, 2014a; RCVMHS, 2021b, 2021d; Senate Select Committee on Mental Health [SSCMH], 2006). Therefore, I deemed it essential to adopt a critical approach to understanding mental distress and service delivery responses.

A critical orientation questions the epistemology of the biomedical paradigm and theorises the processes by which its dominance continues in the mental health sector (Whitaker et al., 2021). Critical theory reveals how power dynamics are inherent within the biomedical paradigm and how it operates in mental health services, resulting in marginalisation and oppression. Thus, mental distress is viewed in this project as occurring alongside and related to experiences of marginalisation, oppression and inequity (C. Brown, 2021). Additionally, critical orientations unsettle the privileging of technical and professional knowledge as the sole authority or truth, instead positioning service users as experts about their own lives (Day & Petrakis, 2018). A critical orientation challenges explanations that rely on fixed, rigid and binary categories; instead, it recognises peoples' identities and subjectivities as changing, multiple and sometimes contradictory (Fook & Pease, 1999). For example, it is often assumed that people are either practitioners or service users when many participants in this research identified as service users *and* practitioners, or as practitioners *and* family members.

A Critical Orientation to Organisations and Organisational Culture

Critical theory is evident in Weber's (1922/1962) theory of bureaucracy and Willis's (1989) early theory of medical dominance that drew heavily from Marxist traditions. Both draw on critical theory traditions in their focus on power relations in organisations and society. Many approaches to defining and thinking about culture can be traced in the literature; however, this project drew on interpretive and critical organisational theories to conceptualise culture. This section first describes the interpretive and critical organisational theories applied here. Second, the theoretical framework of culture adopted in this project is explained.

Organisational theories have followed social science developments, moving from positivist understandings (e.g., scientific management approaches largely intra-organisational in their focus) to critical and postmodern organisational theories. Interpretive and critical approaches to organisational cultures emerged in response to the limitations of positivist managerial approaches, which view organisations as objective, concrete entities that can be studied by examining elements of a functioning whole in a value-free and scientific manner (S. Wright, 1994; Yanow & Ybema, 2009). From a positivist managerial approach, culture is viewed as a variable that is object-like, easily defined, measurable and able to be manipulated through management interventions (Greckhamer, 2017; Smircich; 1983; S. Wright, 1998; Yanow & Ybema, 2009). In contrast, an interpretive and critical approach considers organisations in terms of their expressive, ideational and symbolic aspects (Smircich; 1983). Critical organisational approaches add to interpretive ideas by promoting a particular focus on questioning established social orders, dominant practices, discourses, ideologies and institutions (Alvesson & Ashcraft, 2009; Greckhamer, 2017). The social, political and economic contexts in which organisational cultures exist are emphasised in interpretive and critical approaches. Accordingly, this approach is suited to the current project given the history of mental health services, social and statutory responses to mental distress, and the shift in the political and economic environment due to neoliberalism and NPM.

From a critical perspective, the structure and operation of organisations are not naturally occurring or apolitical (Alvesson & Deetz, 2000). For instance, in mental health contexts, organisational structures are shaped by the coexistence of, and tension between, medical and administrative authority. Critical approaches analyse organisational structures and cultures to show how they produce and reproduce authority and control (Barker, 1993; Scherer, 2009). Mental health services are inscribed with political and economic forces created through social practices and discourses such as NPM and sociocultural understandings of mental distress. A critical and interpretive view of organisations interrogates the processes and parts of mental health services that seem common sense and naturalised. Deetz (1982) describes this as making "strange" the things in organisations that become institutionalised and, therefore, unquestioned (p. 133).

I used critical and interpretivist ideas to understand mental health service culture as an active process of meaning-making that is dynamic, contested and shifting. Culture is ideological, manifesting in multiple ways and situated in historical, relational and political contexts. Organisational culture also has varying and sometimes differing impacts on practitioners, service users and families. Street (1993) argues that there is little purpose in defining what culture *is*; instead, the focus should be on what culture *does*. He notes that "the job of studying culture is not of finding and then accepting its definition, but of discovering how and what definitions are made, under what circumstances and for what reasons" (p. 25). This conceptualisation of culture emphasises language and power, showing how discourses are constructed and contested, and explores the resultant outcomes. This emphasis aligns with the application of critical theory in this research, which demands a questioning stance towards the exercise of authority and unquestioned assumptions, and an awareness of power relationships (Allan, 2009; Pease, 2009; Renouf, 2016). Treating culture as a political process provides a theoretical approach for exploring organisations, acknowledging the significance of context and placing organisational settings within ideological and material systems of relations (S. Wright, 1994).

A Framework of Culture

Culture is an elusive construct often understood in different ways. Therefore, at the beginning of this project, it was apparent that a framework for understanding culture would be useful, particularly when considering communication with participants and framing the intangible and tangible ways in which culture manifests. I provide a brief overview of cultural frameworks applied to health care before detailing key elements of Schein’s (1992, 2010) ideas and how they were applied in this research.

Two examples of cultural frameworks used in health contexts include a typological framework and a multi-perspective framework, neither of which were deemed suitable for this project. The typological framework, known as the Competing Values Framework (Cameron & Freeman, 1991), has been used to measure organisational culture and its relationship to factors such as leadership and hospital performance (H. Davies et al., 2007; Helfrich et al., 2007; O’Neill et al., 2021). Due to its positivist focus on measuring culture, the Competing Values Framework was not appropriate for this qualitative project’s focus on developing a deep and rich understanding of participants’ experiences of culture. The multi-perspectives framework for understanding culture developed by J. Martin (1992) has been used in healthcare research (e.g., P. I. Morgan & Ogbonna, 2008). It draws attention to the uncertain, shifting and social aspects of organisational culture from three general perspectives: integration, differentiation and fragmentation. While this framework could have been useful in considering different perspectives, the exploratory nature of this research favoured Schein’s (1992, 2010) layered framework of culture. Schein’s framework provided useful information on how cultures operate and function; it allowed for exploring differing and contested cultural constructions and experiences, including the deeper and underpinning layers.

Schein (1992, 2010) identified three layers of culture: cultural artefacts, values and beliefs, and basic assumptions. These three layers capture the collective thought processes and understandings informing actions and conscious and unconscious behaviour within organisations. The first and most visible layer is cultural artefacts—the tangible or intangible factors that reinforce a particular culture, such as language, the layout of spaces or symbols, and organisational structures and hierarchies (Mannion & Davies, 2018; Schein, 1992, 2010). Cultural artefacts in a mental health service include the physical layout of buildings, for example, the nurse’s station, and the language describing service users in records or case notes.

The second layer of culture includes the espoused values and beliefs of an organisation (Schein, 1992, 2010; Schein et al., 2015). These are described as “shared ways of thinking” (Mannion & Davies, 2018, p. 2) used to explain cultural artefacts. I have applied a broader understanding of this layer of culture to include values and beliefs espoused by the organisation and/or those held by people working in and using mental health services. This layer of culture might include beliefs and expectations about safety in a mental health service, which are used to justify cultural artefacts such as processes when conducting home visits or perspex screens at reception desks. Beliefs are also used to justify improvement or changes in services (Mannion & Davies, 2018). For example, the belief that service users should be treated with dignity and respect contributed to deinstitutionalisation.

Basic assumptions form the third layer of organisational culture and sit at a subconscious level (Schein, 1992, 2010). Basic assumptions are born from the continuity or apparent success of specific values and beliefs over time. This layer of culture sits below acute awareness, shaping patterns of behaviour. Basic assumptions are vital to examine when considering cultural change within an organisation as they create conditions that sustain and reinforce the culture’s physical and surface manifestations. Mannion and Davies’s (2018) description of this level of culture in health care can be applied to mental health services. They argue that basic assumptions include taken-for-granted ideas about appropriate professional roles, expectations about service users’ and families’ knowledge and dispositions, and assumptions about the relative power of mental health practitioners, collectively and individually.

There are contradictions between the definition and framework of culture espoused by Schein (1992, 2010) and the critical interpretive view of culture adopted in this study. Schein is criticised for adopting both an interpretivist and positivist approach to studying culture (S. Wright, 1994). For example, Schein views culture as object-like, stable and shared. I sought to unsettle the view that culture is shared, recognising that the different participant groups in this project were likely to experience and understand culture differently. Thus, in applying Schein’s (1992, 2010) framework, the positivist and reductionist aspects are excluded so that differing perspectives and meanings are explored. This approach aligns with S. Wright’s (1994) view that striving for a consensual notion of culture is unhelpful as it neglects social and power relations.

Key Concepts and Terminology

Several key terms and concepts used in this project are complex and contested. Language is the medium by which engagement takes place in research; it reflects positioning concerning the construction of reality, meanings and the negotiation of social positions and power (Lee et al., 2019; Reynolds, 2012). The identities arising from particular terminology can profoundly impact mental health service users, their families, and their relationships with mental health practitioners (Tew, 2011). The terminology used throughout this research was considered to avoid language that discredits or marginalises service users' and families' experiences and identities.

Biomedical Model

The biomedical model (also referred to as biomedicine, biomedical paradigm or biological determinism) is situated in the scientific paradigm and posits that 'mental illness' is caused by biological, neurological or genetic anomalies and defects of the brain (Bracken et al., 2012; Deacon, 2013; Tew, 2011). These anomalies are largely viewed as independent of the person's context, culture, relationships and values (Bracken et al., 2012). Biomedical explanations of mental distress sit on a continuum, ranging from organic brain disease models focused on chemical imbalances to a biopsychosocial perspective that includes biological, psychological, social and environmental contributing factors (Fawcett, 2012). Such approaches are reductionist, whereby aspects of meaningful human behaviour are explained in terms of biological factors such as neurotransmitters and genes (Bracken & Thomas, 2005). Within a purely biomedical paradigm, mental distress is framed as a problem; it focuses on establishing causal processes that can be scientifically explained. Thus, practitioners are experts with technical, specialist and scientific knowledge that authorises them to create accounts of what is happening for a service user, describe symptoms and prescribe treatment responses.

Mental Distress

Constructions of mental illness are debated and disputed and have changed over time (Bainbridge, 1999; Bland et al., 2021; Boyle, 2013; Bracken et al., 2012; Porter, 1987; Speed et al., 2014). Many terms are used to describe human distress, experiences of altered states, or what is commonly referred to as mental illness. The dominant language used to conceptualise mental distress closely aligns with the biomedical paradigm (Tew, 2011). Such medicalised language is positioned as a more legitimate and scientific way to explain experiences and mental states that exist outside social norms (O’Reilly & Lester, 2017). While medicalised language is dominant in the mental health field, many other terms and language are preferred and used to reject the positioning of people’s minds, bodies and identities as faulty or broken (O’Reilly & Lester, 2017).

Consistent with a critical approach, I avoid biomedical terms such as mental illness and disorder, except when referencing policy and literature that uses such terminology. I have used the term mental distress to denote mental and psychological states and experiences that go beyond the challenges and difficulties of everyday life to those that affect a person’s day-to-day activities and often include stigma and discrimination (Tew, 2011). Mental distress is a broad and arguably more neutral term (O’Reilly & Lester, 2017) that does not imply illness, deficit or incapacity but, instead, a human experience (Tew, 2011). Mental distress allows space for people to make their own meaning without imposing a medicalised conceptualisation on their experiences.

Mad/Madness

Some people defined as ‘mentally ill’ have reclaimed the term ‘madness’ as a political identity. Madness was a term that signalled prejudice and intolerance. However, madness is now used to name neurodiversity and the emotional and spiritual experiences that differ from what is viewed as ‘normal’ (Menzies et al., 2013). Reclamation of language, such as madness, is a political endeavour adopted by marginalised groups to take back language that has historically been used to oppress and render them voiceless (Kafai, 2013). I use the term Mad with an uppercase ‘M’ to signify the politicisation of madness as a subjugated identity (Beresford, 2020; Cresswell & Spandler, 2016).

c/s/x Movement

The c/s/x movement originated in the 1960s alongside other human rights liberation movements (Daya et al., 2019). The first c/s/x organisation established in Australia in the 1970s was the ‘Campaign against Psychiatric Injustice and Coercion’ (Epstein, 2013). The c/s/x movement challenges and resists oppressive and discriminatory treatment approaches and has brought major breakthroughs for service users and their families inside mental health services and beyond.

Lived Experience

Lived experience denotes the expertise and collective knowledge of people who have lived and living experiences of mental distress, service use and/or recovery (as an individual or as a family member) (Byrne & Wykes, 2020). Lived experience involves the "experiences on whom a social issue, or combination of issues had a direct impact" (Sandhu, 2017, p. 5). The notions of 'lived experience expertise' or 'experts-by-experience' (Bland et al., 2021) often accompany this phrase and relate to the "knowledge, insights, understanding and wisdom gathered through lived experience" (Sandhu, 2017, p. 5). In some iterations, this expertise includes individual experiences and decades of collective knowledge generation and scholarship (Byrne, Wang et al., 2021; Byrne & Wykes, 2020).

Lived Experience Workforce

The lived experience workforce refers to distinct roles that focus on and emphasise lived expertise, including personal lived experience of mental distress or being a family member of a person experiencing mental distress. An important distinction within this workforce is that there are various paid roles as employees, including direct and indirect work with service users and families such as peer support or advocacy, leadership, consultation, system advocacy, education, training or research. Lived experience work is underpinned by distinct values, principles and theories (Byrne, Wang et al., 2021).

Recovery

The multiplicity of definitions of recovery in the international literature reflects broader ideological contestation about the nature of mental distress (Harper & Speed, 2012; Pilgrim, 2008; Recovery in the Bin et al., 2019; Wyder & Bland, 2014). Recovery is variously characterised as an idea, movement, philosophy, set of values, paradigm, policy and guideline for change (Leamy et al., 2011; Roberts & Wolfson, 2004).

Pilgrim (2008), R. Coleman (2011) and Slade (2009) explicate three broad notions of recovery: (1) clinical or biomedical, focused on symptom cessation and cure, (2) social, aligned with a rehabilitation model centred on improvements in symptoms and social functioning according to normative standards, and (3) a c/s/x notion of recovery. The latter is also known as personal recovery and is centred on self-determination, citizenship and choice (Australian Health Ministers' Advisory Council [AHMAC], 2013; Bland et al., 2021). Numerous definitions of personal recovery exist. For example, Deegan (1996) noted the importance of hope and choice when describing recovery as a unique non-linear process of “becoming more deeply, more fully human” (p. 92). Speaking from a New Zealand context, O’Hagan et al. (2012) emphasised social justice, citizenship and addressing discrimination as central tenets of recovery. Dillon (2011) similarly emphasises a collective and political approach to recovery, placing the need to address oppressive political structures at its centre.

Recovery as a concept entered the Australian policy landscape in 2003 with the *Third National Mental Health Plan* (Rosen, 2006). However, it was not until 2013 that the Australian *National Framework for Recovery-Oriented Mental Health Services* (NFROMHS) was released (AHMAC, 2013). This framework was developed with people with lived experience and provides a comprehensive guideline to embed recovery principles into everyday service delivery and practice. In the NFROMHS, recovery is described as “being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues” (AHMAC, 2013, p. 11). I now provide an overview of the different ways recovery is conceptualised and key debates regarding its utility and implementation in practice.

Although conceived by the c/s/x movement, the concept of recovery has been misappropriated and co-opted by services and practitioners through the translation of personal recovery (referred to hereafter as recovery) concepts into service paradigms (Bland et al., 2015; Byrne, Happel & Reid, 2015; Harper & Speed, 2012; Slade et al., 2014). Despite recovery being heralded as an alternative to coercive, deficit-based mental health practices, it is criticised for its conceptual vagueness, focus on individualist worldviews, and potential for subversion and appropriation by practitioners through alignment with biomedical discourse (Pilgrim, 2008; Price-Robertson et al., 2017). Therefore, instead of a focus on social change via recovery-based rights activism, as was intended by the c/s/x movement, existing practices are merely tweaked and rebranded as ‘recovery-oriented’ (McWade, 2016). Clinical and social notions of recovery also align with neoliberal agendas that render invisible structural factors involving inequity and injustice that contribute to and exacerbate mental distress (Bland et al., 2015; Harper & Speed, 2012). Consequently, some scholars have called for a recentring of the political tenets of recovery, arguing for a demedicalised and collectivist approach to mental distress (McWade, 2016).

Understandings of recovery have been extended to include family experiences and adapted in culturally responsive ways. Individualist conceptions of recovery fail to recognise that recovery takes place within social contexts and through relationships; thus, individuals, family members and supporters experience their unique journeys of recovery (Bland et al., 2021; Jacobson & Farah, 2012; Price-Robertson et al., 2017; Tse & Ng, 2014; Wyder et al., 2021; Wyder & Bland, 2014). Relational recovery is considered a necessary approach because it acknowledges the inherent interdependence of human lives (Price-Robertson et al., 2017). Additionally, Tse and Ng (2014) note that recovery concepts and individual goals are inseparable from the family and community in collectivist cultures. Similarly, a culturally responsive approach to recovery recognises the need for services to support families and communities alongside service users. Therefore, recovery occurs within a "fluid web of relations constituted by the family, community and larger socio-political units" (Jacobson & Farah, 2012, p. 334).

I adopt the NFROMHS definition of recovery in this project as a "transformative conceptual framework for practice, culture and service delivery in mental health service provision" (AHMAC, 2013, p. 2). The focus on transformation symbolises a departure from traditional and enduring psychiatric attitudes, practices and ideologies evident in clinical and social recovery. A central feature of the NFROMHS is its emphasis on knowledge and skills from lived experience, which challenges traditional notions of professional power and expertise (AHMAC, 2013). Despite the ubiquity of recovery in policy in Australia for almost two decades, the literature suggests that its implementation and influence on practice are varied and inconsistent in Australia and internationally (McKenna et al., 2014; Park et al., 2014; Piat et al., 2010; Senneseth et al., 2022; Slade et al., 2014; Tse et al., 2013).

Recovery-Oriented Services and Practice

Recovery-oriented describes incorporating personal recovery principles into existing mental health services and practice (Hungerford et al., 2016; Piat et al., 2010). The NFROMHS differentiates recovery-oriented services from recovery-oriented practice (AHMAC, 2013). Recovery-oriented services are understood as providing services that are flexible and adaptive to service users' needs and wishes. Additionally, recovery-oriented services operate from a recovery vision demonstrated by a commitment to recovery at all levels of the organisation. Recovery-oriented practice is identified as mental health practice that embraces the idea that recovery is possible, maximises service user self-determination, and acknowledges and addresses the range of factors that influence wellbeing (e.g., housing, employment, poverty, social connectedness and discrimination).

Successful delivery of recovery-oriented services depends on practitioner training and broader organisational support and commitment (Roberts & Boardman, 2014). However, due to the conceptual contestation of recovery and lack of radical change in how mental health services are organised and delivered, there is a disjuncture between policy intention regarding recovery-oriented services and actual service delivery, particularly as clinical recovery approaches continue to dominate (K. Davies & Gray, 2015; Le Boutillier, Chevalier et al., 2015; Le Boutillier, Leamy et al., 2011). For example, a recent review of international literature identified that funding models emphasising measurable outcomes do not align with personal recovery principles. These funding models sanction traditional approaches within mental health services focused on clinical recovery ideas such as symptom reduction (Jaiswal et al., 2020). Therefore, how recovery is incorporated into services is defined by the service in accordance with financial needs and organisational priorities.

Consequently, the transformative aims of recovery principles are not adopted into service delivery or practice. Le Boutillier, Chevalier et al. (2015) have coined this phenomenon a “service-defined understanding of recovery” (p. 12). Additionally, some argue that a recovery orientation sets a precedent sufficient for services to align with and orientate towards recovery principles rather than enacting a deep commitment to embedding recovery principles intended to transform service delivery as signified in the NFROMHS (AHMAC, 2013).

Person-Centred Approach

A guiding principle of mental health service reform is that mental health services are structured to respond to the needs of people, rather than people having to adapt and fit into the requirements and priorities of existing services (NMHC, 2014a). A person-centred approach should involve services and practitioners adjusting flexibly to the unique person and their self-defined needs, concerns and aspirations. This approach is central to recovery-oriented mental health services (Slade et al., 2014). While person-centredness is a core feature of mental health policy, the concept and practice are ill-defined, which leads to misinterpretation and inconsistent application (Waters & Buchanan, 2017). Person-centredness has been similarly misrepresented in services and practices; neoliberal discourses dilute its meanings, and the underpinning tenets of citizenship and rights are lost.

Research Participants

This project has three groups of research participants: service users, families and mental health practitioners. Throughout the research, I aimed to use and respect the terms used and preferred by the individual. However, to ensure clarity and brevity, I use the following terms: service users, families and practitioners.

Several participants identified as service users *and* practitioners or family members *and* practitioners. They presented their experiences and perspectives on service culture from their multiple and intersecting embodied positions and identities. Such multiple subjectivities represent embodied knowledges—to separate them would be antithetical to the project's aims. Thus, fixed and binary constructions of service user-practitioner and family member-practitioner are avoided in this research (Macfarlane, 2009). Instead, participants' dual positioning is recognised and signified throughout this thesis (see Chapter 3).

Service User Participants

Terms used to describe people who use or have used mental health services are changing and contested. The term consumer has been used in Australian policy since 1992 and reflects neoliberal terminology developed from notions of marketisation of health care. The language of the consumer precipitated a shift from the view of a patient receiving services to that of a consumer able to exercise choice and exit from any service not meeting their needs (Epstein, 2012; Hensley, 2006; McLaughlin, 2008). I originally used the term consumer in this project, as illustrated in the Participant Information Sheets (see Appendix A). However, as I consistently heard participants describe their lack of choice within mental health services, it seemed that the term did not fit the project's findings. Therefore, I use service user to denote a person who is or has used mental health services. This term is also contested; referring to people as service users can categorise, ascribe a fixed identity and imply that one is no longer a whole person (McLaughlin, 2008). It neglects the multiple socially constructed identities we all inhabit and can exclude those who are unable to access services or choose not to (McLaughlin, 2008). In this thesis, the term service user denotes only that a person has used a mental health service and is positioned to comment on that experience; it is not intended to ascribe a label or identity.

Family Participants

Family refers to biological and non-biological family members, family carers, partners or anyone who provides significant support for a person experiencing mental distress (Wyder et al., 2021). The term carer is used and preferred by many and features in national, state and territory policies. However, this term is rejected by others as it can suggest a relationship of dependency that does not reflect relationships involving interdependence, love and reciprocity. The term supporter recognises that service users often have friends who support them (Bland & Foster, 2012; Stanbridge & Burbach, 2007). For brevity, the term family is used; it encompasses biological family and those identifying as carers, friends and supporters.

Mental Health Practitioner Participants

Mental health practitioner (also known as a professional or a clinician [in clinical settings]) is used throughout this thesis to refer to any person who works in public, private or non-government mental health services providing support or treatment. Where relevant, the practitioners' disciplines will be noted. Mental health practitioners include the following disciplines and roles: nurses, occupational therapists, social workers, psychiatrists, peer workers, recovery workers and non-peer individual advocates.

Scope

This project included a broad scope of mental health services to reflect the interactions of service users and families with many types of mental health services. For example, most participants had previously, or were currently, using a combination of public, private, non-government, inpatient and community services. Likewise, practitioners had, or were at the time of involvement, working across private, non-government and public, or inpatient and community mental health services. Exploring only one organisational setting would have limited the project by providing a partial picture of the layered and complex nature of culture in mental health services.

Public Mental Health Services

Public mental health services comprise a broad range of state and territory government-funded mental health services delivered in acute hospital and community settings. State and territory governments are responsible for enacting legislative, regulatory and policy frameworks for public mental health services within their jurisdiction (Council of Australian Governments Health Council [COAGHC], 2017). Public mental health services are clinical, meaning the practices focus on assessment, diagnosis and treatment (Australian Institute of Health and Welfare [AIHW], 2022). Importantly, public services can legislatively mandate involuntary treatment in hospital or community settings, whereas non-government and private services cannot (McMillan et al., 2019; NMHC, 2019).

Non-Government Organisations

A broad definition of non-government organisations (NGOs) is adopted; it includes any not-for-profit service that provides advocacy, programs or support to mental health service users or families. Many NGOs provide services beyond mental health, addressing a wide range of interrelated needs (e.g., housing and residential services, employment, social connectedness and substance use) (COAGHC, 2017). NGOs are a key part of the overall provision of mental health services across Australia (Byrne, Wilson et al., 2014; National Health Workforce Planning Research Collaboration, 2011). The NGO mental health service sector typically provides non-clinical services and adopts person-centred and recovery-oriented approaches (AIHW, 2022; Gerrand et al., 2012; Hungerford et al., 2016). These services are governed by their boards of management (COAGHC, 2017); they receive funding from Commonwealth, state and territory governments and other entities such as Primary Health networks, Local Health Networks and philanthropic sources (AIHW, 2019).

Private Mental Health Services

Private mental health services include hospital-based individual and group psychological therapies and inpatient treatment (AIHW, 2019; Khoo et al., 2019). Private services are also delivered in community settings by psychiatrists, psychologists and other allied health practitioners (AIHW, 2022). Fees for private services are covered by private health insurance and/or the service user. Private mental health services are privately owned and managed, and most in Australia are classified as for-profit services (AIHW, 2014).

The next section outlines a brief recent history of policy and service reform in mental health services providing important background to the research. I then present the motivations, guiding commitments, research question and objectives, and conclude with an overview of the thesis structure.

A Recent History of Policy and Service Reform in Australia

Considerable change has occurred in mental health policy and services in the past 35 years, most notably deinstitutionalisation (Mendoza et al., 2013). Before the 1990s, mental health policy and legislation were the domain of states and territories, with minimal Commonwealth government involvement or leadership (Bland et al., 2015; Singh, 2012). Growing pressure in the 1980s for a national approach resulted from consultancies, submissions from practitioner groups and service user forums (Singh, 2012). Demands for human rights and citizenship by c/s/x (Epstein, 2013), and numerous inquiries detailing inadequate levels of care in the mental health system (Department of Health [DoH], 2005), resulted in one of the most significant reforms in Australia: a shift in the philosophy and location from institutionalisation to community-based services.

In 1983, the *Richmond Report* in Australia recommended the closure of standalone psychiatric hospitals and institutions; this provided the first policy framework to guide deinstitutionalisation (DoH NSW, 1983). All states and territories passed new mental health legislation incorporating the United Nation's principles focused on human rights and providing community care and treatment in the least restrictive environment (Sawyer, 2018). However, 10 years later, the report *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, also known as the *Burdekin Report*, underlined systemic failures in community and institutional settings (including hospitals and prisons) (Burdekin, 1993). The report raised significant concerns that the promise of appropriate, accessible and community-based services, explicit in the rhetoric of deinstitutionalisation reforms, had not materialised (Burdekin, 1993). The *Burdekin Report* highlighted that despite deinstitutionalisation and policy reform, service users' and families' needs and rights were grossly unmet (Savy, 2005).

Both the Richmond and Burdekin inquiries resulted in federal, state and territory governments establishing the first national framework for mental health reform (Bland et al., 2015; Gerrand et al., 2012; Rosen, 2006; Savy, 2005; Singh, 2012; Whiteford, Buckingham & Manderscheid, 2002). This framework, published in 1992, is known as the National Mental Health Strategy. The strategy promoted increased community-based organisations, mainstreamed services with mental health inpatient units in general hospitals, and integrated hospital and community services (Henderson, 2005; Rosen, 2006; Sawyer, 2018). This strategic commitment was supported by a significant increase in funding from the federal government. Between 1992 and 2007, funding to Australian NGOs for mental health services increased more than sevenfold (Whiteford & Buckingham, 2005).

Since 1992, five National Mental Health Plans (NMHPs) have been developed and implemented every five years (Australian Health Ministers' Conference, 2009a; COAGHC, 2017; Rosen, 2006). The evaluation of each NMHP informed the next iteration. The *Second NMHP* (1998–2002) built on the priorities of the *First NMHP* with the addition of mental health promotion, prevention, reducing community stigma, and an expanded scope of reform to include all mental health diagnoses (Gerrand et al., 2012; Rosen, 2006). The *Third NMHP* (2003–2008) emphasised integration and coordination of mental health services across and within service sectors and reaffirmed the need for a full spectrum of services (Rosen, 2006). While the principles of the *Third NMHP* were similar to previous plans, a unique feature was the introduction of recovery, reflecting an emerging focus and expectation that service delivery was driven by a recovery orientation (Gerrand et al., 2012).

The *Fourth NMHP* (2009-2014) and the *Fifth National Mental Health and Suicide Prevention Plan* (2017-2022) included several new priority areas. One was social inclusion, which included citizenship rights to social and economic participation, belonging and social connectedness (Le Boutillier & Croucher, 2010; Sayce, 2001). The remaining priority areas comprised recovery, early intervention and prevention, greater coordination between mental health and other human services, continuity of care, quality improvement and innovation, and accountability to service users and families (Australian Health Ministers' Conference, 2009a). The *Fifth National Mental Health and Suicide Prevention Plan*, released in 2017, outlined eight priority areas: integration of regional planning and service delivery, suicide prevention, coordinated treatment, support for people with complex mental illness, improving the mental health of and suicide prevention for Aboriginal and Torres Strait Islander Peoples, physical health of mental health service users, reducing discrimination and stigma, service safety and quality, and effective system performance and system improvement enablers (COAGHC, 2017).

Mental health services have undergone significant change in recent decades. While some improvements have occurred (Mendoza et al., 2013; Whiteford, McKeon et al., 2014), it is consistently noted that policy aspirations have not been realised, creating an enduring gap between policy aspirations and the realities of practice (Mendoza et al., 2013; NMHC, 2014a; G. P. Smith & Williams, 2016). The NMHC's (2019) National Report states that mental health services must meet the "needs of consumers and carers, [acknowledge] consumers' dignity [and provide care] that is both coordinated and relevant to the person's needs"

(p. 10). The Productivity Commission (2020b) reported that negative workplace cultures "expose workers to stigma, stress and burnout, lead to high staff turnover and poor outcomes for consumers" (p. 699). These statements suggest that despite longstanding reform aspirations, current services are inadequate and do not prioritise service users, families or practitioners. Culture is commonly cited in these policy frameworks; therefore, this project is well-placed to explore how culture mediates reform aspirations (see Chapter 2).

Research Motivations, Question and Objectives

The motivations for this research are grounded in several personal and professional experiences. However, the 'tipping point' leading to the project's development was my experience as a research assistant on a project with a local grassroots lived experience group. The project considered the experiences and outcomes for individuals and families with multiple unmet needs, defined as mental distress, substance use, compromised physical health and criminal justice system involvement (Doherty et al., 2021). My role involved working on a critical scoping literature review on families' involvement in mental health services. The review concluded that widespread cultural change was required to involve families within mental health services in a meaningful way (see R. M. Martin et al., 2017). This project led me to question the nature of culture in mental health services and what it would take for change to occur in mental health services.

The wonderings guiding this research were generated from consultation with several key stakeholders in the field, including the Western Australian peak body for mental health consumers, directors from the WA Centre for Mental Health Policy Research and my Lived Experience Supervisor (LES). From these consultations and reflections, it was apparent that the culture of services was an issue, and while there was some empirical evidence about mental health service cultures, a broad explorative study focused on barriers and enablers of cultural change was lacking. This gap led me to the overarching question of the research: how do mental health service cultures mediate reform aspirations in the Australian mental health sector?

The following objectives were developed to answer this question:

1. To describe how mental health service cultures are understood, experienced and enacted by service users, families and practitioners

2. To explore how current mental health service cultures mediate and are mediated by the implementation of national and local mental health policies
3. To identify barriers and enablers of cultural change in mental health services
4. To identify the requirements and mechanisms for cultural change in mental health services.

Additionally, this project was informed by several commitments developed through my experiences working with Lived Experience Educators, being supervised by a Lived Experience Academic during my Honours research and throughout this project, in addition to working with two Lived Experience Consultants (LECs). These commitments are iterative; some became clearer and were justified during data collection and analysis:

1. I take seriously that expertise and knowledge are varied and widely distributed, including learned knowledge and practice wisdom, but insight and wisdom are cultivated in the bodies and communities of those most intimately wounded by unjust conditions and structures (Fine, 2016). I take a positioned approach to the research; the design and 'doing' is informed by, and centred on, privileging people with lived experience of mental distress and service use as individuals or family members.
2. This research includes experiences of oppression, and research on oppression must be linked to research on the accumulation of privilege (Fine, 2016; Rose & Kalathil, 2019), including professional privilege. I have significant privilege in this space and this research—particularly as a person who has not been labelled with a psychiatric diagnosis, as a PhD student and as a social worker. I also have epistemic privilege in conducting research in a university that is a "privileged site of knowledge production" (Rose & Kalathil, 2019, p. 7). I pay attention to the harm and hurt that research can and does cause. I do not position myself as inherently different or 'other' to service users and family participants; however, I acknowledge the structures that sit around and between us and how they may affect our citizenship and lives differently.
3. Research is most relevant and useful when designed by or alongside people who are the most wounded and impacted by the issues being explored, and through meaningful engagement and collaboration in the application and translation of research. As Michelle Fine (2016) says, research is most valid

> when the interests of social justice movements inform the research. I am informed by the c/s/x movement history, knowledge and scholarship. This included engagement with the c/s/x lived experience scholarship to learn and hold myself accountable to research participants. I acknowledge that although I am informed by lived experiences of mental health service use, I am not presenting it. Therefore, my capacity to present the interests of service users and families is partial and limited.

Overview of Thesis Structure

This thesis comprises eight chapters. This chapter has established the background and context for this project. I outlined the theoretical framework adopted, including my critical theory orientation. This critical orientation is applied in two key understandings: organisations and organisational culture, and mental distress. Key concepts were outlined, followed by an overview of Australia's recent history of policy and service reform in mental health services. I introduced my positioning in the project by outlining the motivations for the research, overarching question and objectives, and guiding commitments.

Chapter 2 locates culture in policy and mental health literature. First, references to culture in national, state and territory policies are identified to explain how culture is discussed and constructed in policies. Second, the literature review presents six themes in Australian and international literature concerning mental health service cultures and cultural change.

Chapter 3 describes the project's methodology and methods. The ontological and epistemological assumptions, research design, ethical issues, recruitment processes, data collection and analysis are presented. This chapter also outlines the involvement of my LES and two LECs.

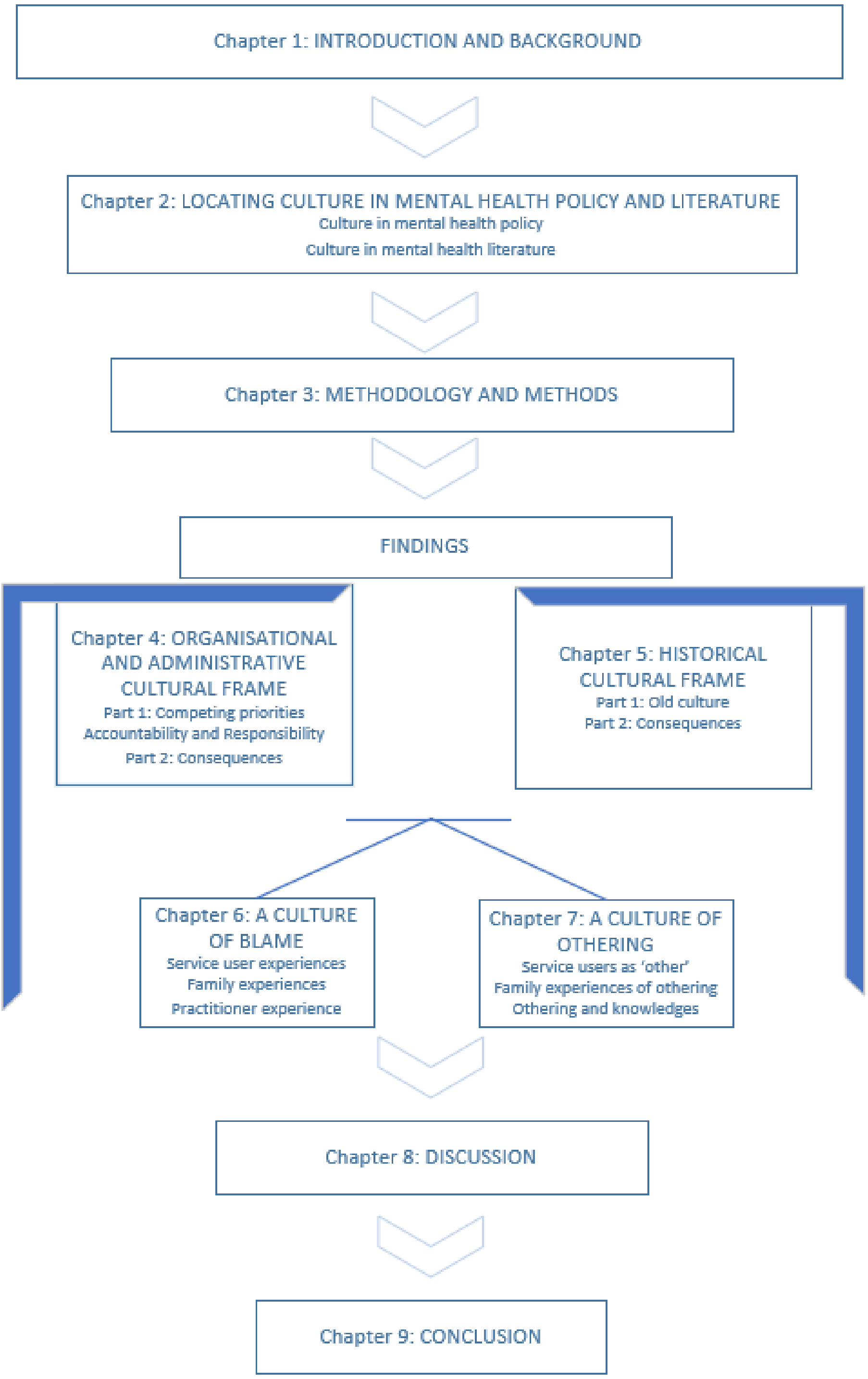
The first two findings chapters present two overarching cultural frames. Chapter 4 describes the organisational and administrative cultural frame and Chapter 5 presents the historical cultural frame. These chapters briefly summarise the relevant background literature to situate the findings. Both include a section titled 'Consequences' that speaks to the direct impacts of the cultural frames. Chapters 6 and 7 present two key elements of culture: blame and othering. These elements of culture are produced and sustained by the workings of both cultural frames, which explains their complexity and multifaced nature.

Chapter 8 answers the research question by addressing each objective, identifying key understandings, experiences and enactments of culture and highlighting barriers and enablers of cultural change. Subsequently, how culture mediates and is mediated by policies is discussed. Following the new understandings of culture generated from my analysis, I argue for culture to be reconceptualised as a ‘wicked problem’. Implications for policy and practice are discussed. Addressing Objective 4, I suggest requirements and mechanisms for cultural change. The final section of this chapter discusses the project’s limitations and possible avenues for future research.

The final chapter returns to the research question, highlighting key findings. The contributions to knowledge are outlined, followed by a short reflection and closing statement. Figure 1 illustrates the thesis structure.

Figure 1

Overview of Thesis Structure



Chapter 2: Locating Culture in Mental Health Policy and Literature

In Chapter 1, mental health policy reforms were identified as not being translated into large-scale change or coordinated improvements in mental health services, resulting in an enduring gap between policy and practice (Mendoza et al., 2013; NMHC, 2014a; G. P. Smith & Williams, 2016). Culture is often cited as a reason for this lack of change (Mendoza et al., 2013; Rosenberg & Harvey, 2021; RCVMHS, 2021d). To better understand how culture is located and framed in Australian mental health policy and international literature, this chapter commences with a review of selected national, state and territory policies to identify where and how culture is framed and discussed. A review of the literature on culture in mental health services follows.

Culture in Mental Health Policy

National, state and territory mental health policies emphasise the requirement for cultural change in services. A key theme across policies is cultural change focused on the adoption of recovery-oriented service delivery and practices. Given the elusiveness within which culture is used in policy, I conducted a review to provide a snapshot of the policy context, focusing on where and how contemporary policies address culture. I completed a preliminary review of historical and current national, state and territory mental health policies since 1992, focusing on where culture was cited. Given the intertextual nature of policies (Gale, 1999), this preliminary stage was useful in identifying the relationships between policies and related documents relevant to this study (e.g., workforce strategies). The concept of culture was a relatively recent inclusion in policy, first discussed in the *National Mental Health Policy* in 2009 (Australian Health Ministers' Conference, 2009b).

From this preliminary review, relevant contemporary policy documents which cite culture or cultural change, were selected. These documents included overarching state, territory and national policies, standards and plans; the NFROMHS (AHMAC, 2013); national workforce strategies and plans; and the *National Safety and Quality Health Service User Standards* (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2018). The second stage of the review involved a synthesis analysis of selected policy documents centred on how culture was framed and discussed. Culture was commonly addressed in these policies in relation to workforce culture, recovery-oriented culture and quality and safety culture. Except for the NFROMHS, mental health policies primarily describe culture in generic management statements.

Workforce Culture

Workforce issues have been a key focus of mental health policy since 1992. Culture is discussed in relation to recruitment, retention and improving workforce support. However, culture pertaining to the workforce is not explicitly defined. An example of this absence is the *National Mental Health Policy* which states that mental health services should encompass an “environmental and organisational culture [that promotes] a positive and inclusive culture” (Australian Health Ministers’ Conference 2009b, p. 22). This statement reflects generic management ideas about improving culture, not necessarily mental health service contexts and constraints.

The policies appear to be based on the assumption that improving mental health service cultures will address workforce issues (Mental Health Workforce Advisory Committee [MHWAC], 2011b). For example, in the *National Mental Health Workforce Plan* (*NMHWP*), enhanced staff retention strategies are said to “improve workplace culture to better support staff morale, motivation and job satisfaction” (MHWAC, 2011a, p. 7). While specific definitions and mechanisms to improve workplace culture are not clearly articulated in the *NMHWP*, the role of leadership and management in improving workforce culture is emphasised. The *National Mental Health Workforce Strategy* highlights the central role of clinical leadership across disciplines to support “cultures of continuous improvement and a focus on consumers, carers and families” (MHWAC, 2011b, p. 18).

In some state and territory policies culture is discussed in relation to the workforce (Capital Health Network, 2020; Government of SA, 2020; Mental Health Commission [MHC], 2020; NSW Ministry of Health, 2018). Consistent themes include workforce support and retention. Like the national policies, specific strategies are not clearly outlined; it is implied that improving organisational culture is key to improving workforce issues. For example, the *Australian Capital Territory Mental Health and Suicide Prevention Implementation, Performance and Monitoring Plan 2019–2024* states that developing a skilled and sustainable mental health workforce requires strategies to address “workplace culture” (Capital Health Network, 2020, p. 9).

A second key theme in the South Australian and New South Wales policy is the importance of all the workforce levels in improving workforce culture (Government of SA, 2020; NSW Ministry of Health, 2018). This focus recognises that organisational leaders and managers are integral to the workforce culture, and practitioners should be involved in change processes and workplace initiatives. For example, the South Australian *Mental Health Services Plan 2020–2025* asserts that organisations' leaders should be equipped with "tools and training to proactively support staff …. and foster positive culture" (Government of SA, 2020, p. 60).

The *NSW Strategic Framework and Workforce Plan for Mental Health* (2018–2022) is the only state and territory policy that identifies specific strategies to address workforce culture (NSW Ministry of Health, 2018). The five strategies aim to minimise harm to staff, ensure good organisational processes in areas like psychological safety and staff wellbeing, promote worker resilience through training, mentoring and supervision, and support workers to address and recover from mental distress (NSW Ministry of Health, 2018). While there is some acknowledgement in this framework of the conditions and impacts of the work, it focuses on the individual worker improving their capacity and resilience. These strategies do not appear to address the underlying factors that cause workforce members to feel unsupported and in need of building resilience.

Overall, workforce issues are a key focus of national, state and territory governments' policies. These issues are longstanding–identified as key challenges since 1992 (Australian Health Ministers' Conference 2009a; Rosen, 2006;). Since 2009, organisational culture has been recognised as a mediating factor in workforce retention, recruitment and staff support. All levels of the workforce were thought to be responsible for improving mental health service cultures and addressing workforce issues. However, the policies lack definitional clarity or advice on specific strategies, with the *NSW Strategic Framework and Workforce Plan for Mental Health* the one exception (NSW Ministry of Health, 2018).

Recovery-Oriented Culture

Recovery is a key focus in national, state and territory policies and a guiding principle of mental health service reform. The development of recovery-oriented services is often framed as requiring a cultural shift. For example, Standard 10 in the *National Standards for Mental Health Services 2010* states that services must incorporate recovery principles in "service delivery, culture and practice" (Australian Government, 2010, p. 21). Similarly, the *National Mental Health Workforce Strategy* states that a more inclusive approach to implementing change in line with recovery requires improvement in workplace cultures

(MHWAC, 2011b). These examples indicate that culture is considered a foundational element of recovery implementation.

In 2013, the NFROMHS was released outlining a clear policy direction towards enhancing mental health service delivery and supporting "cultural and attitudinal change" at all workforce levels, regardless of seniority, discipline or contact with service users (AHMAC, 2013, p. 8). This framework articulated the different dimensions of a recovery-oriented culture, including key indicators such as language and expectations of services and practitioners. The first of 17 domains in the framework outlines the importance of "promoting a culture and language of hope and optimism" (AHMAC, 2013, p. 5). Key indicators of recovery-oriented culture include communicating a culture of positive expectations, hope and optimism to service users and families, so they feel valued, important, welcome and safe (AHMAC, 2013).

Other national policies mirror this focus on adopting recovery-oriented cultures. Sector leaders are tasked with the responsibility to support the development of a recovery-oriented culture, and some policies outline specific strategies (Health Workforce Australia, 2014; MHWAC, 2011a). One example is the *National Mental Health Workforce Strategy*, which states that "access to support and mentoring will be of great benefit [to the workforce] during this time of culture change" (MHWAC, 2011b, p. 11). This strategy highlights that recovery-oriented cultural change overlaps with ideas about improving workforce culture.

At state and territory levels, all policies make explicit reference to recovery-oriented culture. For example, the *Living Well: A Strategic Plan for Mental Health in NSW* (2014–2024) highlights that recovery is not well-understood or implemented, and this should be viewed as an opportunity to "change the culture towards a recovery-oriented mental health system" (Mental Health Commission of NSW, 2014, p. 29).

Quality and Safety Culture

Reference to cultural change that is focused on quality and safety in mental health services is evident in national, state and territory policies (COAGHC, 2017; Safety and Quality Partnership Standing Committee, 2013). A key responsibility of all Australian governments outlined in the *Mental Health Statement of Rights and Responsibilities* is to "encourage and evaluate a continuous culture of quality improvement among services and for service outcomes to meet standards" (Standing Council on Health, 2012, p. 25). Safety culture is generally understood as a collective focus on continual improvement and learning. Across national, state and territory policies, safety culture encompasses three areas:

1. Involving service users and families in developing strategies to build a safety culture and respecting their rights (e.g., see ACSQHC, 2018; Government of SA, 2020; Queensland Government, 2016; Safety and Quality Partnership Standing Committee, 2013)
2. The role of boards of management and leadership in engendering a culture of quality and safety (ACSQHC, 2018; MHWAC, 2011b)
3. Focusing on continual improvement as central to developing a culture of safety and avoiding reactive responses and a “blame culture” (Government of SA, 2020, p. 83).

Additional safety culture dimensions include an organisational commitment to safety, open communication and trust, a non-punitive approach to adverse event reporting and analysis, teamwork and shared beliefs about the importance of safety (Halligan & Zecevic, 2011). This focus on quality improvement and safety reflects how the safe delivery of high-quality care has gained traction in health and mental health care in the past two decades (Hogden et al., 2017).

In summary, culture is a consistent theme in the selected policies reviewed; however, the concept is not defined and rarely involves specific strategies. Requirements to improve and address culture are framed in generic management terms, evident in the common focus on leadership and meeting standards. There is limited reference to incorporating service users and families in cultural change strategies. Objective 2 of this research study was to explore how culture mediates and is mediated by service cultures—culture is framed in these policies as both an enabler and barrier to change. For example, a positive culture is viewed as an enabler of workforce retention (Australian Health Ministers Conference, 2009), whereas organisational culture is framed as both an enabler and barrier to recovery-oriented services (AHMAC, 2013). The policies also emphasise that culture and cultural change are supported via all levels of organisations, including leadership and governance. Given their authority, those in leadership roles and governing bodies have a key responsibility to foster the cultural changes outlined in government policies. However, there is limited recognition of the complexity and nuance of existing cultures and the factors and power arrangements that influence or reinforce problematic practices and cultures.

Culture in Mental Health Literature

This section of the literature review partly addresses Objectives 1, 3 and 4 which focus on how cultures are understood, experienced and enacted, and the enablers, barriers and mechanisms of cultural change. A methodical and comprehensive approach was employed to identify relevant literature, map key issues and identify gaps in knowledge (Khalil et al., 2021; Peters, Marnie et al., 2021).

The overarching question guiding the literature review was: How are mental health service cultures understood, experienced and described in the literature? The two sub-questions were: How do mental health service cultures need to change? How is cultural change in mental health services achieved? These questions were purposefully broad, as was the search strategy, matching the project's exploratory scope.

Commentary, small-scale cultural change projects and the grey literature were viewed as offering important contributions to the knowledge base. Following a preliminary literature search to understand relevant terminology, a search strategy was developed guided by the *Joanna Briggs Institute Reviewers' Manual 2015 Methodology for JBI Scoping Reviews* (Peters, Godfrey et al., 2015) (see Table 1); however, an appraisal of the materials was not undertaken as recommended by Arksey and O'Malley (2005).

The search process was iterative, and as my familiarity with the research and evidence increased, additional search terms were added or excluded. For example, research about 'smoking culture' within mental health services was identified as irrelevant to this study. Additionally, where culture was used in relation to race, ethnicity or cultural background, these studies were not included, nor were research articles where culture related to a place or space (e.g., Australian culture). No time limit was applied to the search to allow for a broad scope of literature. The review focused on studies about adult mental health services published in English and with full-text availability. The databases searched included Proquest, Scopus, CINAHL, PsychInfo, Medline, Informit and Google Scholar. Additional literature was identified in the reference lists of relevant articles and included in the review. Numerous literature searches were undertaken throughout the 6.5-year life of this project. Additionally, my LES and LECs[1] shared resources with me, which were included in the review.

---

[1] The role of the LES and LECs will be elaborated in Chapter 3.

Table 1

Literature Review Search Strategy

Concept		Search terms
Concept 1 [a]		Mental health service OR Psychiatric service OR Clinical practice OR Mental health organisation OR Mental health agency OR Mental health program OR Mental health Practice OR Psychiatric Hospital OR Mental health hospital OR Mental health clinic
Concept 2 [b]	AND	Culture OR Organisational culture OR Service culture OR Service delivery OR Service practice OR Service values OR Service approaches OR Relationships OR Values OR Ways of working OR Workforce reform OR Mental health nursing culture OR Professional groups?
Concept 3 [c]	AND	Change OR Culture change OR Cultural change OR Policy implementation OR Cultural shift OR Recovery implementation OR Implementing recovery OR Recovery Oriented services OR Reform OR Transformation OR System change OR Organisational change OR System accountability
Concept 4	AND	Lived experience OR Consumer OR Patient OR Service user OR User OR Individual experience OR Personal experience OR Experience OR Client OR Perspective OR Understanding OR Family OR Carer OR Supporter OR Madness OR Distress

Note. Limits were English language, adult mental health services (18 years +), no time limitations and full text available. Additional searches: Safewards, System accountability

[a] Mapped to the subject heading. [b] Search in title and abstract only. [c] Search in full text.

Six themes were identified in the literature: (1) entrenched cultures, (2) risk management and risk-averse cultures, (3) coercive and restrictive practices as markers of culture, (4) impacts of cultures on workforce and practices, (5) resistant and rigid cultures as barriers to change, and (6) approaches aimed at cultural change. A limited number of studies exploring service cultures from multiple perspectives (e.g., service user, family and practitioner) and a multi-level organisational lens were found. Although the importance of organisational culture was a key finding in numerous studies, there was scant literature examining this issue.

Entrenched Cultures

In the Australian and international literature, mental health service cultures are characterised as having entrenched attitudes, values and practices that discriminate against and exclude service users. Descriptions and elements of this entrenched mental health service culture vary; however, there are key themes. Entrenched cultures reflect historical and institutionalised practices and ideas about mental distress and appropriate responses. Biomedical understandings of mental distress are dominant in entrenched cultures which promote discrimination and stigma towards service users. Entrenched cultures also form barriers to implementing new practice approaches (e.g., service user involvement, recovery-oriented practice and a lived experience workforce).

An Australian study by Byrne, Happell and Reid-Searl (2016) that explored the perspectives of lived experience workers found that biomedical approaches to understanding and responding to mental distress dominated service delivery and were an entrenched part of service cultures. Key dimensions of this culture consisted of the exclusive, undisputed dominance of biomedical knowledge and legal authority to enforce treatment (Gee et al., 2016; Lakeman, 2013), a mistrust of service users, a totalising focus on diagnosis, and significant power differentials and interpersonal barriers between lived experience workers and practitioners (Byrne, Happell & Reid-Searl, 2016). Paternalistic practices antithetical to recovery ideas and values were characteristic of this culture (Byrne, Happell & Reid-Searl, 2016). A Western Australian study that explored the implementation of peer work roles in government and non-government mental health organisations similarly reported that an entrenched culture in which service users are viewed through a lens of diagnosis and deficit was a significant barrier to the adoption of peer workers (Zeng et al., 2020).

Other Australian studies also emphasise the entrenched nature of “old institutionalised thinking” (Bennetts et al., 2011, p. 155), which is a significant barrier to increasing service user participation. Additionally, an entrenched “culture of discrimination” creates stigmatised responses to service users (Black et al., 2021, p. 14). The Productivity Commission (2020a) echoed these assertions describing “a culture of superiority that places clinicians and clinical intervention above other service providers, consumers and their families and carers” (p. 8).

The international literature also highlights cultures in which discriminatory views about service users prevail. In Irish mental health services, entrenched biomedical cultures with paternalistic and coercive practices result in a deficit view of service users (Norton, 2019). Organisational culture in United Kingdom (UK) mental health services are characterised by perceptions about service users having limited capacity, resulting in unequal power relations between service users and practitioners (Carr, 2016). Norwegian research exploring practitioners’ experiences of person-centred practice, collaboration and involvement of service users found the persistence of a culture in which service users are considered passive recipients of care; reflecting a biomedical approach in which service user exclusion from decision-making is the norm (Sommerseth & Dysvik, 2008). Sommerseth and Dysvik (2008) argue that for improvements in service user involvement, practitioners need to critically consider their professional culture, including how ideology, education and professional experiences have shaped their attitudes and practice.

Entrenched cultures obstruct the implementation of recovery principles and practices. A systematic review of 70 articles reported that "traditional organizational culture" (Piat et al., 2021, p. 9) inhibited recovery implementation and included unequal power relations, hierarchical structures, paternalism and punitive responses to service users. Practitioners' understanding of their roles and priorities also contributed to the continuation of entrenched service cultures. For example, practitioners prioritised medication prescription, compliance and managing risk, which conflict with personal recovery principles (Piat et al., 2021). These studies suggest that entrenched cultures in mental health services are a significant barrier to creating change for recovery-oriented practices and service delivery (Black et al., 2021).

Risk Management and Risk-Averse Cultures

In the Australian and international literature, risk management and risk-averse approaches dominate (Bee et al., 2015; Clancy & Happell, 2014; Cui et al., 2021; G. Davidson et al., 2016; Felton & Stickley, 2018; Henderson, 2013; Holley et al., 2016; Morant et al., 2016; J. F. Morgan, 2007; Sawyer, 2008; Slemon et al., 2017). Risk management culture can be broadly understood as an organisational focus on assessment and expectation to minimise and avoid risk; this gives rise to defensive practices where safety is prioritised, and positive risk-taking is discouraged (Cui et al., 2021; Cutler et al., 2015; J. F. Morgan, 2007; Tickle et al., 2014). Practices in risk management cultures include confinement, seclusion, restraint, monitoring and surveillance, and restricted access to personal belongings within inpatient wards (Cui et al., 2021; Slemon et al., 2017). In contrast, a Scottish study found that when an organisational culture embraces a positive attitude towards risk-taking, practitioners feel supported to uphold the service users' rights, autonomy and choice (Nolan & Quinn, 2012).

Tied to a risk management culture is a risk-averse stance characterised by the view that all risks can and should be predicted and ameliorated (Muir-Cochrane, Grace et al., 2011). This approach involves a preoccupation with risk at the expense of promoting service user choice and autonomy (RCVMHS, 2021e), which is a barrier to safe and compassionate service delivery (RCVMHS, 2021d). In their qualitative Australian study, Fletcher et al. (2019) concluded that a recovery-oriented environment within inpatient acute settings required a cultural shift from risk aversion to facilitating safe, therapeutic relationships that position risk as expected and tolerable. However, practitioners in inpatient mental health services experienced tension between the risk-averse practices permeating organisational priorities and recovery-oriented practice (Fletcher et al., 2019).

Risk-averse cultures are a significant barrier to implementing recovery practices. L. Davidson (2005) reported that risk-averse environments in UK mental health services reinforced practitioners' self-perception as experts and inhibited their willingness to cede control to service users. One explanation of practitioners' reluctance to relinquish control could be their experiences of feeling pressure to conform to risk-averse practices within such cultures (Holley et al., 2016), in addition to the tensions in practice concerning service user choice and practitioners' responsibilities for ensuring service user safety (Samele et al., 2007; Slemon et al., 2017). Practitioners may wish to work in recovery-oriented ways; however, this aspiration is often overshadowed by organisational and legal mandates to intervene and mitigate risk (Sawyer, 2008; Slemon et al., 2017). Some authors have situated risk-averse cultures within a wider culture of blame and litigation within mental health services and the broader society (Tickle et al., 2014; Wand, 2017).

Coercive and Restrictive Practices as Markers of Culture

Coercive and restrictive practices within inpatient facilities are often considered key markers of organisational culture. Risk management culture underpins an acceptance and tolerance of coercive and restrictive practices within mental health services because they are deemed necessary and the only option when responding to risk and safety (Brophy, Fletcher et al., 2020; Slemon et al., 2017). *Coercion* is an "action or practice of persuading in a way that uses or implies force and threats—forcing someone to do something" (RCVMHS, 2021d, p. 556). *Restraint* involves the restriction of a person's freedom of movement by physical (bodily force controlling their freedom of movement), mechanical (a device that controls a person's freedom of movement such as belts, harnesses or straps) or chemical (medication to subdue or control a person's behaviour, not to treat a mental or physical condition) (NMHC, 2015; M. Wright et al., 2017). Seclusion refers to the deliberate, isolated confinement of a service user so that they cannot freely exit (M. Wright et al., 2017).

As McSherry and Maker (2020) observe, the use of restrictive practices is controversial. However, in many health and social care contexts, these practices are deemed acceptable and necessary to contain service users' behaviour perceived as risky, harmful, challenging or unwanted. This suggests that cultures of restrictive practices are tied to the entrenched and risk management cultures previously described. Some forms of restraint are inherently risky and dangerous. Such restraints involve the deprivation of liberty with significant impacts upon physical and mental integrity, and they create a loss of dignity and, in some cases, injury or death (McSherry & Maker, 2020). Some service users, families and practitioners have called for the elimination of restrictive practices. Authors such as Roper, O'Hagan et al. (2020) write from a service user perspective and note the significant impacts of the types of restraint regulated by law. They also discuss the "indirect, hidden restraint, which refers to restrictions of people's sense of self from, and interconnecting with, experiences of direct restraint" (Roper, O'Hagan et al., 2020, p. 16). Hidden restraint involves the oppressive and cumulative detrimental impacts of restrictive practices on selfhood, meaning-making, self-expression, hope and the ability to trust oneself (Roper, O'Hagan et al., 2020).

Research highlights a longstanding culture of restrictive practices in mental health services. A review of the use of seclusion, restraint and observation in New South Wales mental health facilities in 2017 identified a "discriminatory and traumatising culture" evident in the staff's disparaging comments and criticisms of service users (M. Wright et al., 2017, p. 23). M. Wright et al. (2017) argue that coercive practices align with custodial rather than therapeutic settings, and while the use of seclusion and restraint has been justified on therapeutic, safety and duty of care grounds, the evidence does not support this stance. An Australian study by Brophy, Roper et al. (2016) explored service user and family views and experiences of seclusion and restraint; they identified cultures that positioned restrictive practices as commonplace rather than last resort interventions. These findings are supported by Kinner et al. (2017), who found that approximately 72 per cent of Australian mental health practitioners believe physical restraint always increased the safety of a service user. These findings emphasise disparate ideas about restrictive practices, suggesting practitioners' belief in the perceived utility of such practices is an embedded element of mental health service cultures.

The RCVMHS (2021a) found that “coercive cultures” are barriers to cultural change (p. 3). Similarly, in their scoping review, Gooding et al. (2018) identified organisational cultural change characterised by recovery, trauma-informed and human rights concepts and practices as key to reducing coercive and restrictive practices. Similar findings were reported by Fletcher et al. (2019), where service users, carers, family members and practitioners emphasised the need for “a culture that rejects restrictive and coercive practices and embraces recovery-oriented practice” (p. 548).

Strategies to reduce restrictive practices in Australian inpatient wards have been shown to influence culture. For example, Safewards is a model to reduce conflict and containment in inpatient wards by implementing 10 interventions to improve relationships between staff and service users (Fletcher et al., 2019). A recent study exploring staff perspectives on Safewards in inpatient units in Victoria, Australia, revealed that it positively changed culture; staff described “less social distance and enhanced mutual regard” between themselves and service users (Fletcher et al., 2019, p. 6). Consequently, relationships between service users and staff improved, and a renewed focus on person-centred and recovery-oriented practices was reported. Importantly, these findings reported staff views and may differ from those of service users and families.

Brophy, Roper et al. (2016) and Perkins et al. (2012) contend that a cultural shift is required to address the use of restrictive practices. An explicit focus on developing and maintaining cultures that create safety and respect for service users and practitioners is essential (Murphy & Bennington-Davis, 2005). However, as McSherry (2020) argues, the “complex dynamic of institutional cultures reflects broader societal concerns” and the rise of risk management, coupled with stigma about the apparent dangerousness of service users, may explain the cultures that sustain and rely on restrictive practices (p. 230).

Impacts of Cultures on Workforce and Practices

Thus far, this literature review has established that service cultures are characterised by entrenched practices, risk management and risk aversion, and coercive and restrictive practices. Australian mental health policy emphasises culture as a critical factor in workforce issues such as recruitment, retention and support, and the literature also supports this emphasis on culture as a mediating factor in workforce wellbeing and practices.

Positive organisational culture is said to foster worker satisfaction and improves service quality (Corlett, 2014; Prodromou & Papageorgiou, 2021). The evidence also demonstrates that an unsupportive organisational culture adversely affects practitioners' wellbeing and the quality of their practice. A qualitative study on a UK community mental health team found that an increased focus on regulation, performance management and proceduralism signified a cultural shift for practitioners (Hanley et al., 2017). A "bullying and punitive management culture" created fear and anxiety for practitioners, negatively impacting their practice and leaving them feeling alienated and unsupported (Hanley et al., 2017, p. 187). Further, a competitive team culture affected practitioners negatively (Hanley et al., 2017).

Tied to the risk management culture, Wand (2017) noted a culture of blame in Australian mental health services, which results in "poisonous and paralysing power" where negative dynamics between workers arise and practitioners do not feel trusted by their organisation (p. 4). Other research from the United States also suggests that organisational culture influences staff attitudes, retention and performance (Glisson & James, 2002). These findings support the assumptions identified in Australian policy that culture is a significant factor in workforce satisfaction, level of support, wellbeing and retention.

Service cultures also impede service user and family involvement. A UK-based study found that practitioners experience tensions between contemporary philosophies advocating service user empowerment and longstanding socio-medical constructs founded on notions of safety and containment (Bee et al., 2015). Top-down risk-averse cultures were found to challenge the integrity of user involvement, as they conflicted with principles of recovery and hope and negated opportunities for meaningful engagement between service users and practitioners. Additionally, the researchers highlighted that policy translation gaps in service user and family involvement were more likely when practitioners were overburdened with administrative responsibilities, the service culture was not person-centred, and staff were unsupported or unacknowledged when providing person-centred and holistic support (Bee et al., 2015).

The literature highlights how practitioners and staff are enculturated into existing mental health service cultures. For example, new employees quickly adjust to dominant cultures, accepted practices and prevailing attitudes towards service user and family involvement (Bee et al., 2015; Berlin & Carlström, 2015). The *National Mental Health Workforce Strategy* has argued for a change in workforce culture, highlighting that the attitudes and values of the existing workforce powerfully influence the attitudes of entry-level workers and students on placements (MHWAC, 2011b).

Resistant and Rigid Cultures as Barriers to Change

Organisational culture is a barrier to implementing changes such as service user involvement and establishing a peer workforce, most likely because mental health service cultures are robust and resistant to change (Dark et al., 2017). Resistant cultures, also described as “professional culture” (Rose et al., 2003, p. 99), are attributed to practitioners wanting to maintain power differentials and professional status. In their literature review of 112 articles, Rose et al. (2003) found that cultures resisting service user involvement were the most important factor impeding change, resulting in tokenistic service user involvement and measures more reflective of a tick box exercise.

Inflexible service cultures are also described as particularly resistant to change initiatives. For example, in statutory services in the UK, a highly structured and established culture posed significant barriers to implementing peer workers (Gillard et al., 2014). Further, a rigid and hierarchical culture constrained the potential of peer workers “to bring meaningfully different practice to the team” (Gillard et al., 2014, p. 691). On the contrary, Ibrahim et al. (2020) suggest that a culture of reflexive practice and an openness to change are enablers of organisational change.

Approaches Aimed at Cultural Change

Strategies to bring about cultural change often arise in response to systemic failures and media attention. For example, McKella and Hanson (2020) described an approach to cultural change in the Oakden Older Person’s Mental Health Service in South Australia that resulted from a report documenting failures in governance, clinical practice and organisational culture. Similarly, in the UK, following high-profile incidents in the Mid Staffordshire National Health Service Foundation, a public inquiry chaired by Sir Robert Francis identified systemic failings attributed to cultural problems (Francis, 2013). This inquiry led to a range of initiatives aimed at changing culture in health care more broadly (Dixon-Woods et al., 2014; Muls et al., 2015).

Approaches to changing organisational culture in mental health services often involve practical shifts or strategies. For instance, Boardman and Shepherd (2011) present a framework for implementing recovery-oriented approaches into services as a key indicator of cultural change. Roberts, Good et al. (2011) argue that a recovery agenda requires recovery ‘champions’ and leaders who grasp key concepts and requirements. Thus, recovery cannot be easily and successfully implemented without support from the service provision level to the executive level of an organisation.

Addressing existing power relations in mental health services and involving people with lived experience are central to cultural change initiatives. Bogg (2011) argues that strong leadership addressing traditional power structures is required to improve service user outcomes and engender cultural change. Additionally, the contribution of lived experience to training and workforce development, collaborative co-working, research and evaluation are central to cultural change in mental health services (Roberts, Good et al., 2011). Key to addressing power relations and involving people with lived experiences is recognising the unique expertise of lived experience as an essential step to engendering empathy, commitment and cultural change (Ning, 2010).

Initiatives aimed at generating cultural change across a range of settings illustrate the complexity of the task and the importance of stakeholder involvement at all levels of organisations (Beckett et al., 2013; Manley et al., 2019; McKellar, Renner et al., 2020; Miller, 2015). Two examples of cultural change initiatives include a self-advocacy group in a UK service for adults with learning disabilities and mental health support needs and a cultural change project in an older adult mental health service in South Australia. The UK self-advocacy group initiative aimed to increase the confidence and recovery of service users and improve service culture (Miller, 2015). Existing service users were invited to participate in the group, and senior managers and clinicians attended group meetings; however, ward staff were not invited. Key outcomes included changes in the service culture that enabled senior managers to enact and strengthen their espoused values of service user engagement. However, the ward staff reported that their exclusion symbolised their feelings of powerlessness and disconnection from senior management. Although the self-advocacy group changed some aspects of service culture, the wider organisational culture, including policy and processes about resource allocation, and ward staff experiences of culture, remained unchanged (Miller, 2015).

The second example is a three-phased cultural change project in an older adult mental health service in South Australia. This project used a co-designed framework (developed by people with lived experience, clinicians and community stakeholders) as a blueprint for organisational culture reform, which built upon philosophies of compassionate and relationship-centred care (McKella & Hanson, 2020). A range of staff were involved in the project, from administration officers to the consultant psychiatrist, nurses and allied health. This project resulted in cultural change, with staff reporting they felt safer at work, reduced distance between senior management and frontline staff, increased motivation, more support and an overall increase in positivity. The researchers highlighted several factors in the project's success: leadership buy-in, frontline change champions, a bottom-up approach that engaged staff in co-creation processes and promoting workplace learning and growth that fostered self-refection and awareness (McKellar, Renner et al., 2020). The successes of this project highlight that cultural change requires a collaborative, whole-of-organisation approach and a willingness to recognise and address power relations.

The literature suggests that cultural change in mental health and human services includes multiple interconnected factors. First, all staff must be involved and committed to change (Nightingale, 2018; Ross et al., 2014; T. Stanley & Lincoln, 2016). Second, the organisational and policy context should be open to change. Third, collaboration among leaders across the sector and management support are essential (Ross et al., 2014). In the context of creating change for trauma-free mental health services, Ross et al. (2014) contend that too little credence is given by those with power to the need for cultural change across all levels of the mental health service sector. Senior leaders and managers must foster and be involved in cultural change.

In summary, the literature about organisational cultural change in mental health services is limited, particularly in Australia. However, several initiatives have focused on cultural change towards recovery-oriented services, service user involvement and improved relationships between service users and practitioners in inpatient wards in Australia and the UK. Most of these initiatives focus on service providers, except for Miller's (2015) study on the self-advocacy group in a UK secure service and the co-designed blueprint for change in the Oakden Older Person's Mental Health Service (McKella & Hanson, 2020). Long-term outcomes of cultural change projects are under-researched, as is the involvement of service users and families.

Conclusion

In this chapter, culture was located in mental health policy and literature. The review identified that culture is discussed in policy as both an enabler of and barrier to cultural change for the workforce, recovery-oriented culture and safety and quality. Previous studies highlighted the role of culture in the continued use of problematic practices that exclude service users and are risk-averse, coercive and restrictive. Culture is identified as negatively affecting the workforce and a barrier to cultural change towards recovery-oriented services, service user involvement and development of a lived experience workforce.

Several studies have explored culture in particular contexts and cultural change initiatives. However, there is limited research that has comprehensively explored service cultures across settings and from multiple perspectives in Australia. This project seeks to move past the use of culture as a rhetorical tool in policy edicts and aims to explore the unquestioned, entrenched dimensions of service cultures (Mannion & Davies, 2018). In this chapter, I demonstrated the need for a focused inquiry into service users', families' and practitioners' experiences of, and perspectives on, mental health service cultures in the Australian mental health sector, including how cultures mediate change. In the next chapter (Chapter 3), I outline this study's methodology and methods.

Chapter 3: Methodology and Methods

Introduction

In this chapter, I describe the project's research methodology. I begin by restating the research question and objectives. Next, I discuss the research paradigm, which comprises the methodology and ontological and epistemological assumptions. I then describe the research design and the contribution of people with lived experience, a central feature of the project's methodology. The strategies I used to enact critical reflexivity are presented, followed by a discussion of ethical research practice and recruitment procedures. Finally, I outline the participants, data collection and analysis.

Research Question and Objectives

The overarching question guiding this research was how do mental health service cultures mediate reform aspirations in the Australian mental health sector? Four objectives were developed to answer this question:

1. To describe how mental health service cultures are understood, experienced, and enacted by service users, families and practitioners
2. To explore how current mental health service cultures mediate and are mediated by the implementation of national and local mental health policies
3. To identify barriers and enablers of cultural change in mental health services.
4. To identify requirements and mechanisms for cultural change in mental health services.

Research Paradigm

A research paradigm is "the net that contains the researcher's epistemological, ontological and methodological premises" (Denzin & Lincoln, 2005, p. 22). An interpretive and critical paradigm informed this research. Applying an interpretive paradigm facilitated an understanding of and accounting for the meaning of human experiences and actions, emphasising participants' interpretations of their experiences (Fossey et al., 2002; McLaughlin, 2007). Taking a critical approach meant focusing on the social and historical origins and contexts of meaning and experiences (Fossey et al., 2002). For example, I viewed the understanding and meanings ascribed to mental health service cultures as situated in the historical context of societal responses to mental distress. I understood power dynamics as part of the broader organisational context. As described in Chapter 1, critical approaches are derived from socio-political and emancipatory traditions and view knowledge as acquired through discourse and debate (Guba & Lincoln, 1994). Therefore, I have examined mental health services' historical, social, political and cultural contexts to understand how these conditions shape and constrain mental health service reform (Guba & Lincoln, 1994). Inquiry within a critical paradigm focuses on promoting transformation rather than only understanding and reporting on a phenomenon (Fossey et al., 2002; Pease, 2009).

Methodology

Research in mental health contexts has consistently privileged some truths and knowledge and silenced others (MacFarlane, 2009). Therefore, I deemed a critical approach necessary as qualitative approaches coupled with critical theories can advance the interests of under-represented stakeholders such as service users and their families (Alvesson & Deetz, 2000). A qualitative methodology, informed by a critical and interpretive paradigm, facilitated a rich and robust exploration of the complex workings of mental health services and service user, family and practitioner perspectives of service cultures (Deetz, 1982).

Qualitative methodologies are oriented towards understanding the meaning and experience dimensions of human lives and social worlds; hence, they are suited to developing knowledge in areas of limited understanding and great complexity, such as mental health service cultures (Fossey et al., 2002). Therefore, my approach was "historically and theoretically located, and flexible rather than dogmatic" (Carter & Little, 2007, p. 1318). This situated and flexible stance was integral to maintaining a naive inquirer position in my research practices, processes and interpretations of the data.

Given that service cultures are relationally and historically situated, it was important to examine not just the broader influences, such as the economic and political environment, but the subjective experiences and perspectives of service users, families and practitioners. This bifocal approach meant zooming in on individual experiences and out to the broader contextual factors informing experiences and meanings.

Ontology

Ontologies are theories of being that raise questions about the essence of existence and reality (Denzin & Lincoln, 2008; Pascale, 2010). Ontologies address questions of what can be known and inform the foundations of social inquiry (Pascale, 2010). Another way of thinking about ontologies is as a world view (Strega, 2005). My world view as a researcher has shaped the research project at every level (Strega, 2005). For example, my positioning and values shaped the research question, design, methodology, interpretation and analysis (see Chapter 1). The impacts of my world view, including assumptions and orientations, are explicated in an account of my reflexivity.

Ontological positions exist on a continuum from a realist to a relativist view. A realist position constructs the world as knowable, with a single truth that can be discovered via correct research techniques; therefore, reality is independent of human ways of knowing (Braun & Clarke, 2013). I sought to explore multiple truths and meanings ascribed to cultures of mental health services, so a realist position conflicted with the project aims. The opposite end of the continuum is a relativist view that considers reality dependent on human interpretation and knowledge, where multiple constructed realities exist and what we know reflects where and how knowledge is generated (Braun & Clarke, 2013). Relativist positions assert that all knowledge is constructed, and all constructions are considered equally valid. Relativism limits the ability to develop standards determining what is just and unjust and does not lead to social action or political commitment (Pease, 2009). Additionally, relativism can negate material realities of oppression, silencing and abuse, which potentially mirrors how mental health services can subjugate service users' and families' experiences and knowledges.

Critical realism sits between realist and relativist positions and is an ontological view that acknowledges that what is real and knowable in the world is shaped by subjective and socially located knowledge, which is only partially accessible by research (Braun & Clarke, 2013). A critical realist ontological position was adopted in this project for its utility in recognising the socially constructed nature of knowledge while also acknowledging that social structures and material realities exist, and some forms of knowledge have more influence and power to challenge oppression and social injustice (Haigh, 2019; Pease, 2010). Critical realism offered a way to negotiate the complexity of organisational culture from the perspective of different actors, simultaneously identifying opportunities to recognise alternative realities. A critical realist ontology facilitated the amplification of service user and family perspectives while recognising alternative and competing knowledges.

Epistemology

> An 'epistemology' is a framework or theory for specifying the constitution and generation of knowledge about the social world; that is, it concerns how to

> understand the nature of 'reality'. An epistemological framework specifies not only what 'knowledge' is and how to recognize it, but who are 'knowers' and by what means someone becomes one, and also the means by which competing knowledge-claims are adjudicated and some rejected in favour of another/others (L. Stanley & Wise, 1993, p. 188).

A social constructionist epistemology was employed to critically explore the understandings and perspectives of mental health service cultures from multiple perspectives. From a social constructionist stance, ways of knowing are tied to the social world in which we live (Braun & Clarke, 2013). I understand social constructionism as the active and evolving co-construction of knowledge of the social world through interactions and experiences between self and others. Knowledge is situated in social and cultural contexts and constructed and produced through various discourses, systems of meanings and how we understand the world (Braun & Clarke, 2013; Guba & Lincoln, 1994).

Thus, I view culture as a socially constructed phenomenon, subject to and situated in broader contexts, including the economic, political and relational spheres. Schwandt (2000) notes that "there is an inevitable historical and sociocultural dimension to this construction. We do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, language" (p. 197). Therefore, social constructionism was a valuable epistemological framework to deconstruct historical and socio-political issues in mental health services, including the long-term reform agenda within which concepts and understandings of culture have been noted but rarely defined.

Social constructionism ensured a focus on participants' definitions of situations as a way to "understand how social actors recognise and reproduce social actions and how they come to shape an intersubjective understanding of specific life circumstances" (Schwandtz, 2007, p. 39). Given that social constructionism begins with "radical doubt" in that which is taken for granted (Gergen, 1985, p. 267), the approach invited me to question mainstream management theories about organisational culture. It challenged me to continually question deeply embedded and naturalised elements of mental health service cultures. This stance aligns with a critical approach that questions perceived truths and unquestioned knowledges and interpretations (Braun & Clarke, 2013).

Social constructionism acknowledges that humans and organisations are complex; it honours the relationality between social structures and practices, people and the phenomena that shape organisations, and the lives of those within them (Bradbury & Lichtenstein, 2000). Social constructionism allowed a focus on the ways people who work within mental health services and existing power structures produce and reproduce 'the system'. This stance facilitated the exploration of new ways of understanding and possibilities for change. Organisations were viewed as constructions of these social relations rather than static entities. This relational approach breaks from a long-held view that organisations are separate from the people constructing and reproducing them (Bradbury & Lichtenstein, 2000).

Research Design

The research design, methods and processes are presented in this section. An integral feature of this research has been a Lived Experience Academic supervisor and the involvement of LECs, so this is where I begin.

Lived Experience Involvement

Research in mental health contexts consistently privileges some truths and knowledges and silences others (MacFarlane, 2009). Service user and family knowledges and experiences are frequently excluded or discredited in the mental health service system and research. Their knowledge is marginalised and added on rather than foregrounded. Underpinning this research is its hoped-for relevance to service users and families. I tried to operationalise this intent by working with and being informed by an LES and LECs to focus on and privilege service user and family knowledges at every stage.

Before the study, I was supervised by an LES in my Honours research and worked as a research assistant in the Valuing Lived Experience Project at Curtin University (see Dorozenko et al., 2016). My role included administration work, organising events, consultations and supporting a Lived Experience Academic in various tasks. My experience with an LES was transformative; it involved what Petersen (2007) describes as an "intense negotiation of identity", wherein postgraduate research is as much about identity formation as it is about knowledge and research production (p. 477). It is not simply coming to know but coming to be; a process of identity development, negotiation and enactment (B. Green, 2005; Petersen, 2007). Lived Experience Supervision during my Honours research shaped my researcher self, particularly thinking about my positionality, the importance of the political and historical contexts of a research area or topic, reciprocity and mutuality, and the impacts and end products of the research. This experience emphasised that research should be shaped by and with the community it is intended to benefit.

When I began this project, I was committed to involving lived experience in either supervision, consultancy or through an advisory group. In addition to a LES on my supervisory panel, two LECs were contracted to the project, representing service users' and families' lived experiences. The LECs were paid a consultancy rate, as per industry standards (MHC, 2022). Before outlining the specific involvement in this project, I provide an overview of lived experience knowledge and general involvement in research as this context informed my approach to working with the LECs and my LES.

Lived experience is knowledge and expertise representing a person's experience of mental distress, service use and/or recovery. As with other marginalised knowledges, it is often devalued, discredited and rendered invalid (Beresford, 2016; Boxall & Beresford, 2013; Faulkner, 2017). In contrast, professional or academic knowledge is ascribed a higher status, dominating mental health research with an emphasis on technical expertise and individualistic frameworks (Faulkner, 2017). Survivor knowledge is denigrated due to its "anecdotal, subjective and unscientific" status (Sweeny, 2016, p. 50), which extends to practice, policy and education (Beresford, 2016).

It is acknowledged that many people have expertise gained through training and expertise from experience. A key issue is the longstanding marginalisation and devaluing of experiential knowledge, which is now challenged by the c/s/x movement (Beresford, 2016). Lived experience comprises collective, diverse and multiple knowledges, which raises an important point about representation of service users and families in this project. People with lived experience, whether service users or families, are not a homogenous group and do not represent one voice. Therefore, the aim of lived experience involvement in this research was not to be representative but to recognise lived experience expertise. The LES and LECs provided invaluable, unique and necessary contributions to ensure the project's relevance and enhance my learning as a researcher (Happell & Roper, 2006, 2009). Additionally, the involvement of two LECs throughout the project's duration promoted continuity and prolonged, meaningful engagement with the researcher and project.

People with lived experience bring more than their direct experiences of distress and service use and have more to contribute than working to improve service quality. As mentioned in Chapter 1, lived experience expertise includes wisdom and insights gathered through individual experiences and collective knowledge generation (Byrne, Wang et al., 2021; Byrne & Wykes, 2020; Sandhu, 2017). This point has been emphasised by Roper, Grey et al. (2018):

> Over time, consumers have developed ways of knowing, theorising, and thinking about their experiences that constitutes a unique discipline in the field of mental health known in Australia as consumer perspective. Consumer perspective contributes leadership, knowledge and expertise beyond the context of service improvement. (p. 4)

The involvement of people with lived experience is a more inclusive research approach, enhancing the relevance and trustworthiness of the outcomes for people with lived experience (Happell & Roper, 2009). This project's LECs and LES were best placed to determine the relevance, value and worth of this project and the findings. I felt it essential that I was accountable. I welcomed challenge and questioning from the LECs and my LES involving feedback and critical reflection from and with LECs and in regular supervision sessions with my LES.

The two LECs were people I had previously worked with, and the supervisory team supported the decision to approach these individuals. The university's Human Research Ethics Committee (HREC) stipulated that the LECs' involvement could not commence until ethics approval was obtained. Therefore, LECs were involved following proposal development and candidacy approval and after the research question, objectives and design were finalised. I contacted the LECs and provided a brief overview and background to the project. I also shared the guiding principles stated in Chapter 1 and outlined what I thought their involvement could form while stating that I was flexible and interested to hear their ideas. Both LECs agreed to be consultants on the project, and their involvement took the form of critical reflection meetings at three stages.

The Stage 1 meeting involved me providing an overview of the project and gaining feedback from LECs and their review of the interview guides. I wanted to ensure that I did not exploit LECs' unpaid labour. Therefore, I provided an overview of the research at each meeting and did not expect them to spend unpaid time preparing beforehand. I prepared questions for their consideration and feedback. For example, I described HREC feedback about my understanding of culture expressed in the interview guide preamble (see 'Ethical Research' and Chapter 9). I was aware of the complexity of the concept and the possibility of ‘academic speak’ overshadowing the participants’ understandings. The LECs provided feedback and suggestions on the preamble, which I included in the amended interview guides.

The LECs’ suggestions on the interview questions were incorporated into the final guides submitted to Curtin University’s HREC as an amendment. The LECs’ feedback recognised that participants might have multiple identities (e.g., service user *and* practitioner), so questions needed to account for this. The LECs also encouraged me to think about culture as a felt experience that is difficult to define. Therefore, the following question was added to the interview guide:

> Sometimes the cultures within mental health services create feelings that may be difficult to define. Can you think of a time when you experienced strong feelings which may have been connected to the way you were treated, the language used, the rules you had to follow or the layout of the space you were in?

Additionally, I was encouraged to think about how service users and family experiences are broader than the mental health sector, with intersecting social determinants of health influencing their experience of distress, mental health services or both. Therefore, the following question was added to recognise these experiences: Mental health services can only offer a narrow band of help. If you could get any support beyond the mental health system, what would it be?

The second and third stage meetings occurred during data collection and analysis. These meetings involved discussion and reflection on my processes and approaches during data collection, challenges encountered during interviews, and my judgements and early interpretations of the data. We discussed initial codes and themes and how these were generated, and the LECs shared their reflections on my interpretations. I also consulted with the LECs when other issues arose or decisions needed to be made.

Reflexivity

Critical reflexivity is central to critical social work theory, research and practice; it involves consistently examining one’s social locations, values and beliefs (Allan, 2009). Guillemin and Gillam (2004) draw on the work of Harding (1986, 1987, 1991), who describes how social and political locations influence all aspects of research, including the research questions posed, choice of research design, how the data is interpreted and presented, and to whom we make research findings available. Reflexivity is an ongoing and active process that permeates every stage of research and involves a critical reflection on the kinds of knowledge generated and how it is produced (D'Cruz et al., 2007; Guillemin & Gillam, 2004).

Reflexivity is informed by epistemology and ontology and can be employed in different ways. Finlay (2002) describes various ways reflexivity can be employed when informed by critical realist approaches. For example, postmodern deconstruction highlights socio-political contexts and unexamined power relations, which requires that researchers are explicit about their position and interests within the research (Finlay, 2002). In qualitative research, reflexive processes contribute to rigour and ensure trustworthiness, transparency and accountability (Finlay, 2002; Guillemin & Gillam, 2004).

Critical reflexivity formed an integral component of my research practice and incorporated a critical postmodern approach to deconstructing assumptions. Additionally, it meant being attentive to power relations and considering the possible and actual implications of the project and its outcomes (Allan, 2009; D'Cruz et al., 2007). Critical reflexivity facilitates reflection on values, beliefs and emotions, and social, cultural and political locations and perspectives (Allan, 2009; D'Cruz et al., 2007). Within this research, critical reflexivity was essential to consider my positionality, power and privilege. Berger (2015) describes the reflexive process as turning the research lens back on oneself to consider our situatedness within the research and how this affects the participants, the questions asked, the data collected and how data is interpreted.

The critically reflexive processes and strategies employed in this project included examining my positionality and social location with active acknowledgement and explicitly recognising how my position influences research processes and outcomes (Berger, 2015; Finlay, 2002). This process included examining the relationships and interactions between myself and participants, considering power relations, questioning how unquestioned assumptions came to be established and adopting a position of 'not knowing'. Additionally, it involved reflecting on my approaches as an outsider in service user and family spaces (Berger, 2015), asking how I could respectfully engage and work in ways that built trustworthiness and reflected solidarity? What was my agenda, and did I make it explicit?

I continually reflected on my research practice and sought to place participants' needs and interests above the research agenda. I aimed to enact reciprocity and create mutually beneficial research relationships. Examples of this included sharing research and information on peer organisations and connecting participants with people in the service user community if they expressed interest in attending or being part of peer spaces. However, apart from purchasing refreshments and the remuneration payment of a $20 voucher, my relationship with participants was largely transactional rather than mutually beneficial (Aluwihare-Samaranayake, 2012; Bell, 2011).

The practical ways I enacted critical reflexivity throughout this project included reflexive journaling, guidance from my supervisory team, engaging in reflexive conversations with the LECs and my LES and seeking advice from them. I was committed to staying connected to participants' everyday lives and realities by placing my agenda and time constraints below their wishes or needs. I did this by 'leaning into' and placing myself in participants' worlds and realities. Engaging with lived experience literature and people in the c/s/x movements enabled me to deepen my critical reflexivity and ask different questions, uncomfortable questions, learn from these knowledges, develop my research practices and gain an understanding of the politics of such spaces.

Reflexivity can open "a window" (Finlay, 2002, p. 541) on aspects of the research that in other contexts would remain obscured from awareness. Reflexivity exposes what Finlay (2002) refers to as "researcher silences" (p. 541). There were moments when I was silent or complicit in professional privilege and discussions that constructed people who experience mental distress in particular ways. Despite disagreeing internally with some participants, I remained silent and sometimes found myself justifying their positions. I missed opportunities to explore with participants how dominant ideas or processes within mental health services become naturalised and shaped their experiences, which may have opened up critical engagement with other problematic structural conditions in mental health services. Journaling and supervision enabled me to identify and address these gaps in my critical reflexivity and ask questions such as: why was I ambivalent in challenging particular ideas or broaching particular subjects with some participants and not others? These reflexive practices have strengthened my capacity to respectfully and meaningfully engage with all the participant groups and extend my thinking and interpretations.

A Reflexive Account of Interpretation and Representation

I began this project with a deep commitment to doing justice to participant experiences, voices and perspectives; however, that became challenging when making decisions about data analysis and interpretation. I developed an attachment to some perspectives and participants, especially service users and family members, as I placed significant value on such expertise and was aware that all too often, service user and family knowledge is undermined or discarded by dominant mental health cultures.

There are inherent challenges associated with conducting research from a critical position, including critiquing certain practices, views and discourses. Ethically there is a requirement to ensure a just and fair representation of participants' voices (Mantzoukas, 2004). Throughout data collection and analysis, I became more aware of how complex, political and contentious this research topic was. Perhaps I was naive and too ambitious in my approach to include the perspectives of at times divergently positioned individuals and groups. My commitment was not only to be fair and honest towards all participants' accounts but to carefully consider how my interpretation would be received by those who had let me 'in' to service user and family spaces and practitioners who had shared their experiences and views honestly and with trust in me. I found myself wanting to protect some participants' accounts, particularly service users whom I felt could be viewed through a pathologising lens.

I was also wary of translating people's experiences in ways that were overly theoretical, inaccessible and de-contextualised from their realities. I questioned if I was being respectful enough to the wholeness of people's experiences. I also questioned if I was respectful in the way that I was examining, deconstructing and reconstructing participants' narratives that include sacred, deeply personal and sensitive experiences. It was important that I accurately represented participants' multiple, varied and divergent viewpoints, carefully presenting their words and noting what was included and omitted. I was committed to ensuring that I did not reproduce patterns and processes of epistemic violence and injustice concerning marginal knowledges (Fricker, 2007). I considered questions such as: How can I centralise marginal narratives and discourses in research findings? Am I neglecting some narratives over others? Why? Am I replicating processes of hegemony in my analysis and interpretations? Have I presented participants in fixed or universalising ways?

Some changes were made to the project due to time restraints. While my original intention was to share the initial findings of the research with participants and gain their feedback, input and interpretation—several participants communicated their interest and willingness to be involved in this stage—this became difficult due to time (e.g., delays with ethics approval) and resource constraints. Following extensive discussion with my supervisory team and LECs, I completed the analytical work without participant input. However, I did seek participants' feedback on transcripts and re-presentation letters, which acted as a form of analysis and accountability. In consultation with my LES and one LEC, I emailed all participants explaining my decision, inviting their ideas about how and in what ways the findings may be useful once the thesis was submitted. Some participants said they appreciated the update and were interested in reading the findings; others did not respond.

Researcher reflexivity is more than a tool employed to ensure quality, rigour and validity in research; it can explore relational and ethical dilemmas (Finlay, 2002). Reflexivity has ethical functions whereby the process creates space to consider the potential impact of one's research on participants before the research is conducted. This function is in addition to how to respond to and be aware of ethically important moments in research (Guillemin & Gillam, 2004). In summary, Tracy (2010) suggests a self-reflexive researcher is one who:

> examines their impact on the scene and notes others' reaction to them … thinks about the types of knowledge readily available as well as that which is likely to be shielded or hidden … interrogate[s] their own predilections or opinions and ask[s] for feedback from participants (p. 842).

I established reflexive safeguards that kept me accountable and assisted me in sustaining reflexive practices throughout this project. There were times during data collection and analysis when I was undoubtedly deeply impacted by the information shared. Due to the isolated nature of PhD research, these instances possibly dulled my reflexive lens and my reflexive capacity and processes lapsed. However, in measuring my level of reflexivity according to Tracy's (2010) suggestions, I believe I have sustained a satisfactory level of critical reflexivity throughout this research.

Ethical Research

This research involved several iterations, mostly due to the challenges of gaining ethics approval. The first iteration was a mixed methods study involving survey data collected from mental health practitioners and an institutional ethnographic methodology informed by Dorothy Smith's (2005) work. The data was to be collected from two sites in Perth, Western Australia, and I obtained agreement to involvement from two area Clinical Directors. I commenced the ethics approval process from the Western Australian DoH's HREC. After the initial review, I addressed all issues and questions raised by the reviewers. After several months and no indication from the DoH about when I would receive a decision, I adjusted the project to enable it to proceed without their approval. I changed the methodology from mixed methods to qualitative and from an ethnography in specific sites to an exploratory design, including interviews of service users, families and practitioners Australia-wide. I was concerned that the project would not be approved based on the feedback from the DoH HREC, which I expand upon in Chapter 9. As a result of these project changes, only Curtin University ethical clearance was required, which was obtained on 18 September 2017, six months after the initial application to DoH.

Ethics is more than merely obtaining procedural approval; it is fundamental to the research integrity. Ethical considerations and tensions are part of the everyday practice of doing research. I used Guillemin and Gillam's (2004) framework for working through ethical tensions, which contains the two dimensions of procedural ethics and 'ethics in practice'. Procedural ethics involved seeking approval from ethics committees via the application process. Ethics in practice concerned the everyday ethical tensions and issues arising while conducting the research, my ethical obligations to participants, and research practices that were humane, non-exploitative and self-aware (Guillemin & Gillam, 2004). An example of ethics in practice was working with participants to ensure the anonymity of information via a collaborative and careful process of sending transcripts or excerpts to participants and them making changes to ensure their data was adequately de-identified. This procedure was especially important for participants whose identification could significantly affect their employment or future service delivery experiences. Another way I enacted ethics in practice involved inviting participant feedback on the research process in interviews. I also described what would happen with the data and who would have access during and following project completion. This communication created a space for participants to ask questions and for me to respond ethically, guided by the participants' preferences.

Ethics in practice aligns with a researcher's responsibilities in the Australian Association of Social Workers' (2020) *Code of Ethics* and the National Health and Medical and Research Council's (NHMRC's) (2018) *National Statement on Ethical Conduct in Human Research*. These documents outline ethical responsibilities for research merit and integrity, justice, respect, avoiding harm to participants, ensuring informed and voluntary consent, privacy and confidentiality, and upholding the participant's right to withdraw without consequence.

Engaging with the ethics committees highlighted discrepancies between the ethical issues they considered important and my understanding of ethics in practice. I questioned how I could ensure that my research practice was ethical and reflected my commitment to do research that did not replicate the harmful dynamics of institutions or participants' experiences of discrimination or invalidation. During data collection, I encountered many moments of doubt and uncertainty regarding what was ethically right and necessary in my contact and relationships with participants. Such moments included buying food for participants, responding to suicidal ideation and assessing safety, connecting participants with peer services and having ongoing contact. I frequently questioned if I was doing enough, ill-prepared or inexperienced as a researcher. There was tension between what I considered important and necessary in participant relationships, my internalisation and perhaps enculturation into 'good' procedural ethical practice, and what it meant to be a good and professional researcher.

Reflexivity was central to acknowledging such tensions. Feminist ethics, the core principles of anti-oppressive practice, trauma-informed approaches and co-production guided my approach to navigating and enacting ethics in practice (Dickson-Swift et al., 2007; Kezelman & Stavropolous, 2012; Roper, Grey et al., 2018; Rossiter et al., 1998). These guiding principles included attention to relationships, boundaries, power, reciprocity, mutuality, partnership, challenging notions of service user, researcher or professional, epistemic justice and trauma-informed approaches, including safety, trustworthiness, choice, control, collaboration, empowerment and dignity promotion (Kezelman & Stavropolous, 2012).

Critical reflexivity provided me space to ensure I was cognisant of how I may have been 'a well-meaning researcher' with the potential to cause harm and co-opt participant narratives (Costa et al., 2012; Guishard et al., 2018). To enact ethical practice, I considered participants' possible experiences of injustice within and outside mental health services as people with psychiatric diagnoses. I was attentive to how my language could mirror oppressive knowledge about service users, for example, imposing a biomedical model of madness or distress (A. Wilson & Beresford, 2000). Additionally, I attended to how I might mirror the power dynamics that people might experience in patient–professional relationships.

Boundaries in research relationships are often considered in the context of effectively managing boundaries with participants. Notions of boundaries can reinforce constructions of ‘us’ and ‘them’ where the research participant is kept at a distance. My approach to relationship with participants in this project was informed by the notion of ‘safe connections’ rather than boundaries, which involves researcher accountability, empathy, collaboration and partnership (Dietz, 2000).

I employed a trauma-informed approach that emphasised physical, emotional, social and relational safety. I was attentive to the physical safety needs of participants by ensuring they chose the interview location and mode of contact. I considered their emotional safety by being prepared for interviews, transparent and predictable in all contact. Before the interview, I telephoned or emailed participants to build trustworthiness and create conditions where they felt they had some control and choice. Social safety was of utmost importance; it involved renegotiating anonymity and confidentiality and careful attention to the potential consequences of participants’ speaking out.

I wrote summary letters to service user and family participants (except where full transcripts were preferred) to re-present what I heard in interviews and demonstrate respect and accountability for my interpretation of their data. Summary letters condensed the interview transcript to a two-page document ensuring adequate detail, accessibility and use of participants’ words and meaning-making. I followed a narrative approach when writing the summary letters (Denborough, 2021; Marlowe, 2010). This approach included reflective and clarifying questions where appropriate (e.g., Is this an accurate interpretation of your experience here?). I invited participants to make changes or clarifications to the summaries (see ‘Interviews, Transcription and Follow-Up’).

Finally, I endeavoured to ensure that the interview venues were physically and financially accessible. I sought to minimise or attend to power imbalances by keeping interviews informal and sharing information about myself when asked. However, in some interviews, I was acutely aware of the structural imbalances between the participant and myself. Although I obtained the research data, the immediate needs of some participants, such as money, food and stable housing, remained unmet.

Informed Consent

Central to research ethics is the requirement for informed consent, which implies that participation in the research is voluntary, and that sufficient information is provided to allow participants to consider the benefits and risks of participating (Engel & Shutt, 2013; McLaughlin, 2007). I provided information sheets and consent forms to participants before the interview via email; where this was not possible, I provided hard copies when we met for the interview. Before interviews, I asked participants if they had read the information sheet, provided a brief overview of the project and invited their questions.

Confidentiality and Anonymity

Ensuring confidentiality, anonymity and privacy of all participants was integral, and attention was paid to ensuring open and transparent processes. Protecting the identity of participants and ensuring written material could not be linked to them was of utmost importance given the sensitive nature of this research (McLaughlin, 2007). In the findings, I have reduced the contextual information to ensure that participants cannot be identified. As mentioned, participants were invited to contribute to de-identifying their transcript, and I followed their direction when re-presenting their experiences.

Participants' names, places of work or location and other identifying details were adjusted or excluded. Codes indicate the participant's group (SU = service user; P = practitioner; F = family), and a number represents individual participants in a group. All hard copy documents, including consent forms, transcripts, field notes and audit materials, were stored in a locked cabinet. The signed consent forms were stored separately from the interview transcripts to ensure confidentiality. Electronic documents and recordings were stored in files on password-protected devices only accessible to me, the student, and my supervisors. De-identified excerpts of interview transcripts were shared with my supervisors during data coding.

Risks, Harms and Impacts

The potential risks, harms and impacts of the research are linked to confidentiality. The implications for individual or service reputational damage were carefully considered throughout data collection, analysis and write-up. The implications were discussed with all participants, given that speaking out could result in potentially unfavourable consequences. The risks associated with whistleblowing were raised while obtaining ethical clearance, which alerted me to this issue. Consequently, I emphasised with practitioner participants that the focus of the research was on the mental health sector, not individual services and programs, thereby avoiding individuals or services being singled out in a way that would implicate them or diminish their reputations.

People who have experienced mental distress, and their family members, are often constructed as vulnerable; however, this denies agency and self-assessed capacity. Therefore, while I adhered to Section 4.5 of the *National Statement on Ethical Conduct in Human Research* (NHMRC, 2018), which outlines research guidelines concerning people with a mental illness, I positioned service users as having the capacity to assess and self-determine their participation in this research (R. Coleman, 2011; Hilton et al., 2020; Slade, 2009). Further, all participants were citizens living in the community and making daily decisions about their best interests. I adopted a reflexive and open approach that valued participants' agency and rejected limiting constructions based on their experiences of mental distress and service use. This stance enabled me to challenge my assumptions and listen more deeply to peoples' contexts and experiences of survival, despair and resistance.

Potential participant distress was another important consideration. Some of the strategies I implemented were discussing the possibility of distress or strong emotions with participants at the commencement of interviews, asking them about their support networks, and spending time with them after interviews to debrief as necessary. While many people had emotional responses during interviews, and some became upset, this was in the context of reflecting on experiences of mental health systems as a service user or family member. Some people's experiences of hopelessness and despair were current; I was aware that their involvement in this research would not meet their immediate needs and could potentially reinforce hopelessness that their situation would not improve. Although I attempted to validate their experiences and perspectives, my responses felt hugely inadequate. I followed up after the interviews with a summary letter and acknowledged their contribution, hoping to validate that they had been heard respectfully. Following these interviews, I was most unsettled by the futility of the research and frustrated by my limited capacity to do anything to address participants' immediate needs. While I could acknowledge service user and family participant contribution with a small remuneration voucher, buying food and drinks, or providing information and connecting people with organisations or advocacy groups, this felt insufficient. Participants reminded me of their agency, noting that they had participated because they wanted to "help others" and see a change in the mental health system and service delivery, yet my sense of inadequacy sat with me.

Access and Recruitment Approach

When considering the inclusion and exclusion criteria for participants, I sought to mitigate the possibility of replicating experiences of exclusion, silencing or power imbalances that service user and family participants may have experienced when using services. Parameters were included in the inclusion criteria to ensure that experiences were not discredited on the basis that accounts were historical. Consequently, the inclusion and exclusion criteria included:

- Mental health service user, family member/carer/supporter, or mental health practitioner
- Experience of using, supporting a family member or loved one, or working within mental health services in Australia currently or within the past five years
- Aged 18 years and older
- Not currently hospitalised within an inpatient mental health unit.

Sampling Approaches

Purposive and snowball sampling were used to recruit participants with knowledge and experience of the phenomena being studied to provide in-depth insights and understanding (Liamputtong, 2012; Morse, 1995a, 1995b). Purposive sampling was implemented by contacting key mental health organisations, service user groups and family groups. Snowball sampling involved asking existing participants if they know of others who met the research criteria (Liamputtong, 2012); for this, I invited participants to share the research with people in their networks.

The recruitment strategy included a staged approach beginning with contacting local Western Australian groups, followed by groups in other Australian states and territories. I contacted local mental health organisations, key consumer and family groups, and services. My supervisors' networks, relationships and reputation in the local and national mental health space aided this process. My existing and previous context with organisations and consumer and family groups enabled my access; in some cases, it allowed me to connect with participants. This staged approach was important to ensure timely contact with participants.

Following the initial wave of interviews, state and national professional groups were contacted, including the Australian Association of Social Workers, Occupational Therapy

Australia, the Australian College of Mental Health Nurses and the WA branch of the Royal Australian and New Zealand College of Psychiatrists. An invitation to participate was advertised on the Australian Association of Social Workers' website and via electronic email distribution to all WA members of the Royal College of Australian and New Zealand College of Psychiatrists. No response was received from the Australian College of Mental Health Nurses. Given budget constraints, Occupational Therapy Australia was not included as a recruitment site due to its $200 advertising fee. This omission may have reduced the number of nurses and occupational therapists in the study compared to social workers and psychiatrists. Project details and recruitment material were also posted on a professional Facebook page for social workers and similar professions in WA; a family advocacy group shared the project details on their Facebook page. An advertisement was also placed on Curtin University's research webpage (see Appendix B).

Recruitment Challenges

Data collection was conducted for nine months, from March 2018 to December 2018. By June 2018, I had completed 33 interviews; most were with service user and practitioner participants. Following discussions with my supervisors and Family LEC, I began a more targeted approach to recruiting family members. There were some challenges in recruiting family members due to their limited availability. Their limited availability reflected the amount of informal care provided in Australia, where family members and carers provide an average of 32.6 hours of unpaid support per week to their loved ones and 59.5 hours being "on call" [or] "on standby" (Diminic et al., 2016, p. 60). Most potential family member participants were identified via snowball sampling. Prospective participants telephoned, informing me of their interest but citing time constraints and requesting that I contact them in a week or two; however, they were uncontactable when followed up. I often felt tentative in following up, recognising that a research interview was likely a difficult activity to fit into their already demanding and busy lives. For example, during our interview, a mother whose son was discharged from an inpatient unit that afternoon took four phone calls from her son and hospital staff. This situation aligned with what I heard from family members in interviews about their support and caring obligations.

The number of family participants (n = 11) was approximately half the number of service user participants (n = 21) and less than practitioner participants (n = 19). A decision to cease family interviews was made (supported by the Family LEC and my supervisors).

Although the number of family interviews was lower than the anticipated sample size, rich and complex descriptions and data were gained from those interviews. Additionally, due to time constraints, I could not continue recruitment efforts.

Sample Size and Saturation

The sample size was not intended to produce representativeness as with positivist research approaches. At the project start, I was required to provide a sample size based on the notion of data saturation for the university's candidacy review and HREC. Drawing on the literature and wanting to ensure the project's manageability, I provided an anticipated sample size of 15–25 interviews in each participant group. This requirement reflected how the concept of saturation is part of institutional discourse based on ideas about optimum sampling adequacy and research quality. However, it can be argued that saturation has multiple meanings and limited transparency (O'Reilly & Parker, 2013). In qualitative research, sampling is concerned with information richness; the number of participants required is determined by the nature of the topic and the resources available (O'Reilly & Parker, 2013). Researchers are encouraged to be pragmatic and flexible in their approach to sampling—an adequate sample is characterised by sufficiently answering the research question (Marshall, 1996). As this study was exploratory, recruitment ceased when rich and complex data was obtained, and a multifaceted story about mental health service cultures emerged.

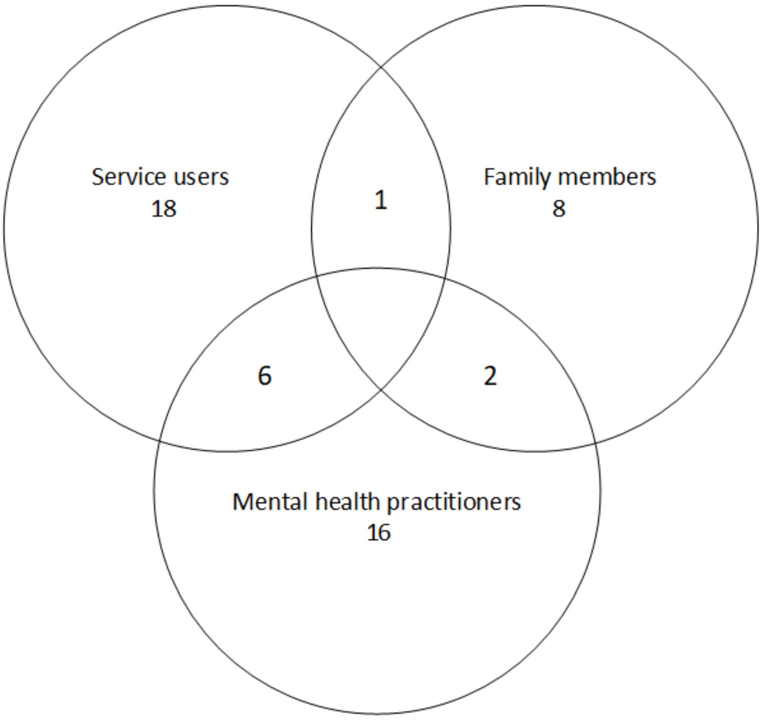
Participants

Fifty-one people participated in the study. Specific socio-demographic details were not collected, as this information was not deemed necessary to answer the research question. Participants voluntarily provided some demographic information before or during the interview. For example, some participants spoke about culture, age, gender, sexual identity or geographic location in relation to their experiences of mental distress and services. Several service user participants were or had lived in public housing or experienced homelessness or housing precariousness. Two service user participants identified as Aboriginal. In terms of geographical location, three service user participants resided in Victoria, New South Wales and Queensland; the remainder were located in Western Australia. At the time of interviews, participants' mental health service use ranged from one to 30 years; some noted a significant gap between the first time they used services and their most recent encounters. The type of services used included public inpatient, public community, NGO and private.

Although recruitment was focused on participant groups, I was guided by participants concerning how they chose to speak about their experiences, acknowledging the potential incongruity and tension in separating service user and practitioner experiences or selves. Many participants reported occupying multiple and intersecting identities. For some, this information was revealed in initial contact, where participants stated that they were both a service user *and* practitioner or a practitioner *and* family member. Others made contact as practitioners and disclosed in the latter part of their interviews that they were also service users, explaining that they did not disclose this information in their workplaces. Therefore, many participants wove their multiple experiences and identities throughout the interview. Figure 2 shows an overview of participant identities.

Figure 2

Overview of Participant Identities



In the remainder of this section, I summarise family participants' relationship to their loved one or friend, then the practitioners' disciplines and roles. Given I have described demographic information about service user participants above, no further information is provided.

All family member participants resided in Western Australia. Participants' relationship to their loved one or friend is shown in Table 2.

Table 2

Overview of Family Participants' Relationship with Service User

Relationship	Number
Mother	5
Sister	2
Father	1
Brother	1
Son	1
Friend	1

The practitioner group's disciplines comprised social work, psychiatry, occupational therapy, peer work, nursing and various community and NGO occupations (see Table 3). Most practitioner participants were social workers and psychiatrists and resided in Western Australia. Six participants resided or worked in Queensland, New South Wales, Victoria, South Australia or the Northern Territory. While participants were not asked how long they had been practising or working in mental health services, some noted they had worked in mental health services for decades, while others had five years or less experience. Practitioners worked across sectors and service types, including public, private and NGO settings.

Table 3

Overview of Practitioner Participants' Occupations

Occupation	Number
Social work	9
Psychiatrist	7
Recovery worker, advocate, engagement officer	3
Peer worker	3
Mental health nurse	1
Occupational therapist	1

Interviews, Transcription and Follow-Up

In-depth, semi-structured interviews were conducted to capture contextualised meanings and insight into the participants' worlds. To position the participants as experts

(Kelly, 2010), I was guided by them in all the procedures, including venue, time, interview flow and the information provided. Given organisational culture's complex and socially constructed nature, in-depth interview methods aligned with the study's exploratory nature (Janićijević, 2011).

Although semi-structured interview guides were developed (see Appendix C), I was guided by the participants deeming what was necessary and relevant to them. This approach allowed participants to enact a choice in how the interview was conducted, which aligned with my positionality. I also sought to create a dialogue with participants in which authoritative discourses or dominant ideas could be unpacked and disrupted by asking participants their opinions about the topics, highlighting dominant discourses, and asking service user and family participants their views on how their experiences with the mental health sector came about. This approach provided space to explore the dominant and unchallenged ideas in mental health services and associated meanings of culture and change. The interviews provided comprehensive description of participants' interpretations and meanings of organisational culture in relation to their own lives and the broader influences and implications for policy and service delivery.

Forty participants engaged in face-to-face interviews, 10 by telephone and one by videoconferencing. Most interviews were conducted one-to-one; two were conducted with two people, one with a family member and a worker, and one with two mental health practitioners. All interviews were audio recorded with consent from the participants.

Interview times ranged from 35 minutes to three hours. One mental health practitioner ended the interview after 21 minutes due to their pressing work commitments. The participants guided the duration of the interviews; after one hour, I checked in with participants to see if they wished to continue. In some cases, mental health professionals had set aside one hour in their working day, and I ensured we completed the interview within that hour. Some interview recordings were interrupted multiple times by telephone calls and other work or life commitments. For example, one interview was conducted in a shared office where other staff entered (this was the participant's preferred space). Rather than affecting the quality of the interviews, these unexpected breaks in the interviews reflected the everyday for participants and provided me with greater insight and contextual understanding.

I commenced interviews by sharing the project overview and why I was conducting it, including previous work and experiences leading to this project. I asked participants if it would be useful if I shared the conceptualisation of culture for this project, asked how this description resonated with them and if they had other ideas or understandings. Participants often stated that this conceptualisation made sense, while others added to my description with their examples, which often provided a lead-in to the interview. I revisited the consent form and information sheet, reiterating that participants were welcome to contact me at any time to withdraw from the project. While data was de-identified, I kept a code book that assigned a number to the participant to ensure I could remove their data if requested. I discussed the potential risks and asked the participants if they had any questions before starting the interview. I provided an overview of the topics, including the purpose of the questions, and noted that they could stop the interview at any time and that there was no obligation to answer all questions. An overview of the process was important to ensure participants were prepared for questions and could make informed decisions about their contributions. My interview approach varied between service users, family members and practitioners. For example, I took particular care in the consent and research processes with service users and family members, as practitioners often indicated that they understood informed consent as it was a part of their role.

The literature and the LECs' ideas and knowledge informed the interview guides. Key interview topics included: perspectives and experiences of mental health services, culture and change, values and principles underpinning services, whose ideas, knowledge and experiences were valued, and barriers and facilitators of change. Open-ended questions were informed by Schein's (1992, 2010) three levels of culture: artefacts, values and beliefs, and basic assumptions. The LECs' review of the interview guides was invaluable in reshaping and adding to the guides, particularly to improve their clarity. I conducted a pilot interview with a mental health practitioner to ensure the interview guide's flow and clarity, which resulted in minor changes. The interview guides varied and were tailored to each participant group; however, they contained core themes. I offered to send participants a copy of the interview guide before the interviews.

The open-ended and conversational approach of the interviews captured participants' perspectives and experiences and facilitated exploration of the organisational context of mental health services at policy, management and individual levels. I sought to create space in interviews for exploration where participants could speak about the meanings they ascribed to mental health service cultures and what was important to them about their experiences in service cultures, including areas I had not raised or considered. One example was a participant who described culture as a “red herring” and not the issue I should focus on regarding change in mental health services. This comment encouraged me to reflect on my assumptions and consider how participants’ conceptualisation of culture differed to mine. It also enabled me to extend how I was conceptualising culture.

I transcribed all service user and family member interviews and one-third of the practitioner interviews. A transcription company transcribed the remaining two-thirds of the practitioner interviews. These interviews were considered to have less sensitive content, and the decision to have them professionally transcribed was based on practical reasons of time and the intensive nature of transcribing and writing summary letters. Summary letters were offered to service user and family participants to share my early analysis and interpretations of their stories, allowing a level of accountability and providing space for participants’ feedback on my interpretations. I noted that there was no obligation to respond or examine the documents. One participant asked for a visual representation or audio recording of their summary letter instead of a written one, and others asked me to send the summary and then phone to discuss the document and feedback. I included clarifying questions where I was uncertain about the accuracy of my interpretations and invited feedback or response. Some participants added detail or made corrections or changes to their summary or transcript. For example, one participant corrected an error I made about the years they had been using a particular service. Most participants said no changes were required, and some did not respond. Participant feedback on the summary letters and transcripts was mostly positive, with participants noting that the conversation was captured well. Some participants asked if they could share their transcript or summary letter with others; for example, one participant asked if they could send it to their psychiatrist as it provided a useful overview of their experiences and history.

One participant expressed dissatisfaction with their summary letter. This participant said the verbatim quotes, which included filler words and verbal thinking such as “ums” and “ahs”, made them feel incoherent. I acknowledged the participant’s responses and apologised for the summary letter’s effect, offering to make changes; however, the participant stated they just wanted to provide feedback. This feedback made me question and reflect on my presentation of summary letters, in addition to verbatim or tidied transcripts. Following this feedback, when sending transcripts, I made explicit that the verbal fillers were typical of everybody.

After the first three interviews with practitioners, I decided to provide them with a transcript due to the intensive and time-consuming nature of writing summary letters. This was a practical decision, given that the contributions of practitioners were not as personal and sensitive as service users or family members. Approximately two-thirds of practitioner participants responded and noted that they accepted the record; the remainder did not respond.

Providing summary letters and transcripts is integral to researcher accountability and transparency and can be meaningful for participants. However, I have reflected on the usefulness and impact of summary letters and verbatim transcripts. At times, I felt a pull towards tidying up people's narratives or perspectives, which I resisted. However, when I critically reflected on why I wanted to do this, I identified that I was concerned about and wanted to bolster or protect the credibility of some participants' narratives. This experience reinforced the importance of normalising the stop-start of conversations and speech, and participants' choices and involvement in deciding member checking processes.

Data Analysis and Interpretation

Braun and Clarke (2019) describe data analysis as "deep and prolonged data immersion, thoughtfulness and reflection, something that is active and generative" (p. 213). I completed a reflexive thematic analysis of the 51 interview transcripts following Braun and Clarke's (2006, 2019) approach. A reflexive thematic analysis involves an organic, fluid and flexible approach to coding and theme development. My process was informed by my researcher standpoint and was responsive to my evolving engagement with the data (Clarke et al., 2015; Terry et al., 2017). Data analysis and the researcher are reflexively interdependent and interconnected. Therefore, researchers must articulate and be transparent about their role in the research process and outcomes, which aligns with my guiding principles of transparency and accountability (Mauthner & Doucet, 2003). Reflexive thematic analysis considers researcher subjectivity as a resource whereby the researcher's activity in the knowledge production process is recognised and emphasised (Braun & Clarke, 2013; Clarke et al., 2015). My theoretical positioning and assumptions shaped how the data was analysed.

Reflexive thematic analysis is an appropriate method for this project given its focus on exploring and developing an understanding of shared patterns of meanings across the data while understanding these patterns were situated in individual narratives and experiences. Thematic analysis is often used in political, social justice and change-driven research where there is a focus on the voices of those who have been silenced or excluded (Braun et al., 2019; Clarke et al., 2015). This method is most useful given the nexus between experiences, culture and mixed or multiple identities within mental health services, which had not been researched in-depth. Much organisational culture research has been conducted from the perspectives of high-level management and has not considered people at the grassroots levels who are experiencing, using and operating within services. Reflexive thematic analysis is appropriate given the limited knowledge and research in this field; it enabled me to openly and curiously explore the multiple perspectives and layers of culture and change.

My constructionist epistemological stance underpinned the thematic analysis and guided how I theorised the data. A constructionist perspective views the meanings and experiences within the data as socially produced and reproduced rather than residing within the individuals. Therefore, I focused on exploring and theorising the sociocultural contexts and structural conditions that shaped and informed the individual accounts (Braun & Clarke, 2006; Clarke et al., 2015). For example, rather than viewing inadequate practices as faults of individuals and singular instances, I considered how practices such as exclusion or restriction sit within a broader organisational and societal context pervaded by risk aversion and fear of litigation. These practices also sit within a historical context in which practitioners have been trained and enculturated to view them as necessary as service users are considered dangerous or as having limited decision-making capacity.

Doing Reflexive Thematic Analysis

Braun and Clarke (2006, 2013) outline a six-phased approach to reflexive thematic analysis; this approach is recursive rather than linear. My approach to each phase was reflexive, messy and intuitive. I collected data over nine months and began familiarisation and preliminary analysis before completing data collection. Clarke et al. (2015) note that in larger projects, data collection and thematic analysis can be conducted simultaneously, whereby an exploratory approach to incorporating new questions and avenues is integrated into data collection based on the data collected. Common themes, experiences and perspectives were described in interviews, and I began integrating these experiences and perspectives in later interviews. Participants often asked about findings thus far, and I shared common themes with them. Sharing of themes provided a lead into interviews and greater insight and depth of understanding of people's experiences and the meanings they ascribed to them. This approach was not only useful for deepening the understanding and richness of data but reflected reciprocity and transparency. Sharing the research and my early interpretations with participants gave them an idea of who I was and how I used and made sense of the data.

The six phases of reflexive thematic analysis are:

1. Familiarisation
2. Coding
3. Constructing themes
4. Reviewing themes
5. Refining and naming themes
6. Writing the report (Braun & Clarke, 2006).

I initially intended to analyse each participant group separately and then consider the similarities and differences across each group. The purpose was not for comparison but to explore and consider the perspectives and experiences expected to differ based on people's roles, positions, power and access to resources. However, I recognised several interlinking meanings ascribed to culture throughout the interviews across participant groups. As a result, following the coding of the three participant groups separately, I collated codes across the participant groups to build themes (see 'Constructing and Revising Themes').

Braun and Clarke (2019) describe the analysis process as recursive, where the researcher moves back and forth throughout the phases. I found myself moving forwards and backwards through singular narratives, whole participant groups, stepping back to view the whole data set, and then sitting in between participant groups to consider the different meanings of culture, experiences and perspectives, grappling with the tension or inconsistencies, and familiarity of perspectives and experiences across the data set.

Familiarisation

Familiarisation is becoming immersed in and engaging with the data in different ways. It entails being curious about the content, noting questions, observations, insights and meanings, and identifying connections between participants and the literature. This phase provides the foundation for robust examination and interpretation of the data (Braun & Clarke, 2006; Braun et al., 2019; Clarke et al., 2015).

I immersed myself in the data in several ways. Immediately after the interviews, I engaged in reflective journaling, where I made notes of general ideas, meanings and insights from the interview. I aimed to transcribe interviews as soon after they were completed as possible. Writing summary letters to service users and family members provided familiarisation with the data and early interpretations. I re-listened to audio recordings to check all transcripts for accuracy and read transcripts two to four times.

A reflective journal was used to record notes of my assumptions, new ideas, perspectives that challenged or aligned with my understandings, and my responses to the data. I made notes on hard copies of the transcripts using highlighters and sticky notes. I wrote summary and reflection notes on each transcript, participant group and the entire data set in a larger Word document. These notations also provided an audit trail of my decisions throughout the analysis. This note-taking process was guided by my overarching research question and broader questions about what was occurring in the data (Braun et al., 2019). For example, the overarching question of 'How do mental health service cultures mediate reform aspirations?' was a sensitising question that guided my focus, and I made notes of how culture was described and the barriers to reform. However, I also observed and began to question the varying ways people spoke about service culture and how it functioned (i.e., what did culture do), which deepened and extended my understanding of culture and my use of the concept. I met with my supervisors multiple times during this phase to discuss my observations of the data and questions. These meetings provided a reflexive space to critically reflect on my ideas and assumptions and to hear my supervisors' perspectives on the data and the early ideas I was communicating to them.

Generating Codes

Generating codes begins with organising the data in a meaningful and systematic way, reducing it into smaller chunks of meaning (Maguire & Delahunt, 2017). Coding practices in reflexive thematic analysis involve an open, fluid and recursive approach where codes are never final (Braun & Clarke, 2019). I completed an inductive coding process, so the analysis stayed as close as possible to the data. However, I acknowledge that a purely inductive approach is impossible, as analysis is always informed by the researcher's theoretical assumptions, personal and political position, knowledge and experiences (Braun et al., 2019; Clarke et al., 2015). An inductive approach aligned with the project's exploratory nature given the limited understanding of service users', families' and mental health practitioners' perspectives and experiences of mental health service culture and change. The bottom-up, grounded approach enabled me to privilege participants' voices, knowledge, conceptualisations and meaning, rather than coding according to existing ideas about culture and change. This approach helped me remain open to the complexity and manifold meanings and perspectives of participants, grounded in their everyday experiences and organisational lives.

The level at which meaning is identified and coded is an important consideration in reflexive thematic analysis and is informed by the researcher's epistemological approach (Braun et al., 2019). I coded data semantically by exploring surface and explicit meanings and latently through a deeper, implicit and conceptual exploration of the data (Braun et al., 2019; Clarke et al., 2015). I started the first round of coding with the service user interviews and undertook a line-by-line analysis. Coding was systematic, using tables containing in vivo codes and short phrases with equal attention to each data item.

The second round of coding involved the development of latent codes. I recorded these latent and new semantic codes in a second column in the table. I also recorded links and connections to other participant groups and codes. Latent codes involved tracing underlying ideas, assumptions and ideologies that shaped or informed the semantic codes. I provided excerpts of a sample of interviews from different participant groups for my supervisors to code before meeting to share and discuss similarities and differences in our approaches and ideas. The aim of this was not consensus or to establish correct codes but to enable me to critically reflect on my approach, hear other ideas and consider where codes required further thinking or development.

The third layer of coding was completed to ensure consistency and robustness in my approach, given the large data set and multiple participant groups. This stage involved generating a small number of new codes and making changes to existing codes, including separating and collating codes. Codes that were contradictory or involved tensions or inconsistencies were flagged and discussed in supervision meetings. This discussion was particularly important to ensure that accounts that departed from the dominant narrative within the data were included.

During the third layer of coding, I noticed myself skipping over particular areas in transcripts that were contradictory to my values and ideas. For example, a family member spoke about their loved one in a way that implied they needed to be more compliant with medication and the rules of the service with which the service user was engaged. I reflected on the tension between wanting to privilege the experiences of family members but was left wondering what their family member was experiencing and how they would respond to the family's perception of their choices. I engaged in reflexive discussions with supervisors and LECs about my response and what this meant for coding.

Constructing and Revising Themes

Following deep engagement across the dataset during and after collating codes from each participant group, I noticed patterns of shared meaning united by a central organising concept or idea. I experimented with collating the codes across all participant groups to test the fit by drawing thematic maps and connections. Following discussion with my supervisors and LECs, we considered that collating codes and presenting themes that represented shared patterns and meanings could show how experiences and perspectives, often presented separately in the literature, are divergent but coexist, and could be useful in creating spaces of dialogues between the groups. We discussed that careful consideration of, and attention to, differences in participant groups was needed. For example, practitioners and service users spoke of experiencing powerlessness; however, given the significant differences in access to power between a mental health practitioner and a person using a mental health service, their experiences of powerlessness had different implications and contexts. What can be called levels of powerlessness occur personally and professionally and need to be teased out and acknowledged. My supervisors and I agreed that the only way I could test the fit was to collate codes across the entire data set with the potential risk that it might not be feasible or appropriate.

I began collating codes and associated data across the entire data set, building what Braun et al. (2019) describe as "prototype" or "candidate" themes (p. 855). I created thematic maps to visually explore potential themes, drawing connections between prototype themes and possible sub-themes (Braun & Clarke, 2006). The next stage involved reviewing, modifying and developing prototype themes (Maguire & Delahunt, 2017). At this point, I used the qualitative data analysis software NVivo to assist in reading all data associated with the collated codes in each theme. My review was guided by questions such as: Am I attempting to fit too many ideas into one theme? Do themes overlap? Are there sub-themes? Is the central organising concept clear? Does the theme address the research question and reflect the content of the data? (see Clarke et al., 2015; Maguire & Delahunt, 2017). I then returned to the entire data set to ensure that each theme and my analysis captured the significant meanings and patterns in the data.

Defining and Naming Themes

I then moved to the 'defining and naming themes' (Braun & Clarke, 2006) phase with questions and open-mindedness about the relationships between themes. To consolidate and refine the themes, I wrote definitions and descriptions of each theme, explaining its essence and central organising concept, scope, boundaries and links with other themes, including a transcript excerpt. This process and the feedback from my supervisors assisted me in identifying further overlap between themes and some broader overarching scene-setting themes that could be amalgamated. At this stage, I shared my themes and the overall narrative in the data with my LECs. I also presented my preliminary findings to a panel of academics at a PhD student forum. Writing up, sharing and presenting the themes provided spaces to enhance my interpretive explanation, think more deeply about the organisation and flow of the analysis and provide a map for writing, which continued to change and develop. Theme names were refined during the writing stage to ensure they signalled the scope and essence of each theme (Braun et al., 2019).

Analytic Write-Up

Braun et al. (2019) state that the analytic writing up is the final analysis phase that "serves as an ultimate test of how well themes work individually in relation to the data set and overall" (p. 857). This phase involved the compilation of existing analytical writing and revisiting research questions, notes from early phases of data analysis, codes and theme descriptions to ensure the final themes remained grounded in the data and answered the research questions comprehensively (Braun et al., 2019; Clarke et al., 2015). Writing up the themes was a recursive and lengthy process; it extended and deepened the analysis; consequently, ongoing revisions to theme structure, content, names and presentation occurred.

Conclusion

In this chapter I have restated the overarching research question and objectives and presented the chosen research paradigm for this study. I have demonstrated the suitability of a qualitative and interpretative methodological approach, a critical realist ontology and social constructionist epistemology to explore mental health service cultures from a critical theoretical perspective. I provided an explanation of lived experience involvement which formed a central part of the research methodology and enhanced the trustworthiness of the research outcomes, and my accountability as a researcher. I outlined the involvement of a LES on my supervisory panel and two LECs whose involvement took the form of one-on-one critical reflection meetings at three stages of the research. I sought to demonstrate quality and rigorous research by explaining how I enacted critical reflexivity and ethical research practices and detailed the practicalities of the research method by outlining access and recruitment, an overview of participants, and data collection methods. Finally, I offered a justification for and description of using a reflexive thematic approach to data analysis, highlighting some of the challenges I encountered interpreting data across three participant groups. This thesis now turns to the analytic outcomes of data analysis.

Introduction to the Findings

The findings of this research are presented in the following four chapters, commencing with the overarching cultural frames in which mental health services operate: the organisational and administrative cultural frame and the historical cultural frame. Frames are organising principles that hold together and give coherence to diverse ideas, understandings and symbols (Fireman et al., 1984; Gamson & Lasch, 1983, as cited in Creed et al., 2002). In the context of this research, cultural frames capture the broader conditions shaping and sustaining particular forms of organisational cultures and direct attention to the contexts integral to understanding such cultures.

In Chapter 4, the organisational and administrative cultural frame is presented, followed by the historical cultural frame in Chapter 5. Both chapters are laid out in the same manner: an analysis of relevant literature is presented to provide targeted and contextual information to illuminate the study findings that follow. Each cultural frame concludes with a section called ‘Consequences’, a construct generated during data analysis as participants consistently spoke of the impacts of cultures. Chapters 6 and 7 present two distinct elements of culture: blame and othering. These two elements of culture are produced and maintained by the workings of both cultural frames; thus, they are complex and multifaceted.

Chapter 4: Organisational and Administrative Cultural Frame

In the past four decades, there have been extensive changes to how health and human services are funded and expected to operate in the government and NGO sectors. These changes are part of a wider ideological and practice shift in which principles from the profit-driven private sector were transferred to the public sector. Key features of this shift are neoliberalism and NPM. Both form an important backdrop to this study's findings as they are part of the organisational and administrative context of the Australian mental health sector. The first part of this chapter presents literature outlining the role of neoliberalism, NPM and the governance and accountability arrangements in mental health services. The second part of the chapter presents findings from the service user, family and practitioner descriptions and experiences of this cultural frame, including the consequences and effects.

The Role of Neoliberalism and NPM

This section expands on the introduction of neoliberalism and NPM in Chapter 1, which established that NPM increased the regulation of practitioners, reduced practitioners' autonomy and increased administrators' authority within healthcare bureaucracies. Here, I examine the influence of neoliberalism and NPM on mental health organisations and practitioners' everyday work, which are well documented in the literature (Carney, 2008; Connell et al., 2009; Gray et al., 2015; Henderson, 2005; Kitchener & Thomas, 2016; McDonald, 2006; Ramon, 2008; Sawyer, 2009, 2011). This background provides the context for how contemporary mental health service cultures have evolved and are sustained.

Neoliberal economic policy emerged in the 1970s in response to a global financial crisis and rising debt in much of the Western world. A significant economic restructuring of the welfare state resulted and caused a radical change to the administration and delivery of services (Bessant et al., 2006; Sawyer, 2009). Key tenets of neoliberalism include valuing individualism, free markets, balanced governmental budgets, deregulation, and promoting choice and self-responsibility for health and wellbeing (Bessant et al., 2006; Henderson, 2005). NPM is an example of how neoliberalism is employed in health and human services. As a form of neoliberal governance, NPM resulted in governments shifting from direct service provision to reduced public sector delivery by contracting services (Bessant et al., 2020). Subsequently, the public sector's role shifted to regulating and monitoring contracted services. This shift, known as responsive regulation (Braithwaite, 2002), seeks to enhance efficiency and effectiveness by devolving risk and responsibility to contracted services (Sawyer, 2009). Evidence of this shift is exemplified in the Western Australian health system's devolved governance model, where the WA DoH is a "system manager" with six statutory Health Service Providers responsible for defined geographical areas (Mascie-Taylor & Hoddinott, 2017, p. 5).

There are several key NPM practices evident across the mental health sector: (1) a focus on improving efficiency and cost-effectiveness, (2) using business-like management discourses and practices (Gray et al., 2015; Hujala et al., 2014) and (3) the increasing establishment of quasi-markets (also referred to as internal markets). These practices have commodified care and led to a focus on costs, evident in the uptake of quasi-market approaches, also known as "a market for public goods" (Boyett & Finlay, 1995, p. 395), in which non-government and private providers compete for public service contracts. This competitive approach replaces the previous bureaucratic allocation of funding and service delivery (Bach-Mortensen & Barlow, 2021; Jordahl, 2019). Many features of quasi-markets have been incorporated into mental health service organisations, including contracting, commissioning, tendering and individualised budgets (Carey et al., 2020). In the mental health and disability sectors, quasi-market approaches (e.g., the National Disability Insurance Scheme) have been enthusiastically taken up by NGOs and private services, with some becoming multimillion-dollar organisations under the NPM regime.

The principles of NPM are evident in the NMHC's (2014a) review of mental health programs and services, advising the Commonwealth Government on service "efficiency and effectiveness" to facilitate service users' independence, economic participation and contributions (p. 9). This focus on cost efficiency, self-regulation and self-responsibility demonstrates NPM principles of economic prioritisation and neoliberal discourses of self-regulation and self-responsibility.

NPM shapes mental health practitioners' roles and responsibilities, particularly curtailing their discretion and autonomy in favour of efficiency and cost reduction. NPM also shifts the authority from dominant professional groups (e.g., psychiatrists) to administrators and managers (Liff & Andersson, 2013). This shift involves explicit and measurable performance standards, delivered through fiscal and management strategies, replacing disciplinary knowledge and expertise (Hujala et al., 2014).

Other NPM practices and mechanisms that place greater authority and influence with administrators and managers include the pervasiveness of formalised accountability mechanisms such as quality assurance, audits, risk management, service targets and key performance indicators (Sawyer, 2011). These mechanisms aim to improve efficiency, meet outcome and output targets and dictate practitioners' work and focus (Liff & Andersson, 2013; Hanley et al., 2017; Sawyer, 2011; Vranbæk & Byrkjeflot, 2016). Thus, professional legitimacy is largely contingent on compliance with key performance indicators and market priorities (Gray et al., 2015), and practitioners often find themselves caught between these imperatives, professional values and practice standards, and difficult practice environments (Stepney & Rostila, 2011). I now consider the influence of NPM on governance, accountability and funding in the mental health sector.

Governance, Accountability and Funding

The concept of governance is used ubiquitously in policy and organisations; however, different meanings and forms of governance exist (Edwards et al., 2012). Governance can be broadly understood as how societies, governments and organisations are managed and led, including how they structure and order their affairs, make decisions, exercise power and manage their relationships and accountabilities (Edwards et al., 2012).

For over 30 years, reviews of the mental health sector have reported recurring concerns about governance (Burdekin, 1993; Mascie-Taylor & Hoddinott, 2017; NMHC, 2014a, 2014b, 2014c; Productivity Commission, 2020c; RCVMHS, 2021a, 2021d). These issues centre on:

- Poor integration of and collaboration between mental health and other sectors
- Inadequate allocation of resources
- Lack of transparency within mental health services
- Lack of accountability by policy actors to service users and families.

Fragmented and complex governance arrangements have been a longstanding policy focus and are consistently raised in state and federal inquiries and policies (Australian Government, 2010; Australian Health Ministers' Conference, 2009a). Accordingly, it could be argued that these persistent concerns indicate that NPM approaches have not delivered better outcomes, greater efficiencies or improved accountability.

Like culture, the importance of accountability is consistently identified in policy, inquiries and reports; however, clear lines of accountability and responsibility are rarely articulated. Evaluation is a key part of facilitating and demonstrating service accountability, although complex governance processes are identified as creating ineffective approaches to service evaluation and outcome measurement (NMHC, 2014a, 2014b; Rosenberg, Salvador-Carulla et al., 2022). There are several challenges in evaluating the mental health service sector, including NPM-driven devolution of services to the NGO and private sectors (Grace et al., 2017), disconnected federal, state and territory funding arrangements resulting in services being contracted through multiple programs (NMHC, 2014a), and a wide range of often competing reporting requirements (NMHC, 2014a). Ultimately, these governance issues drive inefficiencies across the sector, divert resources from frontline service delivery and contribute to limited accountability for service outcomes.

In summary, mental health service delivery sits within an organisational and administrative context underpinned by various bureaucratic, socio-political and ideological factors. Although the broader shift underpinned by NPM presents challenges and contradictions for administrators and practitioners, it significantly affects service users and families. The project findings present perspectives and experiences of practitioners who face the everyday demands of service delivery and the experiences of service users and families who contend with the consequences of these systemic issues. The ways in which culture shapes and is shaped by these factors are also shown.

Competing Priorities

The theme of competing priorities between practitioners and administrators organises this section. In all settings, practitioners referred to administrators (i.e., senior management and executives) in homogenous terms, including “higher end management” (SU9), “upper management” (SU15-P), “exec” (P18), “senior administrators” (P12), “health administration” (P11), and “the bureaucracy” (P13). In this chapter, I mirror this representation by using the term *administrators* to denote those occupying executive and senior administrative positions in public, NGO and private organisations. While all participant groups identified the organisational and administrative context that mediated service delivery, this theme was most relevant for practitioners. The meanings ascribed to this cultural frame by different participant groups were similar. However, there were distinct differences in how participants enacted and experienced the culture, given their different positions and access to power and resources within mental health services.

Competing and different priorities between practitioners and administrators were central to practitioners' understandings of culture and resulted in a disconnect between practitioners' and administrators' experiences. For example, a psychiatrist spoke of "a complete divorce between health administration and service delivery" (P12), which formed a core part of "cultural problems" (P12) across the mental health sector, particularly in public services. Key features of NPM, such as efficiency, performance measures and monitoring (Hood, 1991), were apparent in practitioners' perspectives of administrators' priorities. In contrast, practitioners reported prioritising clinical issues and service provision responsive to service users' and families' needs. These differences resulted in tensions between administrators and practitioners consistent with the literature (see Garelick & Fagin, 2005; Hujala et al., 2014; Liff & Andersson, 2013). Competing priorities described by practitioners were unsurprising, given that from an NPM perspective, practitioners' priorities are inconsistent with health reform objectives based on economic rationalism and performance objectives (Newman & Lawler, 2009). One psychiatrist depicted this disparity of priorities when he stated that practitioners lost themselves and their professional identity when they took on administrative roles:

> I decided a long time ago that I wasn't going to … go for directors' jobs, even though I could've got them … they're desperate because it's … people go up there, and they just disappear, they get owned by the bureaucratic culture. (P15)

Three sub-themes were identified within the broader theme of competing priorities: economic priorities and resources, compliance and risk aversion, and practitioner alienation. The workings of NPM are highlighted throughout these themes.

Economic Priorities and Resources

Economic priorities and resources were a key area of disparity between administrators and practitioners. Practitioners reported that administrators were primarily driven by financial demands and priorities that dictated all mental health service delivery types. While practitioners expressed frustration at this fiscal prioritisation, they acknowledged that it was the administrators' responsibility to manage budgets and monitor and ensure compliance with performance targets. For example, in the following quote, a public psychiatrist described the disparity between an administrator's budget-focused priorities and his priorities of providing quality services according to clinical and professional knowledge and experience:

> There is only one accountability at the [executive director] level, to be fair to [executive director], it's money, it's budget, cutting budget … I mean I said [to senior executive] "look, what this is, is a clinical model of care, it's clinically driven, for clinical reasons and so, it will save money … cuts in budget … don't interest me, we shouldn't actually be selling that, this is about quality of care and it's not expensive and it's not going to cost any more but budget cuts … I don't want to hear that." But of course [executive director] doesn't want to hear a senior psychiatrist saying … "fuck that" which I don't really say, but as a clinical service that's what we're, that's what we need to sell [quality of care], we don't sell budget cuts, I mean we'll deal with them you know … I'm not going to support budget cuts. (P15)

This quote reflects other practitioners' perspectives regarding a culture of economic rationalisation at the expense of clinical priorities and quality service provision. While this example is situated in public mental health services, this theme was apparent in other settings. For example, a social worker in the private sector said "counting the money and keeping the money tight" (P6) was a key priority and focus of administrators, many of whom had backgrounds in accounting and business.

Within the NGO sector, similar concerns and observations were reported, with one practitioner noting how these tensions created value dilemmas for practitioners committed to person-centred approaches:

> [I] used to call it [the service] the McDonald's of mental health, there was like a menu that you could choose … and it didn't feel, I had never, as a social worker, you know I had 20 years practicing as a social worker and I'd never come across the business of an industry … and I guess it was a wakeup call to me to realise how the mental health sector is a business, there's a lot of money to be made by practitioners, or services … or pharmacotherapy companies. So, the culture is driven from that. It's driven, you know, there's commercial interest in mental health, there's money to be made. (P-SU15)

Despite variation in service contexts between private, public and NGOs, these findings suggest a common culture in which cost priorities are privileged, and practitioner expertise is devalued or is second to efficiency.

Economic prioritisation under NPM had implications for service users and families across different types of services. Practitioners in NGOs argued that contractual obligations were prioritised by administrators and often undermined practitioners' ability to meet service user and family needs. In contrast, public service practitioners emphasised a lack of funding and resources. These findings suggested that contractual and funding requirements, which were not the priority of practitioners, dictate the kind of service they could provide and limit their discretion and flexibility in responding to service users' needs.

A stark example of this was described by a practitioner in a small specialist public service. She identified significant resource issues impacting service provision, which ultimately constrained her practice and capacity to support service users' recovery. Some of these resource issues included a lack of suitable spaces for service users within the service (e.g., living areas, shared spaces, kitchen), limited adaptable community services to refer service users experiencing intersecting unmet needs, and inadequate acute beds resulting in prematurely discharging people to make room for people deemed more unwell than them. It was evident that competing priorities and objectives between administrators and practitioners compromised the integrity of the service provided:

> We get propaganda from [Area of Service] … emails saying how well we've done in accreditation, how good our um, patient care is and quality of care … And then you work in this building, and you think, have they even come here? Have they even seen…? You know we have … we have nothing to offer our patients, we're a holding cell … You know we can't offer them long-term support, we are very much a unit where … we put out little fires and help people the best we can, but that better work is probably better done somewhere else because we can't do it. In an ideal world, I think we would have some resources …But at the moment … we are keeping people only as long as the next person who needs the service. (P18)

While inadequate resourcing was emphasised consistently, participants from all groups recognised this was not a justification for poor practice. A psychiatrist stated that limited resources and time "is a reason for not doing a lot of things" (P12).

Similarly, another practitioner-service user said low morale due to working in a resource-scarce system created a default position that absolved services and practitioners of responsibility. Therefore, being under-resourced was a normalised element of culture that justified existing and sometimes poor practices:

> I think that mental health services keep on going back to that. And they definitely are under-resourced, but the more that we say we're under-resourced, the more it sits in the culture, you know "oh, we're under-resourced" or "oh, that's okay, we don't have to do that because we're under-resourced". (P-SU15)

The framing of resource issues as part of culture illustrates how the organisational and administrative context shapes service cultures. Economic priorities and resourcing issues coexisted with compliance-driven and risk-averse environments which I now discuss.

Compliance and Risk Aversion

In their accounts of culture, practitioners emphasised a compliance-driven and risk-averse environment characterised by pressure to comply with performance measures and targets and avoid and mitigate all risks. As a result, rather than services being driven by service user needs, compliance with standardised measures and performance indicators determined and restricted practice: "It's tick box … increasing tick box mentality … it's audits, it's all that kind of stuff and not a great deal of attention being paid to quality of care" (P15). These organisational processes and practices such as risk assessments, auditing and inspection can be regarded as cultural artefacts of compliance-driven and risk-averse cultures (Schein, 1992, 2010).

Practitioners were adversely impacted by scrutinising and risk-averse environments in which administrators' priorities created top-down pressure. This finding supports a previous study which found "increased bureaucratic surveillance, centralised control and managerial accountability through measured performance targets and indicators" were pervasive in acute and community mental health nurses' experiences (Newman & Lawler, 2009, p. 430). The experiences of practitioners in the present study similarly reflect an NPM focus on explicit and measurable standards of performance via a range of hierarchical management structures (Hujala et al., 2014) described as a "bureaucratic culture" (P15). Another participant stated:

> It was quite hierarchical and controlling, too, as a worker. I was the most experienced worker there um and it was quite sort of admin, funding, business

> model, the way of working … I would argue too, that the compliance of workers is important to management because they're … of the risk-averse agenda, um you know, they don't want people to die or things to go wrong so they seem to put a lot more rules in. Like when some tragedy has happened it seems to be a response of, training the workers, removing a problematic worker … um putting more rules in um, and more administrative requirements. (P-SU15)

This quote and similar experiences shared by other participants suggest that the culture of compliance and risk aversion is strengthened in response to critical incidents such as service user deaths or injuries. Similarly, other practitioners described that compliance with organisational priorities was a cultural expectation, which one participant identified as rules: "it's more like this is the rule, this is what I have to follow, so that's what I have to do … so it's not that I value that … it's that there's no choice" (P9).

Risk-averse environments heightened practitioners' concerns that they would be blamed for adverse events and were central to their experiences of culture. In addition to the increased regulation of practitioners via NPM, the compliance-driven environment produced reactive rather than proactive practices. Practitioner accounts identified a focus on individual practitioners being at fault rather than considering the broader systemic issues contributing to incidents or issues. This finding is unpacked further in Chapter 6, as it is characteristic of a culture of blame (Khatri et al., 2009; Wand, 2017).

The literature identifies how a narrow focus on risk has implications for practitioners and service users. Preoccupation with risk promotes defensive practices that emphasise risk minimisation; a culture of blame is reinforced through a conformist and controlling environment (D. Green, 2007; Wand, 2017). In this study, practitioners noted how this feature of culture resulted in risk avoidant practices and lowered staff morale:

> And that risk management approach, um with blame attached to it, is another factor I think in making staff feel negative about their work. The positive things that they do don't feel rewarded and um they're on the lookout to not making a mistake, which is a very um … what's the word I'm looking for? It's very, well it's a counterproductive way of working in any kind of human services. Certainly, in mental health when you want a particular culture of positivity and uh, willingness to make extra efforts. (P12)

The pervasive emphasis on compliance did not appear to engender an open, transparent and honest service culture, which is considered a key element of safety and quality culture in national, state and territory policies (e.g., the *National Safety and Quality Health Service Standards: User Guide for Health Services Providing Care For People With Mental Health Issues* [ACSQHC, 2018]).

The compliance-driven and risk-averse environment correlated with an increase in standardisation and procedural processes imposed by administrators on practitioners. Key examples of such processes included assessments, care planning and outcome measurements, all of which reflect NPM principles of maximising efficiency through mitigating risk to avoid litigation, and conserving resources. Most practitioners rejected the view that increasing systematisation of the mental health sector resulted in increased efficiency and safety. Their position is echoed by recent research that outlined the limits of suicide risk assessment (Large et al., 2011; Saab et al., 2021; Sommers-Flanagan & Shaw, 2017). Instead, the importance of having time to build rapport and relationships with service users and families was emphasised, countering the notion that documentation and assessments provided an accurate indication of risk or adequate response to service users:

> Yeah, it's easy to have flow charts, checklists and all those kind of things which kind of have a, there's kind of a clockwork model notion about that. If we just have enough questions to ask and enough tick boxes then good things shall flow from that … and uh, it's not true, it's just a complete falsity. (P17)

These compliance requirements were considered priorities by administrators, but practitioners viewed them as time-consuming, prescriptive tasks and unreflective of the complexity of service user and family experiences.

These findings suggest that assessment is not simply a feature of practice that aims to understand service users' experiences and needs but has been co-opted by administrators as a process intended to reduce risk and create standardisation. Additionally, a preoccupation with risk assessments and procedures ensured responsibility for adverse events sat with individual practitioners who conducted the risk assessment, promoting a blaming culture and defensive, risk-averse practices. Moth (2020) in the UK and Sawyer (2009) in Australia similarly found that community mental health practitioners in NGOs and public services faced a growing burden to comply with various administrative tasks, which reduced their time with service users and families, ultimately undermining the quality of service.

Service users and families were aware of the impacts of compliance and risk-averse cultures on practitioners. One family member spoke about how risk-averse cultures restricted practitioners and created fear-driven practices, emphasising that practitioner-blaming should be avoided. Her experiences and observations of the "the system" (F3) were that practitioners were not satisfied or supported in their work.

Practitioner Alienation

A key feature of NPM is the shift of influence, power and authority from practitioners to administrators. Administrators' priorities and authority are privileged over practitioners within a hierarchical leadership structure (Hujala et al., 2014). Practitioners spoke of this in relation to their lack of authority and exclusion from decision-making, which highlighted the disparity between priorities. Despite practitioners holding legislative and/or decision-making authority in clinical and care decisions about service users and families, they felt that their exclusion from organisational decision-making, such as service delivery, design, funding, policy and procedures, significantly decreased their autonomy and ability to exercise discretion.

Karl Marx's (1932/1974) concept of work alienation is relevant here. Whereas Marx focused on objective work alienation or physical separation from the means of production, the concept has been adapted to focus on subjective work alienation, whereby workers *feel* alienated from their work (Blauner, 1964). Practitioners in this study described a subjective alienation in which they felt unable to control their immediate work processes, resulting in feelings of powerlessness. Top-down administrative demands and exclusion from organisational decision-making resulted in practitioner alienation from their practice.

Despite this exclusion from organisational decision-making, practitioners were held responsible for and required to manage the consequences of decisions made by administrators and governments. Consequently, practitioners reported a collective experience of feeling demoralised and undervalued. For example, a psychiatrist spoke about administrators making changes to the criteria and funding for a community-supported living program without input from practitioners:

> They [administrators] hadn't involved clinicians in deciding [how the program should run or if changes were appropriate] and when it came to the crunch it was back to clinical services, and I just think it's almost, it's a metaphor for what happens. The shit hits the fan, it's clinical services, and so they become defensive and projective

> and … yeah, you're wanting the culture to change … when the shit hits the fan, they [psychiatrists] have to write the reports, they have to do the thing, names have to be on it you know, that sort of stuff. (P15)

Administrators' decisions about the nature, shape and tone of services were described by practitioners as disconnected from the reality of frontline service provision. This disconnect created difficult workplace environments where practitioners felt alienated from their work and compelled to operate within the constraints and compliance requirements of service models and resources. Consequently, a culture of distrust between administrators and practitioners was notable:

> What I think has happened is that the health administrations and governments have become so utterly preoccupied with containing health budgets, that they literally believe that they can't afford to listen to service providers or consumers about anything that's going to cost money. And they've come to the position where they think that they [administrators] know best, and they're going to decide how services will be provided. [Administrators believe that] to listen to service providers is dangerous and service providers are the enemy, who just don't get below the budget … [so administrators say] "we have to stop them … And we'll do that by telling them [practitioners] what services they can have and they'll operate in those constraints". (P12)

Some service users also shared these reflections. A service user (SU8), who had also been a consumer representative and privy to organisational governance meetings, noted the influence of administrators over service delivery and the exclusion of practitioners from decision-making:

> For the service providers you know, you imagine you're down on the lower end there and you've got these high ranking … I worked with some of these managers … I used to sit on committees. I'd say to them you know, "you're telling me you're arranging to make policy but have you talked to the staff, have you consulted with the staff on the ground floor?" … [They'd say] "Oh … well no this is our policy you know this is [it]". But you know, until they get rid of their little hierarchies … and really get down on the ground, go and have a look to see what the staff are having to put up with. You know nothing will change … money's not the answer by the way, ah it's, it's about reorganising things and attitudinal change first. (SU8)

Practitioner alienation contributed to a culture of blame in public services and NGOs. For example, a practitioner spoke of constant change in the NGO she worked. According to her, there was a cultural expectation among practitioners:

> If anyone's struggling to cope with change it's their problem. It's not the fact that this change has been constant and it's created instability and uncertainty … it's you know, that person is unable to cope with change, so they're the problem. (P9)

Practitioners articulated cultures where questions about, or resistance to, change would not be respected or heard: "[there's a] whole culture around … people are not able to speak and not able to say that these changes are not helpful" (P9). Thus, subjective work alienation contributed to workforce cultures where practitioners felt undervalued and low morale was common.

This section has identified disparate priorities between practitioners and administrators as a key feature of mental health service cultures. So, too, are accountability and responsibility, the second key theme in this cultural frame.

Accountability and Responsibility

Accountability and responsibility were consistently identified as central to the organisational and administrative cultural frame. Participants in all groups identified a perceived lack of accountability and responsibility by administrators for service quality. *Accountability* in this project is understood broadly as the processes by which an individual or group (i.e., an organisation) justify and take responsibility for their activities and explain their actions (Emmanuel & Emanuel, 1996). *Responsibility* is the process of carrying out delegated authority, tasks and functions expected by an employer, professional body or court of law (Vranbæk & Byrkjeflot, 2016). The influence of NPM increased the use of and focus on explicit accountability measures, particularly concerning efficiency and effectiveness (Lewis et al., 2014). Administrative accountability has led to a proliferation of performance measures aiming to gauge organisations' and practitioners' inputs, outputs and outcomes (Power, 1997). Thus, practitioner autonomy is increasingly challenged by attempts to superimpose administrative or market-based accountability, with performance, outputs and efficiency now omnipresent (Vranbæk & Byrkjeflot, 2016).

Accountability and responsibility, or lack thereof, were perceived and experienced differently by the participant groups. However, similarities included limited or dismissive responses from the individual or group they sought accountability from, and perceived complacency and acceptance of the existing conditions of mental health services. Participants used responsibility and accountability interchangeably in interviews, illustrating that they are closely related concepts. To reflect participant views, I use both concepts when presenting the findings on accountability and responsibility, beginning with practitioner experiences, followed by service user and family experiences.

Practitioner Experiences of Accountability and Responsibility

Practitioners identified that a key feature of service cultures was administrators' lack of accountability and responsibility. Some practitioners considered this the result of confusing and complex governance arrangements and poor service coordination. Consequently, clear lines of accountability and agreed expectations about funding, decision-making and responsibilities were absent:

> At the moment, we've got the Chief Psychiatrist, we've got the Commissioner, we've got … there's a Mental Health Director, for some of that, and I think there's a fourth one as well. And when you ring them up and say, "Who's responsible for this?" they'll say, "That's not me, it's them", and they'll say, "No, it's not me, it's them", and they'll say, "No, it's them in there". So no one will take responsibility. (P13)

Practitioners felt administrators' lack of transparency and accountability, particularly in addressing systemic issues such as resourcing, service pathways and coordination, were key examples of a culture of acceptance and complacency towards existing service conditions. For example, one psychiatrist (P13) spoke of an incident with significant ramifications for the service user and staff involved. Despite contacting the head of mental health services in the state each year on the anniversary of the incident, no changes were made to address the problems leading to the incident. This lack of action was considered demonstrative of a culture of complacency:

> We thought that might be the incident which would change mental health services … nothing was done about that … I complained about that, time and time again, every year, I wrote to the mental health person responsible, and said "nothing's changed, we haven't forgotten it"… And still … when the anniversary comes around, it's, it's awful … So when a big incident like that happens, and shit happens, you just hope there'd be some constructive change from it. But there doesn't seem to be. There's everyone saying, "It wasn't our fault", instead of, "Okay something bad has

> happened, how can we stop it from happening in the future?" And I blame it on too many committees. There’s not enough people who’ve got the knowledge to say, "this is what’s happening,"… If I could have been [given] the leeway, to say, "Right, I’m taking responsibility for this, give me the budget, I’ll use it as I see fit. If I get it wrong, sack me, but give me leeway”. And no one’s given leeway, so no one can make any … ballsy moves. (P13)

This practitioner explained how administrators’ priorities and imperatives overrode practitioner knowledge. Additionally, the practitioner’s experiences did not appear to be a priority of administrators. These findings reflected the influence of NPM, where authority lies with administrators and their priorities take precedence. This practitioner and many others in the study firmly believed that their experiences and knowledge of service delivery should be acted upon.

A focus on upward accountability involving a hierarchical chain of command management (Mulgan, 2000) was evident in practitioner accounts. Thus, administrators appeared accountable to government, funders and regulatory requirements or obligations but were not directly accountable to practitioners. For example, when practitioners attempted to raise systemic issues or question decisions, they were ignored by administrators who were perceived to be disinterested in practice concerns, or told they were “too busy” (P15). While practitioners acknowledged that administrators may have had limited power within a larger system, they believed administrators accepted, without critique, the current conditions of mental health services. For practitioners, service cultures were marked by administrators’ limited accountability. While new policies or procedures were frequently implemented, little meaningful change was viewed as an accepted part of service cultures and contributed to a sense of frustration and helplessness among practitioners.

Service User and Family Experiences of Responsibility and Accountability

Service users and families also voiced frustration at what they perceived as a lack of responsibility and accountability in the mental health sector by both administrators and practitioners—illustrated by a lack of improvement in services over time. This lack of accountability was viewed as a central feature of cultures created by the siloed nature of services. Siloed services were characterised by a lack of integration between mental health services and between mental health and other human service sectors, resulting in each service operating according to its own priorities and accountability mechanism. As a result, broader sector responsibility and accountability appeared to dissipate. Silos were also described as symptoms of governance and funding structures that did not promote collaboration or responsibility. As one family member explained: “You can’t have accountability in silos. It doesn’t work” (F4).

Service users who experienced multiple unmet needs, such as homelessness and mental distress, spoke of an enduring ignorance of the intersecting and complex struggles they faced. When services operated in silos, they provided an inadequate service that failed to meet the intersecting unmet needs of the person. This situation resulted in service users engaging with multiple services rather than being treated as a whole person, or people were excluded from services as they did not fit narrow eligibility criteria. Restrictive eligibility criteria are a key feature of service contracts that promote NPM-related efficiency (Hamilton, 2010). A service user linked her experience of service exclusion and unmet needs to a lack of accountability:

> But who is it … in government, whether it be federal or state government, is actually gonna step up and take responsibility for people with mental health problems? Especially when they cross into housing and physical illness. There’s no one neat parcel, people don’t come in a neat parcel. (SU6)

Service users spoke of submitting formal complaints, and either did not receive a response or were not informed of the complaint outcome. A service user-practitioner spoke of her experience in an NGO where feedback from service users was dismissed, and the service user was constructed as problematic. This example suggests a deeply embedded culture of limited accountability to service users at the administrative level of the NGO.

A concept relevant to the findings of this study is parallel processes, which Bloom and Farragher (2011) used to understand complex systems. They reported that conflict or tension that occurs in one area, for example, between administrators and practitioners, was often enacted elsewhere (e.g., in interactions between practitioners and service users). A parallel process was evident in service users’ accounts which highlighted a lack of engagement by practitioners with their concerns; similarly, practitioners spoke of administrators dismissing their concerns. For instance, despite providing feedback that a service was not meeting their needs, such as the impacts of trauma, abuse or housing support, service users reported evasive responses from practitioners.

Service users also acknowledged that the systemic issues encountered by practitioners, due to the resource-scarce system, limited their capacity to enact change. Practitioners' limited accountability to service users may reflect a distancing or detachment approach to coping with the cultures of mental health services and systemic issues. A service user (SU16) illustrated how a culture of limited accountability operated, characterised by apathy and inaction across all parts of the sector:

> The person with mental health challenges is explaining these often systemic abuse issues, and the professionals are just like "oh well, yeah okay". They hear what's happening, but it's as if maybe they just don't have the time or they don't have the capacity to … help bridge the gaps. But I understand … they're hearing from numerous people every day, maybe they'll write-up the report, and it's like … the same with the canary in the coal mine down there with the miners, the canaries were dying to then save the miners. But a lot of people with mental health issues are raising so many fucking systemic issues, and it's as if the service providers … they're hearing, but they're not working with other sectors. I think I kind of look at it, what would it be like if we'd all had to work better together, to address these canary in the coal mine issues? (SU16)

These findings highlight key issues shaping the cultures of services. First, the complex and siloed nature of services and governance structures means confusion and little transparency or clarity regarding roles and responsibilities. Consequently, there is limited downward accountability experienced by practitioners, service users and families. Second, there is an absence of what Russo (2019) refers to as a "praxis of accountability" in which shedding light on critical service issues is encouraged, followed by working collectively to take action (p. 19). Russo argues that practices of accountability for action, coupled with recognition of one's complicity in systemic issues, can create spaces for change and transformation. Participants' experiences and descriptions of culture and accountability suggest that the current cultural conditions, created by the organisational and administrative context, do not promote a praxis of accountability. The mental health service cultures appear to be supported by governance structures and produced and reproduced by administrators and practitioners. Therefore, there is limited space and possibility for hearing concerns and acting to create widespread change. The organisational and administrative cultural frame has consequences for practitioners, service users and families.

Consequences

The organisational and administrative cultural frame directly impacts practitioners, service users and families at individual and organisational levels. Three themes outlining these consequences are presented: an overwhelmed and overloaded sector, workforce issues and a silencing culture.

An Overwhelmed and Overloaded Service Sector

The first key consequence of the organisational and administrative context was an overwhelmed and overloaded service sector. The organisational and administrative context of mental health services was characterised by economic rationalisation, efficiency, risk-averse cultures and governance and funding structures that promote silos. This context created dysfunction and forced services and practitioners to operate at a level of acuity and reactivity; as a peer worker explained:

> I've watched these poor social workers, just absolutely stressed out of their brain, trying to … They're having to turn people away, they get referrals but they can't possibly see everybody that gets referred to them. Even though they've got maybe two full-time positions on one team, it's still not enough, it's not enough. So, under the pump all the time. (P2)

Evident in this and other participants' accounts was an intensified work environment in which practitioners have increased workloads and are required to increase the pace of their work to reach performance outcomes and measures—a direct result of NPM-driven reforms in the health and human service sectors (Moth, 2020; Willis, 2005).

The overwhelmed and overloaded nature of services meant that many service users, particularly those experiencing multiple unmet needs, remained in acute services. For example, a shortage of community services and narrow eligibility criteria were considered key consequences of the organisational and administrative cultural frame. Thus, practitioners had limited opportunity to provide long-term support to address psychosocial and environmental issues. Participants' accounts identified a revolving door cycle of short stays in the acute service sector, or for some, prison, where there was minimal support for distress:

> You know we're putting very vulnerable people altogether because we've only got [so many] beds, we don't have the capacity to have a women's only ward … we have

> a rehab ward, the less acute ward, but we don't have training that we can offer … we're so limited in what we can offer people. We had [a step down] ward for a period of time. [The] exec came in, and said "we need to pass accreditation, [the ward] isn't purpose built", so … it's resources, it's like um, you know everyone talks about patient care, and patient goals and you know being patient-focused, but at the end of the day it's money and what the service only offers within that budget. And a lot of stuff that would benefit patients doesn't happen. (P18)

Participants described the revolving door experience as normalised and accepted because it is a longstanding and complex problem within mental health services. Service cultures were characterised by limited hope about the possibility of change and improvement. The RCVMHS (2021d) similarly attributed the revolving door experience to an inadequately resourced system where "people are patched up and sent home too early" (p. 105). While revolving door experiences are a key consequence of the organisational and administrative culture frame, they are also understood as a consequence of the historical cultural frame (see Chapter 5), highlighting the multifaceted and systemic nature of the issue.

Another key consequence of the organisational and administrative context is the lack of adequately resourced community-based services; this contributed to the revolving door effect. Under-resourcing was evidenced by service users being discharged from public community-based services prematurely with no formal support system, which negated choice or self-determination—key principles of recovery-oriented and person-centred services. Additionally, service users experienced pressure to often agree to premature discharge from community-based public services, and practitioners experienced pressure to discharge service users as soon as possible. This intensified and overloaded environment of services was a key consequence of economic rationalisation as part of NPM and increased performance measures (e.g., bed flow or discharge):

> Community services were still locus of optimism … 20–25 years ago um when the structural reform process was getting going … The community model of care used to be based on the notion of keeping people well, and that the hospital admission in a way of deterioration of health indicated that … there's a problem in that person's care … but I think in the last … perhaps 10 years um there's been a containment of budgets and what I've seen is people in community services, in clinical services, is a focus on acute care. So, triage, only take on the most unwell … If you have people

> who are now considered stable, discharge them … um you gotta reduce your caseload all the time. And reducing your caseload means you do acute care, and I think that's being driven by budget reasons. (P12)

Prevention and early intervention delivered in community mental health services was a central focus of mental health policy in the 1990s and has remained an important policy aspiration (Rosen, 2006; Rosenberg & Harvey, 2021). However, many participants emphasised that community services operated at a level of acuity that suggests the policy vision for robust community support remains aspirational.

The overloaded and overwhelmed nature of the service sector meant that the adoption of new practices, such as recovery, was limited. Participants stated that the limited time practitioners had with service users was reduced to the core activities and the organisation's priorities (e.g., assessment, medication and general monitoring of symptoms). This experience is exemplified by a service user:

> Going to see someone [psychiatrist] in the public system [compared to private], it's even worse, the block of time is even shorter, it's solely talking about medication, you are frustrated again, like being in [public inpatient service] and wanting to see a social worker. Again, you would, you've got only a fraction of time to get access to these things … and it's not their … fault but they don't fully read [your file] … you see different people all the time … so you go in and see one guy and half of the time, the small block of time he's reading your file. Cos he's not up to speed with you, so he's got to get up to speed with your history so he's got … a manila folder that's about 200 mm high, which mine is, flicking through it, flicking through it, trying to get like, to help you … he doesn't have time to read it all before he sees you so in that 10 minutes, he's trying to like, do you a favour to know where you are at, but he has to skim through, go directly to the medication side because that's his responsibility. So he has to end the 10-minute block of … keeping you maintained and from that small fraction of time, all he sees is frustration, angst, anger, so he prescribes the normal medication and then "how do you feel about something that's going to address your anxiety?" (SU11)

Such service responses did not promote dignity or support service users to live a full and meaningful life in the community. Systemic pressures created and maintained by the organisational and administrative context resulted in poor quality services. The frustration expressed by SU11 was common and led to a sense of helplessness, as mental health services were the only source of support for some service users and families. Practitioners were aware of these inadequacies and pressures, often feeling despondent about possible ways forward within existing service contexts.

A range of consequences have been identified in this section, including services across the sector operating at a high level of acuity and reactivity; service users' and families' revolving door experiences; and practice reduced to core activities such as assessment, medication and monitoring, which failed to support recovery or person-centred practices. These consequences present a stark picture of a sector that creates the cultural conditions for service users and families to feel helpless and a disillusioned workforce. These conditions are the antithesis of a recovery-oriented culture of hope and possibility.

Workforce Issues

Workforce issues were identified as the second consequence of the organisational and administrative context. Key issues included: surviving in the system, burnout and lack of safety and support. As discussed in relation to their experiences of alienation, practitioners commonly felt disempowered, undervalued and restricted by untenable demands and pressures. Consequently, to 'survive' working in the sector and keep one's job, practitioners said they had to ignore systemic issues, "toughen up" (P-SU15) and comply with their organisation's priorities. This point was echoed by a peer worker, highlighting the precarity of peer worker roles in the government sector:

> It's a very frustrating system, the word I will use is broken; I know that gets thrown around a lot. But, it is. I see the constraints that staff are under, myself included, which is part of the reason I've burnt out in one of my jobs. There's no job security. And at the end of the day, it gets to the point, people don't feel valued in their roles so they just want to get in and get out, and do the job. There's a lot of that … I think people get a bit stuck, just kind of get a bit over it, if that makes sense, and therefore, care that people are receiving suffers, because of that stuff. I feel deeply sad about the way people get treated and again, I feel for clinicians because they're not given the skills or resources to deal with things in any other way, so they have to fit in with the system. (P3)

A workforce culture in which burnout was accepted and normalised was common. While burnout is critiqued for obscuring systemic and organisational issues and blaming service users for practitioners' experiences of harm (Reynolds, 2011), I use the term as participants reported it to describe the impacts of their workplace's administrative and organisational context, feeling constrained and constantly facing systemic resourcing problems. Given that previous studies have identified individual and organisational implications of burnout, these experiences are a concerning consequence of the organisational and administrative cultural frame. At an individual level, burnout has been associated with impacts on cognition, including the ability to concentrate (Van Der Linden et al., 2005), emotional exhaustion, reduced physical wellbeing (Bakker et al., 2005) and negative feelings about service users (Holmqvist & Jeanneau, 2006). At an organisational level, a contagion effect is reported where burnout affects other workers' morale, resulting in high turnover and poor retention (Bakker et al., 2005). The present study's findings and previous research suggest that workforce burnout is a key consequence of the organisational and administrative context. Workforce burnout shapes the culture of mental health services, ultimately impacting the quality of services.

Peer workers, social workers and psychiatrists noted inadequate support for practitioners and a lack of safe places to report and reflect on their responses to systemic problems:

> People [service users] are really going through a crisis and something very painful and when you work around that you know, you need things as a worker and I guess what I'm seeing is workers are not getting what they need at work. And you know if that, if they do get supervision it's often like management supervision, really you know it's not even a safe context for them to say "Hey I found this really confronting or distressing". (P-SU15)

Here, the practitioner-service user refers to the managerial and administrative function of supervision focused on policies, compliance and monitoring practitioners' workload and performance (Davis, 2010; Egan, 2012). Other key functions of clinical supervision for health practitioners include education and support, focusing on reflective practice (Egan et al., 2017; Pearce et al., 2013). Education in supervision focuses on strengthening knowledge, and support involves workers having a trusting and safe space to discuss the impacts of their work (Egan et al., 2017; Pearce et al., 2013). Practitioners in this research highlighted a lack of safe and trusting spaces to discuss and reflect on the impacts of their work, leaving them feeling unsupported and emotionally unsafe. While many practitioners attempted to implement their own safeguards (e.g., connecting and debriefing with colleagues) from these experiences, they recognised that such unsupportive work environments impacted practice with service users and families. Significant to these findings, the literature also emphasises that mental health services cannot be safe for service users and families if they are not safe for and supportive of practitioners (Bloom, 2006).

Silencing Culture

The third key consequence of the organisational and administrative context is a silencing culture experienced by all participants. For many service users and families, a silencing culture meant they chose not to speak up or resist out of fear that they would lose the services they received. Several practitioners spoke of a fear of speaking out due to the overall culture and tacit knowledge among practitioners that whistleblowing resulted in consequences for the individual worker. This fear led staff to accept problematic workplace environments and work within existing constraints; practitioners were encouraged to 'fit into the system' and 'toughen up'. Consequently, a culture of silencing developed and was maintained as practitioners felt compelled to tolerate systemic problems and intensified environments. Two public service practitioners spoke of this silencing, emphasising detrimental implications for whistleblowers:

> You know we're in a bit of a difficult position because we can't really … do much about it. We've just got to work with what we've got here, because of course we have to be careful about talking out about it too because you know, it's something that is, it's a bit risky for us because you know like, the whistleblowers kind of always (P19) … [are an] easy target. (P18)

A culture of silencing operated discursively and consequently undermined and limited practitioners' sense of agency and capacity to enact change in their practice or organisation.

The presence of NPM is also illustrated by how practitioners are subjected to and controlled by administrative and management demands for predictability and conformity for efficiency (Alvesson, 2002; Kärreman et al., 2004). This finding was echoed by service users and families who expressed an awareness that practitioners were compelled to negotiate and adapt to their workplace environment, which discouraged practitioners from speaking out about the inadequacies of the current service sector:

> I feel that they're [practitioners are] scared that if they break away from the system they're going to get into trouble and they might lose their job. It seems to be safer to

> keep doing what they are doing because there is no support within the system to change. (F3)

These findings suggest that the organisational and administrative cultural frame produces silencing, a collective-level phenomenon where organisational dynamics cause widespread withholding of information about employee experiences and views (Morrison & Milliken, 2000). This silencing is enacted in explicit and implicit ways in the parallel processes of administrators and governing bodies responding to practitioners with limited accountability and responsibility while service users and families experience a similar response from practitioners. There is a culture of limited downward accountability demonstrated and experienced by administrators to practitioners, and from practitioners to service users and families. This situation reflects an inherent paradox and tension for practitioners who know the reality or witness the issues at play but “dare not speak that truth” (Morrison & Milliken, 2000, p. 67).

The organisational and administrative context creates a culture that silences mental health practitioners, and service users and families who have no choice but to ‘take what they can get’ from services. This silencing is sustained and shaped by the power asymmetries between administrators and practitioners, and practitioners and service users and families. Consequently, the existing state of affairs is preserved.

Conclusion

This chapter demonstrated that the organisational and administrative context is influenced by neoliberalism and NPM in a wide variety of ways—this cultural frame shaped and sustained the cultures of mental health services and mediated reform aspirations. Competing priorities between practitioners and administrators were the first theme discussed. While Administrators prioritised efficiency and compliance with funding contracts, practitioners’ priorities consisted of clinical and service delivery issues. Administrators were portrayed as impersonal, unaccountable and disconnected from practitioners’ everyday working realities. Practitioners felt caught between the broader organisational priorities, centred on economic rationalism, compliance measures, key performance indicators (KPIs) and risk aversion, and service users’ and families’ needs. While practitioners were alienated from their practice and excluded from decision-making, they were expected to operationalise organisational directives. A parallel process was evident in minimal accountability and responsibility from administrators to practitioners, and from practitioners to service users and families which resulted in a culture of complacency. This culture was characterised by a perceived acceptance of the existing conditions of mental health services, which limited meaningful and sustained change.

The consequences of this cultural frame were traced in participants' accounts and included an overwhelmed and overloaded service sector, workforce issues and a silencing culture experienced by all participant groups. Each of these consequences impacted service quality, with many service users and families experiencing a revolving door cycle, exclusion from services, or time-limited services focused on assessment, medication and symptom management. The organisational and administrative context negated the development of recovery-oriented and person-centred service delivery. Practitioners felt a sense of impotence in their capacity to improve services and undervalued by administrators and their broader organisations. In considering the overarching question of this study, the organisational and administrative cultural frame identified key contexts which act as barriers to reform being realised. The next chapter presents the second cultural frame, the historical context of mental health services.

Chapter 5: Historical Cultural Frame

This chapter presents the second overarching cultural frame, histories of psychiatry and mental health services, including how this historical legacy shapes and informs current service cultures. To understand participants' experiences of old culture, I begin by outlining the history of psychiatry and responses to mental distress. The findings are presented in two parts: first, how participants described and experienced this cultural frame and second, the consequences and effects for service users, families and practitioners.

Histories of Psychiatry and Responses to Mental Distress

In Chapter 1, I established how psychiatry occupies a privileged medical viewpoint in policy, law and service delivery (Deacon, 2013; Pilgrim & Rogers, 2009; Wallcraft, 2010). Here, I explore the historical context to understand how and why psychiatry and its practices became and continue to be dominant. There are multiple histories of psychiatry and responses to madness. Johnstone (2000) and Newnes (2008) suggest there are dominant and competing accounts of psychiatric practices and social or cultural responses to mental distress. The dominant narrative positions psychiatry's steady progress from pre-Enlightenment, when people deemed Mad were neglected or tortured for the public's amusement, to present-day claims of scientific knowledge (Garton, 2003; Johnstone, 2000). For example, during the nineteenth century, views of madness shifted from focusing on religious and supernatural forces to the medical legitimisation of psychiatric treatment and practice (Bracken et al., 2012; Johnstone, 2000). Through the discovery and widespread use of psychotropic drugs from the 1950s, the number of patients in asylums, mental institutions and psychiatric hospitals decreased, shifting to community-based care (Johnstone, 2000; Shorter, 1997).

These dominant accounts often fail to include the voices of those deemed Mad, who have fought hard for change and opposed forced treatment and segregation (Chamberlin, 1990). Attempts to change the response to people deemed Mad commenced in the late 1800s (Frese & Davis, 1997) and gained momentum in the 1970s when the c/s/x movement contributed significantly to reconfiguring understandings about madness and rationality "via an avenue of engaged, radical and at times risky politics" (E. Coleman, 2008, p. 341). Despite the c/s/x movement being integral to reforms, including shifts from asylums to community-based alternatives (Chamberlin, 1990; E. Coleman, 2008; Epstein, 2013), c/s/x have been denied testimonial justice (Fricker, 2007). In particular, c/s/x accounts and explanations of distress were and often continue to be dismissed and considered unreliable or illegitimate from the viewpoint of psychiatry and mental health services.

Alternative historical accounts of psychiatry exist and represent a critical stance towards the discipline, and the treatment of people deemed Mad. The following discussion outlines these dominant accounts while subjecting them to critique and considering alternative accounts and positions. Acknowledging and highlighting the duality and multiplicity of histories is vital, as it provides context to current contestations, understandings of mental distress and the configuration of mental health services. Such an approach also creates a more nuanced understanding of mental health cultures. In line with the critical theoretical orientation underpinning this project and postmodern ideas, this reading and representation of history pays attention to power and subjugated knowledges and recognises multiple truths. This overview traces the history from the pre-Enlightenment period to the ascendancy of the medical authority of psychiatry (Harper & Speed, 2012; Read, 2013; RCVMHS, 2021a).

Pre-Enlightenment and the Asylum Era

Psychiatry emerged during colonialism and slavery (Gordon et al., 2019; Medlock et al., 2016) and is inherently Eurocentric (C. King, 2016). Early Western conceptions of madness are grounded in religious explanations such as divine intervention, machinations of the devil and supernatural forces (Bainbridge, 1999; Fawcett, 2012). The Enlightenment period saw religious explanations replaced by scientific inquiry and rationalism (Fawcett, 2012). Philosophical commitments to truth, rationality and progress underpinned the assumption that the scientific method offered a way to understand people and the world. As a result, scientific explanations of madness emerged based on assumed objectivity and ‘expert’ knowledge (Fawcett, 2012).

People deemed Mad were segregated from the rest of society, often in asylums or madhouses (Wallcraft, 2010), for the perceived safety of society (Porter, 1987). Private entities established madhouses in the seventeenth century, and charitable volunteer-run asylums emerged in the eighteenth century (Johnstone, 2000; Porter, 2002). The rise of Western industrialism in the nineteenth century was accompanied by an increase in institutional structures to preserve order and control in an evolving capitalist society

(Bainbridge, 1999; Bracken & Thomas, 2005). This period is characterised by discipline, control, surveillance and the segregation of Mad peoples into asylums, 'social deviants' into prisons, and children into schools (Bainbridge, 1999; Burdekin, 1993; Porter, 1987). Asylums rapidly became overcrowded, reflecting the growing intolerance of 'deviance', social misfits and outcasts (Porter, 1987).

Treatments Within the Asylum

During the asylum era, psychiatrists tested numerous treatments and cures for madness (Shorter, 1997). Physical treatments included immersion in cold water, tranquillising chairs, insulin coma therapy, electroconvulsive therapy (the 1930s to today) and psychosurgery (Johnstone, 2000; Read & Sanders, 2010; Shorter, 1997). Women were subject to invasive gynaecological treatments for female-specific 'conditions', which are now considered to reflect the prevailing views on women's place in society (Newnes, 2008). The introduction of drug treatments reinforced the scientific method yet signalled another shift in the conceptualisation of, and response to, madness (Dorozenko & Martin, 2017; Newnes, 2008). Psychotropic drug treatments dominated from the 1950s and included neuroleptics and major tranquillisers, antidepressants, mood stabilisers, barbiturates and benzodiazepines (Busfield, 2013; Johnstone, 2000; Shorter, 1997). The early use of these drugs assisted staff in pacifying disturbed patients in crowded institutions (Dorozenko & Martin, 2017; Newnes, 2008). For example, chlorpromazine made patients more compliant (Elkes & Elkes, 1954, p. 563, as cited in Moncrieff, 2013, p. 33). Concurrently, pharmaceutical companies marketed neuroleptics, emphasising their potential efficacy on the hypothesised chemical imbalances that caused brain dysfunction (Newnes, 2008, p. 13).

Challenges to Psychiatry

Civil rights movements emerged from the 1950s, challenging repressive, authoritarian institutions. A proliferation of counterculture theories emerged from academics like Michel Foucault, Erving Goffman and Thomas Scheff and psychiatrists such as Ronald Laing and Thomas Szasz (E. Coleman, 2008; Porter, 2002; Shorter, 1997). Commonly, their ideas were referred to as 'anti-psychiatry', given their critique of psychiatric institutions and schemes of classification (E. Coleman, 2008). Their central arguments challenged the biological premise of mental illness, asserting that mental distress is a human response to living in an irrational world. Mental distress was viewed as mirroring living conditions and not purely a biomedical phenomenon (Read & Sanders, 2010). Sociologist

Erving Goffman’s (1961) critique of asylums highlighted the role of continual surveillance as a way to control patients. The restriction of patient autonomy was omnipresent and based on the perception that people were incapable and a threat to the broader community. Treatments and practices used to maintain institutional order were legitimised and considered necessary (Slemon et al., 2017). Thus, people experiencing distress were viewed as incompetent, dangerous and lacking insight.

As a point of difference from other academics, and while still critical of psychiatry, Foucault (1961/1973) argued that mental illness must be understood as a cultural construct supported by administrative and medico-psychiatric practices. He proposed that the history of madness was not an account of disease and its treatments but rather about questions of liberty, control, knowledge and power (Foucault, 1980, 1974/2006). From a Foucauldian perspective, Western biomedicine is a discourse situated in an array of institutions, in addition to economic functions and political issues of social regulation (Foucault, 1980). Given that discourses become a means through which power relations are formed and sustained, they empower those who have control over the discourse and subordinate those who do not. People or groups subjugated or oppressed by a discourse are likely to experience epistemic injustice as they are constructed as having limited authority and credibility and consequently excluded from contributing to epistemic resources (Fricker, 2007; Medina, 2012). The biomedical discourse expresses power relations that establish and maintain dominant psychiatric knowledge.

Strengthening and Consolidation of Medical Dominance in Mental Health

Despite a steady critique of these biological claims, psychiatric knowledge and authority continue to dominate mental health services, with drug treatment the primary response to madness (Porter, 2002; Shorter, 1997). This strengthened biological focus continues to be reinforced by the *International Classification of Diseases* (World Health Organization, 2022) and the *Diagnostic and Statistical Manual of Mental Disorders (DSM*) (American Psychiatric Association 2013), which provide standardised criteria to evaluate and diagnose service users (Busfield, 2013; E. Coleman, 2008). The *DSM* operates as a biologically oriented classification system linking behaviour deemed abnormal, brain ‘dysfunctions’, diagnosis and subsequent treatment formulations (Kawa & Giordano, 2012). The *DSM* is an artefact of ontological claims of biomedicine, and it sustains psychiatry’s identity, subsequently rendering psychiatric practice more scientific (Boyle, 1999; Bracken &

Thomas, 2009; Kawa & Giordano, 2012). The *DSM* remains the dominant manual for diagnosis, is highly influential and regularly updated.

The longstanding medical interest in madness, progressed by the scientific claim that a biologically disordered brain causes mental illness, illustrates how psychiatry adopted a biomedical paradigm after moving from nineteenth century asylums to the community (Bracken, 2012; Fawcett, 2012; Porter, 1987). Some argue that this growing area of knowledge became a method of developing and maintaining discursive power and order in society (Bainbridge, 1999; Coles, 2013). Others, such as Shorter (1997), contend that the asylum era was a story of progressive and humane intentions. The beginnings of deinstitutionalisation, including the factors surrounding why and how such a shift occurred, are now discussed.

A Critical Discussion of Deinstitutionalisation

There are differing arguments regarding the economic, social and political drivers and outcomes of deinstitutionalisation (Richmond & Savy, 2005). A humanitarian and rights-based argument grew from the critique of the inhumane conditions in asylums, coupled with growing evidence that asylums were creating rather than curing distress (Johnstone, 2000). The more widely accepted argument for deinstitutionalisation is that psychopharmacology made it possible for appropriately medicated people to live in the community (Porter, 1987; Shorter, 1997). Others argue that the success of psychopharmacology was overestimated, and humanitarian reforms were a guise for economic rationalism and the cost savings of community-based care (Johnstone, 2000; Nettleton, 2006; Richmond & Savy, 2005). Shorter (1997) disputes this and argues that deinstitutionalisation was a response to pressures from critical commentators, such as the ‘anti-psychiatry movement’ and the growing ideology of community psychiatry within medicine.

Australia commenced deinstitutionalisation in the mid-1970s, which is considered late compared to the United States and the UK in the 1960s (Dunlop & Pols, 2022; Johnstone, 2000; Richmond & Savy, 2005). Deinstitutionalisation in Australia, the United States and the UK was fragmented, with limited coordination and shortages of community services (Johnstone, 2000; Richmond & Savy, 2005). Families were left to support their loved ones placed in the community (Johnstone, 2000). In Australia, deinstitutionalisation on a larger scale occurred when the 1991 *Mental Health Statement of Rights and Responsibilities* was released, which sought to ensure consumers and carers were aware of and able to exercise their rights (Standing Council on Health, 2012). The Human Rights and Equal Opportunity Commission's (Burdekin, 1993) inquiry into human rights and mental illness in Australia resulted in the 1993 *Burdekin Report*. Burdekin (1993) concluded that "the savings resulting from deinstitutionalisation have not been redirected to mental health services in community. These [community mental health services] remain seriously underfunded, as do non-government organisations which struggle to support consumers and their carers" (p. 908).

Contemporary Mental Health Services and Psychiatric Practices

The historical context outlined above is central to understanding the current context of mental health services. Psychiatry continues to be contested, with multiple ontological and epistemological positions within the profession (Bracken et al., 2012; Bracken & Thomas, 2017). For example, critical psychiatrists adopt a rights-based approach and challenge medical reductionism, positivism and mechanistic psychological approaches, instead favouring person-centred, ethical, therapeutic and political stances (Double, 2019). Critical psychiatry argues the need for mental health systems to move beyond a 'disease model' (Double, 2019). While there are divergent views about the cause and treatment of mental distress within mainstream psychiatry, the scientific expert paradigm still dominates (Coles, Keenan & Diamond, 2013; Hawkins-Elder & Ward, 2021; Rodgers & Pilgrim, 2014).

The nature of mental illness, psychiatry and responses to people experiencing mental distress are historically, politically and socially situated. The mental health sector has a problematic and debated history, and the current landscape continues to be characterised by contestation and challenge. This study's findings speak to the influence of these histories and show how this context mediates the culture of contemporary services.

Old Culture

Old culture is the key organising finding and theme in this chapter and depicts the continued dominance of biomedical psychiatry, prevailing practices and treatments. Entrenched practices and pervasive biomedical interpretations of mental distress were prevalent in most participants' accounts of culture. These pervasive ideas were similar to the historical constructions reported earlier in this chapter in that they framed service users as lacking capacity and insight, often resulting in paternalistic and punitive practices that limited self-determination. Families similarly identified that biomedical models dominated mental health services, reflected in narrow responses that excluded families and failed to address service user needs. Practitioners explained that the remnants of historical ideologies, such as a continued focus on ‘managing’ patients and harsh practices characterised by limited empathy, were part of service cultures. Hierarchical interprofessional structures reflected psychiatry’s dominance over professions such as nursing, peer work and allied health. While the level of detail about the history of psychiatry and responses to distress may have not been known (or partially known) by service users, families and some practitioners, it played a significant part in their everyday felt experience of mental health service cultures. The findings have three sub-themes: entrenched practices, biomedical dominance and interprofessional hierarchical culture.

Entrenched Practices

The legacy of entrenched historical practices in contemporary mental health services was identified as a key feature of old culture, as exemplified by the expression “the old culture wins out” (F6). Other expressions capturing the entrenched, normalised and legitimised historical practices and ideologies included “outdated ideas” (P11) and the “history of how mental illness was understood” (SU2). For example, service users described practices that can be traced to the history of institutions and longstanding views of service users as incompetent and dangerous. These practices included using control and coercion, a lack of communication regarding service users’ voluntary or involuntary patient status and forced medication, seclusion and restraint. Similarly, a nurse identified “old and rigid” (P1) practices, and a social worker discussed how some practices reflected “old school mental health [practice]” (P6) marked by power asymmetries and adopting a position of ‘knowing best’. Likewise, “treating [service users] poorly” (P1) reflected limited empathy that stemmed from historical ideas about how service users should behave. Staff monitored behaviour, mirroring punitive approaches evident throughout the history of psychiatric institutionalisation (Goffman, 1961). This section describes (1) the dominant culture that reproduces and fosters entrenched practices, (2) service users’ experiences of longstanding and punitive practices and (3) how practitioners interact with service users as part of entrenched practices.

Dominant Culture and Reproduction

A psychiatrist linked “dominant culture” (P15) to areas of the service system where the physical structures and residual practices of institutionalisation pervaded and were signifiers of service cultures. As with this psychiatrist, other participants’ use of the terms “normal” (SU11 and F8) and “dominant” (P17) reflected ideologies and practices operating at the taken-for-granted and unconscious level of culture, which suggests the dominant culture is longstanding and often unconsciously adopted and reproduced (Schein, 1992, 2010). Old practices were portrayed as a “safe norm” (P15), demonstrating the continuation of familiar, entrenched practices, while recovery orientations were understood to be either superficial or only enacted by some practitioners (i.e., they were not normal or taken-for-granted). When new approaches were adopted, they were described as short-lived, with services eventually reverting to “old” (F6) and dominant cultures. Despite policy aspirations and structural changes, institutional ways of operating continued because of heightened anxiety and fear held by practitioners:

> The culture’s hard to change. And then dominant culture, so say, [name of hospital] … is an old-fashioned institutionalised one. It’s changed a lot actually, but when there’s a level of anxiety, individuals and systems regress to the safe norm. (P15)

Contemporary practices and service priorities were viewed as a reproduction of historical values and ideologies, as noted by a service user: “we seem to bring these historical things forward, um into the culture of services … it’s about reproducing the same old thing over and over again … little changes but not much” (SU8). A family member associated the treatment of service users and families, and their continued exclusion in service delivery, with a pervasive “old culture … ultimately, I think the old culture wins out still. And until that changes, we’re not gonna see any meaningful difference in the way people are treated or the way families are included” (F6).

A peer worker also spoke about the reproduction of entrenched practices. She stated that the lack of translation of recovery and person-centred principles from policy to practice, particularly in clinical settings, was due to practitioners preferring to “do things the way they’ve always been done” (P2). She added that “managing patients” (P2) was viewed as more important than person-centred approaches:

> Culture is a big thing as well I think, not having that culture of being recovery focused, [instead] focused, more on just managing patients. I think part of it … it is

> maybe that they [practitioners] have an attitude of "they have a mental illness … and don't know what best for themselves". (P2)

Participants' accounts clearly identified that old culture is deeply entrenched in mental health services, experienced as familiar and perceived as necessary. While there have been efforts to introduce new ideas and approaches such as recovery, old culture was found to smother these attempts.

Punitive Practices

Service users experienced entrenched practices as punitive and harsh, describing a lack of compassion and clear power differentials. These practices included arbitrary rules and overt enactments of control. They reflect Goffman's (1961) assertion of psychiatric institutions as closed systems operating separately from other parts of society. Psychiatry and the mental health system were founded on inequality and symbolised by the power to detain, control and treat where deemed necessary (Bracken & Thomas, 2005; RCVMHS, 2021c).

The continuation of such practices was unsurprisingly positioned in the present study as conflicting with contemporary approaches to recovery, connection and reciprocity:

> You're a nurse to take care and treat a patient, yeah, but a patient also has to be treated as a human being. But in mental health they think, oh, you're mental, they're kind of a bit more hard on you, more assertive, and then the assertiveness takes over and there's no human touch or feelings. (SU19)

This service user's experiences can be traced to the "custodial model" within asylums and psychiatric institutions (Chow & Priebe, 2013, p. 10). Power asymmetries between practitioner and service user were evident; so too was paternalistic treatment, where nurses' "hard" and "assertive" (SU19) interactions with service users were accepted behaviours. These behaviours reflect the tension for nursing staff and other mental health practitioners around their dual role of providing care and support and exerting control (Bates & Stickley, 2013). This tension is sustained by risk-averse policies and practices that promote surveillance and control, contrary to service user self-determination and autonomy.

Experiences of punishment were common across service user accounts of culture. A service user compared her experiences in private voluntary and public involuntary inpatient settings. The latter felt like imprisonment, where she was required to comply with hidden 'rules' that were never made explicit to her:

> So it is with peers [other service users] in the voluntary setting or a private ward you have more opportunity to talk to peers, um other patients, and there seems to be a softness of looking after each other … I remember one person giving me a night light, um other people writing notes to me you know sharing chocolate or stuff like that … in a public ward that's not allowed … You rarely talk to other patients, there's just such a feeling of fear and it's almost like boot camp … I feel that I was incarcerated and that's what it was like for me with the last admission … I wasn't allowed out for two weeks and there was no clear reason why … so I guess that's the feeling of 'this is meaningless' … you know, it doesn't make sense. (SU15-P)

Many other participants and family members described similar instances where practices and decisions seemed groundless or lacked reasonable judgement. These accounts suggest that such rules and practices are employed automatically and are deeply entrenched and unquestioned elements of old culture.

Patterns of Interaction

The third feature of entrenched practices was the patterns of interaction between service users and practitioners. Service user participants talked about experiences in inpatient settings where staff did not speak to them or other patients beyond directives to take medication and instructions regarding where to be at certain times of the day, for example, mealtimes and attendance at groups or activities aimed at 'increasing independence'. These examples can be traced to historical practices in which all elements of patients' lives were dictated by institutional routines (Chow & Priebe, 2013).

Other interactions discussed by service users involved practitioners ignoring them. For example, a participant talked about her repeated experiences of being ignored as an involuntary patient; this happened on two occasions, in two different wards, both events involving three-month inpatient admissions: "No one spoke to me … for three months. No one came and asked how I felt, or wanted to know my story" (SU17-P). Another participant said communication was "a real barrier", stating, "They [staff] don't speak with you at all. At all. Instead … what they do is light your cigarette" (SU11). This service user was ignored when he asked nurses for access to his money to spend at the hospital canteen or to call a family member requesting they bring in clothes for him as he was no longer on pyjama restrictions. He considered this limited interaction and care from nurses and other staff "normal culture" (SU11).

While public inpatient settings were most commonly identified as sites of entrenched practices, this was also experienced in community and private settings. For example, a service user stated: "the view of the service user in terms of what's required of them, and the level of control, of power, changes [depending on the service]" (SU15-P). Another service user (SU5) recalled being threatened, monitored and coerced with forced medication via a Community Treatment Order[2] with little explanation or reason from the psychiatrist and community case worker. Eventually, he successfully argued against what he saw as the unjustified threat of treatment.

Service users and families noted that they were only allowed to access non-government mental health services and homelessness accommodation if they were compliant with treatment. Thus, the implied and actual use of entrenched practices, such as coercion and control in present-day mental health services, cannot be separated from the centuries of coercive and controlling practices (Gomory & Dunleavy, 2017). The next theme focuses on the continued dominance and discursive practices of biomedicine.

Biomedical Dominance

The prevailing dominance of the biomedical model was identified as a key feature of old culture. Biomedicine assumes expert knowledge lies exclusively with professionals. Participants did not dismiss the value of biomedicine; however, they questioned the over-reliance on biologically informed and reductionist understandings of, and responses to, mental distress. Although this experience was most relevant to service users and families, many practitioners also spoke of the dominance of biomedicine. Several psychiatrists pointed to an over-reliance on biomedical treatments, particularly diagnosis and medication, which failed to address co-occurring and intersecting experiences, including trauma, alcohol and other drug use, homelessness, unemployment and poverty (referred to as psychosocial and environmental factors hereafter). This practice has been dominant since twentieth century psychiatry, where the clinician diagnosed and categorised the experience rather than considering the service user's accounts of, or explanations for, their experiences

---

[2] A community treatment order (also known as Form 5A) is an order under the Mental Health Act (2014) whereby a person living in the community is required to receive treatment involuntarily (MHC, 2017).

(Tew, 2011). This section on biomedical dominance reports on service user experiences of being viewed through a psychiatric gaze. Assessment, diagnosis and medication, the core practices of biomedicine, are then discussed, followed by the obscuring of psychosocial and environmental factors central to many participants' experiences of mental distress.

Psychiatric Gaze

Service users consistently reported experiences of being observed through a medical or psychiatric gaze. This concept, developed by Foucault (1963/1976, 1980), is a technology of power by which the observed becomes known to the observer by inspection. Foucault (1980) describes how each person subject to the gaze "will end by interiorising to the point that he [*sic*] is his own overseer" (p. 155). The gaze was evident in service users' accounts of situations where their every action, expression of emotion, and utterance was interpreted through a biomedical lens. The *gaze* is an act of selecting what is relevant about the service user and filtering out details that do not support the biomedical framing of the person (Misselbrook, 2013). This knowledge collected via the gaze becomes the resource by which the practitioner develops control over the service user (Fox, 1993).

The following quote from a service user-practitioner highlights the workings of the psychiatric gaze whereby service users were often viewed and treated as a series of disconnected parts (O'Callaghan, 2021):

> You know … you haven't had a phone call to your children or your family for ages. So you call, you beg and you ask to call and then you cry afterwards and then that's pathologised … You know, you're offered medication, you know … and so I guess that's the thing that the diagnosis and the view of people as a mental illness um sort of means they're treated that way … whatever I did it would be perceived as madness. (SU15-P)

Similarly, service users spoke of their acute awareness of the psychiatric gaze and its potential to frame their behaviour. A key function of the medical gaze is that service users surveilled their own actions and behaviour, thus "exercising this surveillance over and against himself [*sic*]" (Foucault, 1980, p. 155). For example, a service user-practitioner said she had to carefully choose what and how much information she disclosed to services and individual practitioners because "you can't afford to be angry in a locked ward" (SU15-P).

Service users recounted times when they chose not to disclose suicidal ideation due to the possibility of forced treatment or loss of autonomy. Others said they did not disclose that they heard voices given the diagnostic and treatment implications:

> I've only ever mentioned my voices in hospital a couple of times because … voices mean you're schizophrenic, voices mean you're crazy, voices mean that you're dangerous. Voices mean … you're going to do bad things … just that labelling and that. (SU4)

This account and other service user accounts represent a form of testimonial smothering, a "coerced silencing" (Dotson, 2011, p. 244) in which marginalised people shorten and limit their testimony because it is considered too unsafe and risky. Participants spoke of how they self-censored suicidal thoughts or voices. Self-censorship reveals how a culture in which dominant discourses of biomedicine and viewing service users as incompetent, silence them, and create the conditions for distorted communication between practitioners and service users. Additionally, these cultural conditions mean that practitioners will only ever have a partial picture of a person, which will likely hinder their service delivery response.

Assessment, Diagnosis, Medication

Assessment, diagnosis and medication are central to the biomedical framework (Bracken et al., 2012). One psychiatrist said this is informed by an "evidence base", "scientific quality" and the need to "keep up-to-date with the scientific literature" (P17). Therefore, when a service user did not respond to treatment with an improvement in symptoms, the accepted response was to turn to the scientific literature, which rarely offered practice guidance: "there is never a research study on your patient" (P17). This psychiatrist alluded to the flaws of this reliance on scientific literature in guiding practice. He added that adopting biopsychosocial or social psychiatry approaches placed less emphasis on the biomedical model and embraced the psychosocial and environmental factors contributing to mental distress.

Other practitioners expressed similar perspectives, problematising biomedical reductionism that manifested in a narrow focus on assessment and medication. Another psychiatrist rejected the approach of labelling, managing and medicating people:

> I saw this woman today … she's been diagnosed with schizophrenia, post-traumatic stress disorder, borderline personality disorder and substance use. And it seems like she's almost managed with those labels, so the public mental health service just give

> her a needle every month, and that's about all they do with her … no one's addressed her trauma. (P13)

While most participants noted that medication was helpful for some people, they expressed concern about medication as the main treatment response (i.e., if a person experiences mental distress, there is an unexamined expectation that they require medication). A peer worker-service user participant also spoke to this:

> Yeah, so I still think it is a biomedical model. That is applicable to the private sector as well. So my psychiatrist, for instance, had said that I'll never work again, that my life will be very different to how it has been … negating possibilities and opportunities, and medication was what I needed to recover or to get better or to be able to cope … So I still think that medication is the first point of call for all psychiatric patients, um rather than possibly exploring people's understandings and frameworks of understanding as to why they think they're going through those experiences. (P8-SU)

Similarly, a family member-practitioner spoke of the link between biomedical models and the centrality of medication as the main form of treatment:

> I think a lot of the culture is still that like medical model of 'you're unwell and then you have to get better' … it's about medication … you do have to be on the right medication, quite often, but it's not only about that, there's so much more. (F2-P)

A social worker reinforced the views of other participants saying that medicalised approaches to distress were characterised by: "just fix them up with the medications. Make sure they comply with their medications and then they'll be fine without all the other stuff" (P6). Medicalising distress obscured psychosocial and environmental factors, labelled "the other stuff" (P6), which medication could not alleviate.

Obscuring Psychosocial and Environmental Factors

Service users and family participants highlighted how narrow medicalised responses were an unquestioned feature of service cultures. Such responses failed to address intersecting psychosocial and environmental factors or appropriately respond to suicidal thoughts and self-harm. A family member noted this:

> They'd never addressed the alcohol issue, and that was … that was going to be there when he left, he'd just have to start all over again. Um and they said "Oh, no, he

> needs to see a psychologist". In fact, they didn't even [mention alcohol] … I said it many times but they didn't even seem to recognise it. (F7)

A lack of acknowledgement and engagement with the personal and structural context in which distress may have arisen was mentioned in many participant accounts and is illustrated in the following practitioner's account:

> There wasn't a lot of recognition of the content of someone's distress … in my experience working in an outreach setting with people who were homeless … one woman was very mentally distressed, had a diagnosis of schizophrenia and was well known to mental health services. And one young man, and [they] were living on the streets and using all kinds of substances to cope, and very, very vulnerable. I think they had both been assaulted on separate occasions … I took them to their mental health appointments, I think to either be assessed or receive medication maybe and there was just … I … there was just a total lack of … questioning, interest in, perhaps, by psychiatrists and nurses around why this person might be experiencing, the kind of distress in terms of hallucinations and delusions, and behaviours. (P10)

Other participants echoed the lack of therapeutic and psychosocial support within inpatient settings. For example, a service user problematised such reductionist approaches that reflected "a lack of understanding … of the environment" (SU2).

A family member similarly discussed how access to therapy within inpatient units and the community would have been invaluable for their loved one:

> Free therapy, ongoing therapy would have probably been the best thing possible for my mum. And that doesn't happen … in the public health system. It [inpatient stays] didn't really help … I just remember her being drugged up completely. To a point where she was just … she was a zombie. That was a very scary thing, scary times. She got out and then she seemed fine, I guess, for a while. And it would get bad again and she'd go back in [to hospital]. (F10)

This dominant approach to responding to mental distress demonstrates limited to no engagement with the psychosocial and environmental factors that many service users and families deemed central to their experiences of distress. The ways in which these experiences affected and exacerbated distress were ignored. Very few reports of mental health professionals engaging with these factors were identified in this study, which practitioners acknowledged. For example, practitioners spoke of the pressure to discharge service users that contributed to a narrow focus on medication.

A social worker highlighted how the mandate in her service to get people well so "we can get other people into the service" (SU18) meant that addressing environmental or psychosocial factors was not seen as essential. The following example illustrates the direct impacts of the organisational and administrative cultural frame, including rationalisation of resources and unabating pressures for efficiency, which in this circumstance was measured according to the rate at which service users were discharged from a hospital or service:

> Our number one priority is probably to get people well, it's not to look at those psychosocial holistic factors. It's … "this is our main mandate, we only have this many beds, we need to get people well so we can get other people into the service". Yeah it's great if you want to talk about Little Johnny's kid in [child protection] care and getting some contact, but the priority, even you know, where the patient is really stressed about … some of the psychosocial stuff; are they going to have a house to live in, money coming in, um you know that's, that's going to take second to actually, well this is what they need at this instance, they need their depo, that needs to be discussed with them … or they need to be you know, off benzos before they go back to prison or else the prison won't be able to manage them you know, it's all that kind of systemic stuff. (P18)

Personal recovery is unlikely when the underlying and intersecting circumstances contributing to service user's experiences of distress are ignored, as identified in the quote above.

Biomedical interpretations also excluded other ways of interpreting and understanding distress. A service user spoke of how mental health practitioners ignored and misinterpreted her explanatory framework: "growing up in domestic and family violence, and the trauma that that's caused. Not one of the mental health practitioners or psychologists or doctors has ever asked me" (SU16). Ignoring service users' social context resulted in what many participants said were "bandaids" (SU3) and "Fix them up, push them out as quick as we can" (SU3).

These findings support international research evidencing how narrow biomedical approaches dominate the structures and operation of mental health services and render service users' experiences and contexts invisible or irrelevant (Cosgrove et al., 2020). The biomedical model perpetuates ideas about service user pathology and capacity and stems from the longstanding view that mental illness is a disease of the brain that chronically disables people. Practices that centre biomedical discourse are tied to and situated in the broader organisational and administrative context in which the NPM drive for efficiency and rationalisation reinforces the adoption of approaches focused on individual pathology, diagnosis and treatment (C. Brown, 2021; C. Brown et al., 2022; RCVMHS, 2021b).

Interprofessional Hierarchical Culture

An interprofessional hierarchical culture among disciplines, including the peer workforce, was a key feature of old culture. Historically, the medical discipline held authority over the work of other health practitioners and control of esoteric knowledge (Willis, 1989). Medical dominance provided the basis of formal power structures within hospitals (E. Wilson, 2003). This research found that psychiatric and clinical-based disciplines continued to hold more authorised power, responsibility and authority over other practitioners.

Some peer workers and social workers noted that they needed to prove that their role and contributions were valuable to psychiatrists and clinical teams, reflecting their position historically of reduced authority within the interprofessional hierarchy. A social worker described service cultures as “a relic of … outdated ideas that really, for me, are tangled up with power and power structures” (P10). Another social worker said that despite some structural changes as part of deinstitutionalisation, the culture continued to be characterised by old cultural ideologies, practices and hierarchies among professional disciplines:

> They’re saying deinstitutionalise but the culture … especially old school mental health practitioners … you know, we are the bosses, we give them medication, the psychiatrists are the gods, And I think the psychiatrists are still the gods in some way even now. (P6)

A service user-practitioner similarly spoke of inpatient wards as consisting of “very hierarchical culture … they’re all waiting on the doctors to make a decision” (SU15-P).

Hierarchical cultures were also found in non-clinical settings, as identified by a non-government practitioner: “there’s a real hierarchy thing that goes on, like you’ve got your psychiatrists and then your clinical psychologists” (SU17-P). This interprofessional hierarchy shaped rules of interaction, practices and processes; it reflected a tacit knowledge among practitioners, as exemplified by these comments from a social worker:

> We have one interview room [on the specialist ward] so you know, the doctor will take precedence. There's no written rule but you wouldn't … say "oh I'll go in that room actually, I've been here waiting" … like, just wouldn't do that [laughs]. (P18)

The decision-making and legal authority and responsibility of psychiatrists reinforced this hierarchy at a systemic level. The primary response in mental health services was medical, and psychiatrists are the only discipline that can prescribe medication and coercive treatment, so decision-making and legal power resided with psychiatrists.

It was highlighted by several practitioners' that those who did not align with a biomedical discourse were marginalised and challenged, creating a difficult workplace to navigate. This finding is supported by Maddock's (2015) study of a hierarchical working arrangement within multidisciplinary teams where psychiatrists decided whether service users required input from other practitioners (e.g., social workers or occupational therapists). The multidisciplinary team was only involved if the psychiatrist decided to include them, which removed the capacity for other practitioners to deliver any services (Maddock, 2015).

The dominance of biomedicine and its emphasis on diagnosis and treatment intersects with the legal paradigm where the treating psychiatrist is responsible for treatment decisions (Haines et al., 2018). Consequently, although other multidisciplinary team members may contribute to decisions, accountability lies with the psychiatrist (Haines et al., 2018). Historically, the legal responsibility of psychiatrists resulted in insular practice; however, most psychiatrists in this study emphasised the significant benefit and value of working with other practitioners and within a multidisciplinary team. For example, a psychiatrist who valued working collaboratively with nurses in an inpatient setting discussed the importance of team culture. Practitioners from other disciplines echoed these sentiments, emphasising the importance of diverse roles, skills and knowledge. These accounts suggest some changes are occurring in areas of mental health services; however, they appear to relate to individual behaviours and aspirations rather than represent widespread change.

Consequences

This chapter has so far explored how the historical cultural frame of psychiatry and responses to mental distress shape the cultures of contemporary mental health services. Two consequences of old culture for service users, families and practitioners were identified: dehumanising and harmful experiences and inadequate service responses.

Dehumanising and Harmful Experiences

A key consequence of the old culture was dehumanising impacts and harmful experiences for service users and families. Service users were reduced to and treated "as an illness" (P8-SU) and "a bundle of symptoms" (SU4). Such treatment eroded their self-worth and confidence: "From my experience and people I know … I'll just do whatever they [practitioners] say. I'm scared to speak out for whatever reason, whether that's linked to … self-worth … that voice of powerlessness" (SU4).

Service users described feeling reduced to an illness identity. The dominance of biomedicine was reflected in assumptions that service users lacked the capacity to make decisions, therefore, necessitating intervention, close management and surveillance. One service user described mental health services as "big brother" and the service user as "the sick patient" with no other identities: "you might be a really interesting thinker … but you're just a messed up, you know, schizophrenic" (SU5). As SU5 and many others in this study noted, a devalued identity often results from a psychiatric diagnosis (Harper & Speed, 2012). Consequently, service users and families experienced isolation, they were not heard or supported, and such practice affected their sense of self, connections with community and self-esteem.

A service user-practitioner similarly stated that once diagnosed and viewed as an illness, her usual support networks were ignored and discarded. This experience was harmful to her and her family: "I think it ah, they really just saw me as an illness, they stopped seeing me as a person and they stopped listening to my partner, my parents, they didn't consult with my GP or psychiatrist" (SU15-P). These practices are antithetical to the principles of personal and relational recovery that are fundamental to mental health services moving away from individualistic, coercive and deficit-based practices (Price-Robertson et al., 2017; Wyder et al., 2021).

Viewing service users through a deficit lens was another consequence of old culture with significant implications for service users and their families. This deficit-focused approach was characterised by communicating minimal hope and possibility, conveyed in explicit and covert ways, as discussed by this family member:

> They've just … treated him [service user] like he's never going to really work, or he's never going to achieve …he's just going to have this diagnosis … For the rest of his life … like he's just got to be able to exist, and existing is not life. (F1-P)

Consequently, feelings of hopelessness were common for service users and families, who resigned themselves to a maintenance outlook that aligned with the view of mental distress as a 'chronic' illness involving inevitable deterioration, which has led many to feel despairing and sometimes suicidal (Tew, 2011).

A participant who had used services across public, private, inpatient and community settings for 17 years spoke of "a hopeless cycle" (SU4). This participant situated this cycle in clinical approaches where the understandings of people entering services and subsequent ways of responding limited the space for "real growth … it's just maintenance" (SU4). A focus on maintenance refers to a lack of expectation communicated from practitioners to service users that their experiences will improve, instead focusing on preventing the deterioration of symptoms. A maintenance approach was found to guide the way services operate, where people are admitted to hospital and "it would be treatment to get you to here" (SU4) before being discharged, only to return to hospital.

This cycle of maintenance evoked a sense of helplessness for several service users. Pat Deegan (1996) says helplessness leads to "apathy, indifference, hardness of heart that keeps so many people in a mode of survival and prevents them from actively entering their own journey of recovery … it is safer to become helpless than to become hopeless" (pp. 93–94). Practitioners often fail to recognise the existential struggle of service users, instead viewing their sense of helplessness as signs and symptoms of mental illness, poor prognosis or low 'functioning' (Deegan, 1996)—another key consequence of old culture where the prognosis is believed to be poor. Helplessness creates feelings of hopelessness, which seep into practitioners' ideas about possibility and recovery, resulting in a sense of impotence (Deegan, 1996).

Some service users described feeling worse after using mental health services, particularly inpatient services. They felt traumatised or re-traumatised and experienced physical health decline:

> Yeah and I was kept in a locked locked section right, and it just got worse and worse for me, um and I started having heart failure from the medication and so then they then took me off all medication. So, like I was just all over the shop. And um it ended with them putting me in seclusion. (SU15-P)

Similarly, another service user discussed their experience in a public mental health ward and stated that it offered "nothing"; instead, "it's just like, going out having a cigarette … it always just made me feel increasingly worse" (SU18).

Several practitioners also recognised that public inpatient mental health services often create harmful consequences. An advocate practitioner observed that service users and their families were treated as "second class human beings, especially in the public system" (P5). Being treated as a human being was a rare experience. A family member echoed this sentiment describing a kind staff member whom she enjoyed seeing when accompanying her son to his outpatient appointments. This experience contradicted her usual "traumatic" (F8) encounters with mental health services.

Service users and families recognised that practitioners were also impacted by working within services where harmful and dehumanising practices were common, particularly in inpatient settings where old culture was more pronounced. Many service users attributed poor practices to the broader structure and culture where working in such services eroded compassion and "shifts your perspective" (SU7). This perspective shift was said to be compounded by practitioners witnessing "things that they're not okay with and can't change … Or they've spoken up in the past and it went badly for them or you know, so they have experiences of powerlessness too" (SU15-P).

Service users and families also highlighted humanising, validating and caring encounters with individual practitioners; however, these experiences were inconsistent and exceptional, rather than ubiquitous: "I've had some really respectful, beautiful, caring interactions with staff in involuntary wards, so it's hard to say what it is that's not working … the culture, um because it really, it comes down I think to the people" (SU15-P). This account suggests that individual practitioners can make a positive difference and influence culture; however, as accounts from practitioners suggest, this requires broader organisational support. Old culture resulted in service responses that were experienced as dehumanising and harmful. Consequently, services were, in most cases, inadequate in meeting the needs and wishes of service users and families.

Inadequate Service Responses

Thus far, I have argued that the prevailing dominance of the biomedical approach resulted in service responses focused primarily on clinical interventions. This section presents the second key theme of the consequences of old culture, key features of which were frequent service use, difficulties accessing service support, adverse effects of medication and unmet needs. A family member whose loved one experienced all these consequences said:

> I guess what they [services] see is that people come in really challenging and if you drug them up, they get a bit less challenging; therefore, it's working by that model. But that's not really enough if you look at it from the point of view of the person who is in distress is it, or the families of those people, what then? Send them home, wait for the cops to bring them back in for something else. It's just not enough. It left our family and there's lots of other families, because this is the only option and because it doesn't work, there's just nowhere to go … we just don't have an option that actually works and that actually supports people and when hope runs out, where do you go? (F6)

The consequences of discharging people following treatment that is purely medication-focused were that people often returned to the emergency department, acute mental health service, or experienced significant physical adverse effects. For example, a service user (SU3) spoke of having his medication significantly increased just before being discharged home, where he lived alone, and became severely physically unwell.

The adverse effects of medications were significant, particularly neuroleptic medication. While some service users and families found medication helpful, most said the amount of medication was harmful in that it reduced their wellbeing and ability to complete day-to-day tasks. For one service user, the adverse effects were so debilitating that she began using substances to abate the effects:

> And you'll find … well, a lot of people that I've come across who are medicated, you know hugely medicated for schizophrenia, want to use other drugs to … for the motivation, to alleviate the symptoms of that medication … I was put on Quetiapine

> and Effexor and Epilim and Serepax … And I was running a business and I was on 400 milligrams of Quetiapine a day … And because I was on all of that medication, it was really difficult to be able to … you know, I was very suicidal during that time, but I hadn't been suicidal before the medication. And … I'd been 20 years without um drug use, and then I got back into heroin and methamphetamine because I just … couldn't cope with the distress that all of that …pharmacological um interference, it was awful … So things went really pear-shaped. (SU17-P)

A common experience involved service users being trialled on various medications over a number of years' and when there was no improvement they were told, "I can't help you, see this person. They try something else" (SU2). These responses did not illustrate or communicate hope or belief in recovery to service users or families. Consequently, this service user became suicidal and attended the emergency department, which was an equally invalidating experience:

> So after a couple of years … I got to a point where I was very, it's difficult to use the phrase suicidal without explaining that because I don't think I've ever wanted to die … but it feels like it's the only option. So, I felt that if I was left on my own, or to my own devices, that was inevitable. (SU2)

Service users reported that these responses were inadequate and resulted in their frequent attendance of crisis services.

Despite knowing that services were unhelpful, many family members spoke having no other options and nowhere else to go, particularly in times of crisis:

> And I look at it from many different angles now, the fact that … why we might need the [mental health services], ah is because we have nothing, often we have nothing … given the context of [public services] it wasn't really going to be much help but it was the only help that was … that we could access … when we need it. So for example, when I say they [mental health services] weren't going to be much help, it was still going to be very clinical very medicalised help and … I know that that's not necessarily the right … ah it's not really going to be so useful. (F1-P)

For this family member and many others, traumatic and invalidating experiences with services recurred and produced significant frustration and hopelessness.

Due to an over-reliance on biomedical explanations of people's distress and funding structures that relied upon assessment and diagnosis, psychosocial and environmental factors such as safe and stable housing, employment or income, often sat outside the service remit. Consequently, mental health services regularly failed to address basic unmet needs integral to, and the foundation of recovery, and the amelioration of distress. As a service user stated: “you can’t medicate social problems, and basically, that’s what mental health services do at the moment because they’ve got no other option” (SU9). This participant alluded to the limitations of mental health services shaped by biomedical discourse and constrained by resources, funding arrangements and broader issues such as a lack of suitable and affordable housing options: “it’s not their [practitioners] fault … there aren’t homes for people to go to, there are not the supports out there” (SU9).

These findings highlight the fundamental consequences and flaws of the mental health system whereby the obscuring of structural and other intersecting factors resulted in services being unable to meet the needs of service users and families. Consequently, people often became frequent users of the mental health system and survived the best ways they could without adequate support. One service user spoke of this as “existing” without any “purpose” (SU6); therefore, suicide felt inevitable. This consequence relates to the revolving door experience identified as a key consequence of the organisational and administrative cultural frame and as previously noted, highlights this issue’s multifaceted and systemic nature.

Many service users and families viewed the dominance of biomedical discourses as causing the siloed and limited nature of services, contributing to accessibility issues. They shared their experiences of exclusion from services because intersecting psychosocial and environmental factors such as homelessness and alcohol and other drug use were considered better served by another system—reflecting siloed service delivery. The little support that was provided was often too late. Families recounted repeated unsuccessful attempts to access services and find support for their loved ones. One family member mentioned trying to access support from an emergency mental health service and was advised to ring the police, who directed them to ring the emergency mental health service. This experience was exacerbated for those living in rural areas due to a lack of mental health services and resources; no support was provided by mental health services until a crisis eventuated.

Another common experience for families was that they received support only when their loved ones became involved with the criminal justice system:

> So, basically, I couldn’t get any help, and [name of service] actually said to me “We have to wait until there’s an incident”, and of course it did happen … anyway, he [son] got arrested and then put into [name of service] for nine months … We had to wait until there was a crisis … but that was the turning point for getting help. It’s lucky there wasn’t an absolute disaster, and that is the disgrace of it … they wait … they make you wait until there’s a tragedy, they don’t listen. (F7)

Some families similarly discussed being left unsupported to find accommodation and community support for their loved ones; this impacted families’ wellbeing, employment and other relationships.

The limited nature of services meant that there was a lack of recognition of the complexity of peoples’ lives where issues and problems intersect and are related rather than separate entities. Paradoxically, people who made continued presentations to services were positioned as a ‘problem’ that could not be fixed:

> What they [service users] can access based on what they’re being judged to have [presenting issue or diagnosis], so say if they’ve got you know major mental illness, often people … have you know, drug use associated with their illness and so we do see a lot of people … presenting to services unwell but it’s been classed as, “oh, it’s just meth”… “oh, it’s just because they don’t have any accommodation and they’ve come to hospital so they can have a feed and have a bed for the night.” … But we are also seeing a lack of empathy for people accessing services, particularly ones that are frequently being admitted to hospital and are well known to services, seeing a real “oh, it’s them again, there’s not much we can do because you know it’s these problems”… “they’re out of our scope” you know so “it’s not mental health, they’ve got x, y, z, problems, we can’t help them with that”. (P19)

Service users are often blamed and positioned as noncompliant or the problem, ignoring that the current service sector is largely inadequate and ill-equipped to support people and their families.

Conclusion

In this chapter, I have shown how participants from all groups understood mental health service cultures in ways that can be traced to historical contexts and practices, which ultimately mediated reform aspirations. Three key themes were described: entrenched practices, biomedical dominance and interprofessional hierarchical culture. Across each of the themes, the presence of historical ideologies that construct service users as incompetent and lacking insight and the authority of biomedical discourses were apparent. Issues relating to power and control, present since the advent of the segregation of people deemed Mad, were found to pervade service cultures and practices. The consequences of this cultural frame included dehumanising and harmful experiences and inadequate service responses. The next two chapters present two elements of culture produced by the overarching cultural frames.

Chapter 6: A Culture of Blame

In Chapters 4 and 5, I presented the overarching cultural frames that shape and sustain mental health service cultures. Key features of the organisational and administrative context included the different priorities of administrators and practitioners and compliance and risk-averse cultures. Limited responsibility and accountability by administrators were also features of service cultures at the administrative level, which impacted practitioners, service users and families. The second cultural frame, histories of psychiatry and responses to mental distress, highlighted entrenched practices, biomedical dominance and hierarchical cultures. This combined set of cultural conditions commonly led to discourses of blame in mental health services. A culture of blame is defined in the literature as organisational norms and a collective attitude marked by an "unwillingness to take risks or accept responsibility for mistakes because of a fear of criticism or management admonishment" (Khatri et al., 2009, p. 314). Other features of a culture of blame include distrust, limited innovation or initiative due to fear of being wrong (Khatri et al., 2009; O'Connor et al., 2011), fear of litigation and risk aversion (Lau, 2009, p. 679; Runciman et al., 2003).

Within broader society, neoliberal ideas emphasise individual responsibility. The modernist belief is that any adverse incident is predictable and preventable, and someone or an organisation is responsible and can be blamed (Lau, 2009). This focus on individual responsibility obscures systemic and complex factors. Increased regulation of practitioners is central to neoliberalism and NPM, aiming to create efficiency and compliance (Webb, 2006). Such principles have given rise to regulatory audit and inspection processes that "deepen suspicion and anxiety within an already vociferous blame culture" among practitioners (Webb, 2006, p. 70). Practitioners are now preoccupied with managing risk, illustrating how NPM shapes the way risk is viewed and managed; this underpins and sustains a culture of blame (Sawyer et al., 2009). Therefore, risk avoidance becomes a key priority for frontline practitioners within a culture of blame (Godin, 2004; Webb, 2006).

A major contributor to this culture of blame is a control-based management style (Khatri et al., 2009). Hierarchical, command and control-based leadership approaches and organisational structures are ubiquitous in health and mental health organisations (Harber & Ball, 2003). Bureaucratic and hierarchical management approaches perpetuate a culture of blame due to a reliance on rule and compliance techniques, which assign accountability to individuals for system-level failures. This approach perpetuates a cycle of monitoring and regulation of employees to minimise adverse events (Bloom & Farragher, 2011; Khatri et al., 2009). Such an approach is premised on the assumption that employees are incapable of self-regulating their practice and require constant management, guidance and discipline (Khatri et al., 2009).

In contrast, a blame-free culture is presented as an ideal and predicated on the notion that human errors in healthcare are largely unintentional and result from complex and flawed systems (Christakis, 2008; Duthie et al., 2020). The problem is not bad people but bad systems that need to be made safer (Kohn et al., 2000). A blame-free culture is viewed as the best way to uncover and reduce future errors. This type of organisational culture is characterised by voluntary reporting, correction of system failures and shared responsibility (Christakis, 2008; O'Connor et al., 2011). In reality, there is little evidence of blame-free approaches in health and mental health organisations, and a culture of blame continues to underpin poor quality care (Khatri et al., 2009; O'Connor et al., 2011).

Numerous inquiries dating back to the 1993 Burdekin Inquiry (Burdekin, 1993) identify a culture of blame in mental health services. More recent studies have identified a culture of blame as involving practitioners perceived distrustfully by their organisation, distrust among colleagues and practitioners viewing service users with distrust and suspicion (Lemon et al., 2016; Wand, 2017). A culture of blame is intensified through language and dominant pathologising discourses that describe service users as 'manipulative', 'attention seeking', 'noncompliant' or 'lacking insight' (Wand, 2017).

The RCVMHS (2021a, 2021e) emphasised that while practitioner accountability is necessary, blame should be avoided as it further entrenches a culture of blame and fear. Root causal analysis is a widely adopted model in clinical mental health settings to investigate adverse incidents. This model involves a formal and systematic approach to identifying an incident's root cause or causes. Despite its widespread use, root causal analysis is unsuited to mental health service contexts (Vrklevski et al., 2018) and creates an insidious culture that impacts practitioners' decision-making (RCVMHS, 2021a). A culture of blame creates an environment where practitioners seek to avoid blame and work in a controlling manner to avoid risk. For example, practitioners may avoid unpredictable or unexpected variables in their work, such as those that arise when including service users and families in practice. As a result, such practices are avoided. An alternative approach known as ‘restorative just culture’ is recommended in the RCVMHS (2021a) report, intended to shift “the focus from blaming individual clinicians when something goes wrong to looking at systemic and cultural factors that may have contributed” (p. 552).

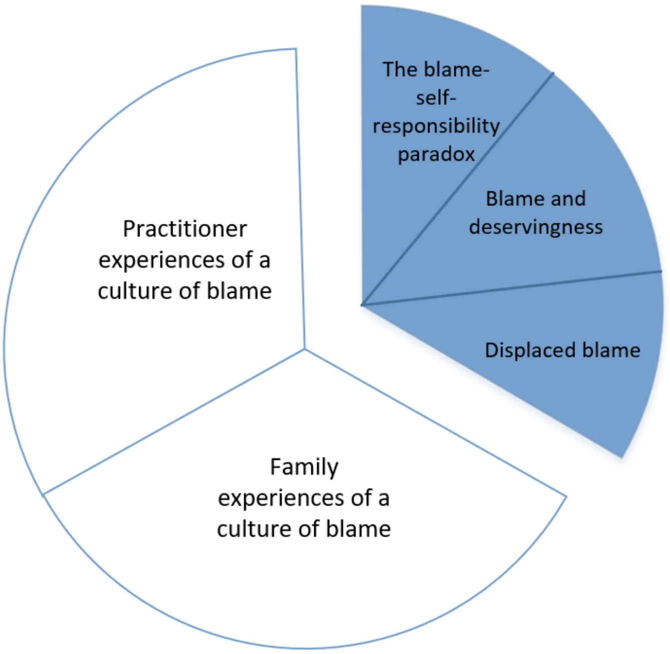
In this thesis, I have conceptualised a culture of blame as operating discursively within mental health services. It is both tangible, for example, the explicit act of telling someone they are to blame, and intangible, in which the broader organisational and administrative context creates a blame culture that is felt, perceived, anticipated and embedded in everyday actions, practices and processes. This chapter now explores how a culture of blame was ‘known’, that is, how participants understood, contributed to and discursively experienced a culture of blame. Factors underpinning and sustaining this culture and its facets and features are explored. Although all participant groups referred to a culture of blame, their meanings and experiences were not homogenous; therefore, I consider the representation of their views and experiences separately.

Service User Experiences of a Culture of Blame

Service user experiences of a culture of blame were multifaceted and broken into three elements (see Figure 3). The first element explores a paradox in which service users felt responsible and blamed for their distress and service use. The second describes how discourses of blame positioned service users as undeserving. The final element, displaced blame, outlines how practitioners’ experiences of a culture of blame manifested in blaming practices and responses experienced by service users.

Figure 3

Service User Experiences of a Culture of Blame



The Blame-Self-Responsibility Paradox

Service users spoke of being positioned as responsible and blamed for their distress when they attempted to access support. This experience was particularly relevant for people diagnosed with eating disorders, borderline personality disorder, or who presented with self-harm or suicidal thoughts. Paradoxically, these blaming responses contradicted biomedical conceptions of mental distress as a biological or genetic dysfunction and, thus, beyond the capacity or control of individuals because, technically, the mental illness is physiological. This blame-self-responsibility paradox was produced by the combination of neoliberal discourses of self-responsibility for health and wellbeing (outlined in Chapters 1 and 4) (Bessant et al., 2020; Henderson, 2005) and the historically situated, deeply embedded biomedical ideas about the nature of mental distress (discussed in Chapter 5).

Agency and choice were integral assumptions in ascriptions of blame—the notion that people were making active choices about their mental distress:

> So I've been an involuntary patient for anorexia and for eating disorder, and some of the comments made while I was in a locked ward … I had a nurse who'd tell me: "Unlike other patients here with psychosis you have a choice about being here". Kind

> of implying that it was my choice that I was in there as an involuntary patient … I guess, with certain other conditions then they're seen as sort of more attention seeking or not … they're more your fault. With things like borderline personality disorder, I guess because that's a diagnosis that I have, I've also experienced it where I guess health professionals have the sort of attitude where they feel like, "Oh, you're always in crisis so it's not that big of a deal". (SU12-P)

This expectation of service user self-responsibility was contradictory to service delivery approaches in which pathologising and neoliberal ideas reinforced practitioners' expert status and positioned service users as passive recipients to be acted upon (C. Brown et al., 2022).

Biomedical and genetic explanations of mental distress were limiting and marginalised service user knowledges and meaning-making. Consequently, the experiences underpinning, exacerbating, or contributing to distress, such as psychosocial and environmental factors, were rendered invisible. Instead, service users were blamed and deemed "too hard" (P3). This frequently reflected service and practitioner inability to respond, as illustrated by a practitioner speaking about a service user with whom she worked:

> And they [services and practitioners] do blame a lot … they are unsympathetic to everything they're [service user] going through like, um someone I work with. I mean it looks like hoarding, but what it is, is the outcome of domestic and family violence … and then things being so chaotic within the home and outside the home that she feels unable to do anything about it. And of course she's got complex trauma anyway … They [services and practitioners] just don't seem to appreciate when she tries to explain this stuff, listen, when she tries to explain: "you don't know how this happened"… So [practitioners] blame her because it's too hard, you know it's just too hard … I think that's the other thing, a lot of people, professionals, tend to sort of have this assumption that they can see a way out that the other person can't, "well, if only you do this and only you do that, and why did you do this or why don't you do that?" There's good reasons why they [service user] don't do that. (P3)

Two features of blame are presented in this practitioner's account. First, the service user was blamed as the services and practitioners were not equipped to work with the person. Therefore, the service user was constructed as too hard and the problem (discussed in more detail later in this chapter under ‘Displaced Blame’). Second, blame was attributed via a self-responsibility discourse in which the service user was expected to assume responsibility for her experiences and distress, marginalising the structural and social explanations of distress. This feature of blaming was evident in the description of the practitioners’ assumptions that they could “see a way out” (P3), and the service user just needed to make obvious changes to help themselves. Blame was also promoted via the attribution of agency to service users, without considering how their agency may be limited by intersecting psychosocial and environmental factors such as unstable housing, employment, trauma or poverty. The positioning of services and practitioners as knowing best and better than service users was also evident (see Chapter 7).

A culture of blame functioned to signify that: “people with mental health issues … should be able to help themselves … or they got themselves into this somehow … you should have enough agency and power to fix yourself” (SU2). In overt and covert ways, practitioners communicated to service users that they were responsible for their distress and recovery. Paradoxically, mental health services adopted controlling and coercive practices and, therefore, did not promote or support service user responsibility or self-determination. Additionally, recovery is “instrumentalised and mainstreamed” (Rose, 2014, p. 217) to align with neoliberal and NPM ideas; it is viewed as a state to be achieved by the individual service user, requiring effort and self-management. When any form of recovery is not ‘achieved’, the service user is blamed and deemed in need of training to develop their capacities.

This failure to achieve recovery also manifested in blame ascribed to service users when prescribed medications or interventions did not help the person. As a result, the service user was positioned as being at fault and blamed for the lack of success and recovery. One participant who adopted a dual positionality of service user-practitioner described this phenomenon from ‘both sides’:

> I think the culture is a culture of pathologising people, and it’s an individual responsibility … it’s rather bizarre, it does your head in because you know it’s like, “ah you’ve got a mental illness, you were born with it or whatever… you’re responsible”. And what they mean by that it is “you really need to work harder on your recovery, you’re obviously not managing your stress well or sleeping well …

> you’ve obviously fucked up and you’ve obviously done something wrong that you’re in here”. (SU15-P)

This participant drew attention to contradictions in a culture of blame where mental distress is based on dominant biomedical discourses and, therefore, beyond the person’s control. Nevertheless, the person needed to be responsible for their symptoms and distress. These findings support McWade’s (2016) assertion that the “prevailing neoliberal socio-economic agenda frames madness and distress as the consequence of irresponsible behaviours and choices that need to be controlled and contained” (p. 70). Similarly, Dej (2016) found that people who experience homelessness and mental distress must negotiate the discourses that treat mental distress as biological, simultaneously calling for them to be responsible for their circumstances. This section located the blame-self-responsibility paradox experienced by service users in the context of biomedical discourse and neoliberal logic.

Blame and Deservingness

Deservingness was another aspect of a culture of blame. The more blameworthy a service user was, the less deserving of services they were deemed to be. Thus, blameworthiness functioned as a heuristic device employed by practitioners and services within a culture of blame. Services and practitioners communicated implicitly to service users that they were responsible for their distress and therefore undeserving of care, as evidenced in a service user’s account of practitioners’ attitudes towards her diagnosis of borderline personality disorder: "you’re just seeking your hospital admission … you shouldn’t be in hospital with that sort of attitude” (SU12-P).

A focus on bed management, accompanied by resource scarcity, meant that practitioners used their assessment of service users’ deservingness to decide who was and was not worthy of a bed, support and treatment. A service user recounted being told by a practitioner: “you shouldn’t be here … you’re in this bed, you’re taking up our time, it’s something you do to yourself” (SU4). This assessment reinforced the service user’s feelings of self-blame and undeserving of care: “you’re already thinking it yourself, you know, ‘I brought this on myself … shouldn’t be here’ …” (SU4). This approach dehumanised service users as they were viewed through a lens of bed occupancy and workload pressures. If occupying a bed, it was implied that service users should be grateful and offer no resistance to treatment:

> During my first stay at [public hospital], um it’s a technique that is unfortunately used sometimes to encourage people to accept discharge is, [a practitioner said] “I’m not really seeing that you’re trying hard enough in your recovery.” Um and someone said that because I didn’t feel like I could make plans for the future … [so they said] “Well, do you even want to recover?” (SU13)

In summary, the use of power and subtle coercive practices were evident in mental health services, and these practices were unquestioned features of a culture that attributed blame to service users. The influence of the organisational and administrative cultural frame was illustrated and showed how efficiency was deeply embedded in practitioners’ operating methods, used as way to determine deservingness. Pressure on practitioners filtered down to service users and sat at the taken-for-granted level of culture. The RCVMHS (2021a) similarly reported that mental health services are under significant pressure, which has created a culture overly focused on managing demands and gatekeeping resource allocation rather than keeping an “open-door policy” and a person-centred approach (p. 462). The next theme, displaced blame, unpacks this filtering down of pressure from practitioners to service users.

Displaced Blame

Chapter 4 highlighted the crisis-driven nature of mental health services resulting from limited resources, particularly in relation to public services. Participants in all groups recognised that practitioners were overstretched and operating within a compliance-driven and hierarchical context, which in turn produced a silencing culture. This final feature of a culture of blame experienced by service users, entitled displaced blame, is considered within this organisational context.

Practitioners’ lack of resources and skills to support or work with service users and often intersecting and multiple unmet needs fostered a culture of blame. Blaming thus represented a transference process where practitioners’ feelings and experiences of pressure and inadequacy were redirected to and manifested in their responses to service users. Speaking about inpatient settings, a practitioner stated that blame was part of the: “culture of psych wards” (P5). She described how people come into the ward setting experiencing overwhelm and distress, and when services and practitioners did not have the skills or resources to work with the person, or were limited in what they could offer, the result is “you [practitioner] just blame them [service user]” (P5). These dynamics were a manifestation of practitioners' feelings of pressure, fear of blame, disillusionment, and the erosion of their professional identity and purpose in the broader organisation.

While many service users and families acknowledged the pressure on practitioners, they were unequivocal that blaming service users was unacceptable:

> When someone's having the worst time of their lives and they, you know, land in a psych ward, if the response is more harshness and blame, what are we doing? … I don't know, maybe it's got to do with going to work every day for 15 years in a psych ward, it erodes you. (SU15-P)

These findings align with the work of the Mental Health Council of Australia (MHCA) (2005), Bloom and Farragher (2011) and Fotaki and Hyde (2015). As early as 2005, the MHCA noted: "what we do not need is continued blaming of those who use services, those professionals who provide services or those independent bodies who report on them" (MHCA, 2005, p. viii).

The concept of parallel processes was introduced in Chapter 4 in relation to limited accountability and is also relevant to these findings. As mentioned, Bloom and Farragher (2011) argued that conflict or stress that occurs in one area of an organisation, for example, the stress experienced by practitioners, was often displaced and enacted elsewhere (e.g., in interactions with service users). The present study found that the stress and fear of blame experienced by practitioners was projected or enacted in practice. Parallel processes are "destructive" (Bloom & Farragher, 2011, p. 21) when an individual, group or organisation unconsciously re-create damaging scenarios with the people they should be supporting. Pertinent to the findings of this study, Bloom and Farragher (2011) suggested that complex interactions between service users who often have trauma histories, stressed practitioners and pressured organisations result in a "social and economic environment … that is frequently hostile" (p. 22) and counterproductive to the aims of recovery.

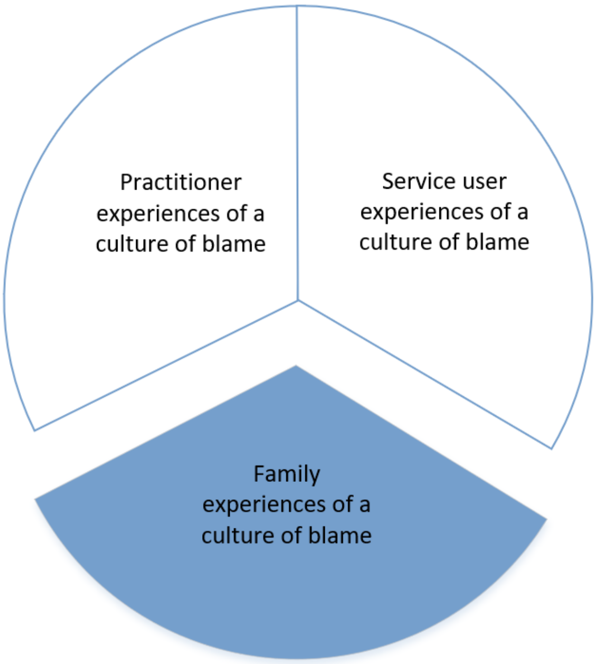
Participants from all groups noted how blaming responses from and interactions with practitioners reinforced their existing feelings of shame and exacerbated distress. Attributing blame was counterproductive; it did not create conditions for connection or validation that were dignifying or helpful to service users. These processes operated at an unconscious and accepted level of service culture, leading to negative or harmful experiences for service users and families.

Family Experiences of a Culture of Blame

Family members also reported feeling blamed and witnessed their loved ones being blamed (see Figure 4). Some family members viewed a culture of blame as contributing to and reinforcing their exclusion from service delivery processes. This exclusion took many forms, including a lack of communication from practitioners to families, even when families tried to initiate contact.

Figure 4

Family Experiences of a Culture of Blame



One participant stated that the family was made to feel as though “you’ve done something wrong if you’ve brought your child there [mental health services]” (F3). Another participant emphasised the way he and his family *felt* they were blamed, as was his brother, who was a service user:

> I think there’s a culture … in a sense that um just feels very blaming to families and consumers, “it’s your [service user] fault for … being this way … it’s your fault as a family for not looking after your loved one”. (F1-P)

In a similar vein, a service user talked about how her partner was subjected to a “responsibility discourse” (P-SU15). Likewise, one mother reported being so accustomed to the implied blame in her interactions with services and practitioners that she addressed this directly with them. She said during a meeting with a team of practitioners:

> "So, you can blame the mother, you can blame everything on the mother". And I said: "If we've got that out of the way now we're going to save months, and months, and months, of having to get to that point, and we can start to focus on what can you do to help me support my son" … It was kind of like, let's get [to] the point! (F3)

Family members experienced everyday practices as conveying blame, including obtaining consent and applying confidentiality:

> I think it's practices that make us, that make us feel blamed. So practice like … um sort of this consent. So if we push up against that we become the crazy family member so yeah … and then when they start seeing us as the crazy family member they go "oh well your mum's the problem" and then my brother gets told "well don't speak to your mum". (F1-P)

The experiences of families in this research reflected the deeply engrained historical ideas and attitudes that families somehow caused their family members' mental distress (Bland, 1998; Bland & Foster, 2012; R. M. Martin et al., 2017; Nicholls & Pernice, 2009; Rowe, 2012; Wyder & Bland, 2014). For example, a psychiatrist linked the practice of blaming and excluding families to historical research and embedded ideas: "The problem of lack of involvement of families, it is a devastating one, and a profound one, and an enduring one, and a severe one. It's a massive issue. And it's a culture issue" (P12).

Clinical research conducted in the 1960s and 1970s suggested that the 'schizophrenogenic mother' was the cause of their child's diagnosis of schizophrenia (Harrington, 2012). Other research connected family traits and expressed emotion within families to patient relapse (Bland & Foster, 2012). Despite these ideas being widely discredited and discounted (Bland & Foster, 2012; Harrington, 2012), the findings of the present study and others (Nicholls & Pernice, 2009; O'Grady & Skinner, 2012; Productivity Commission, 2020c) suggest that blaming families for their love one's mental distress, and subsequent exclusion of families, persists (SSCMH, 2006; R. M. Martin et al., 2017). Holding families responsible for the mental distress of their loved ones appears to be an enduring element of mental health service culture.

This blaming of families by services and practitioners was an example of culture stemming from a historical context, where practices of blame and exclusion signified the devaluing of family experiences and knowledge. R. M. Martin et al. (2017) argued that practitioners should view family involvement as an opportunity to learn more about the family and service user. However, the authors also recognised that there is a need for cultural change in mental health services to embed family involvement; currently, practitioners face multiple challenges that do not support or encourage practices that value family involvement (R. M. Martin et al., 2017).

Practitioner Experiences of a Culture of Blame

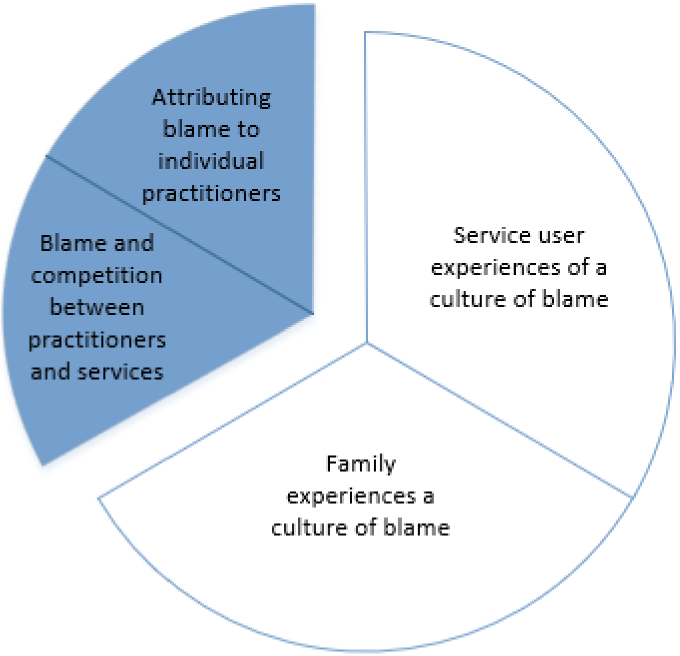
Most practitioners spoke about a culture of blame as a part of, and a by-product of, the organisational and administrative context of mental health services. They emphasised their fear of being blamed. Psychiatrists emphasised their legal responsibilities, and some noted their fear of being blamed for adverse events by the coroner: “extremely anxiety provoking” (P14) and “many people working at the sharp end feel quite vulnerable and wonder when they’re going to have to go talk to the coroner … go to the inquest and be told that they’ve been negligent or something” (P11). Practitioners witnessed other practitioners being blamed for incidents, which they viewed as the inevitable outcome of systemic issues, creating, fuelling and sustaining a fear of being blamed.

The organisational and administrative context of mental health services is shaped by neoliberalism and NPM, constituting hierarchical, compliance-driven, risk-averse environments. These contexts disproportionately attribute blame to individual practitioners for systemic failures; frontline staff are monitored to avoid adverse events. Administrators’ risk-averse stances prioritise efficiency over service user needs; practitioners operate from a stance of fear that they will be legally accountable for service user harm or death (Cohen, 2017; Godin, 2004; Khatri et al., 2009; Wand, 2017).

The experiences and perspectives of practitioners in this project are situated in this context. Service users and family participants also said that practitioners experienced a culture of blame. While not found in this research, previous studies (see MHCA, 2005) report that practitioners have experienced blame from service users and families. This section describes two facets of the culture of blame particularly relevant for practitioners: attributing blame to individual practitioners and blame and competition (see Figure 5).

Figure 5

Practitioner Experiences of a Culture of Blame



Attributing Blame to Individual Practitioners

Practitioners emphasised how blame was frequently attributed to them by administrators rather than understood as a shared organisational responsibility. Practitioners did not deny their professional accountability but argued for acknowledgement of the often untenable conditions within which they worked. This stance aligns with an assertion by O'Conner et al. (2011) that blaming responses provide a simplistic evaluation and solution to multifaceted issues and impede the exploration of more complex explanations and understandings. Additionally, the outcome of the methods of investigation and identification of the root cause of incidents involves partial and decontextualised explanations for incidents and results in individual practitioners being blamed. Elements of NPM, such as hierarchical leadership structures, and explicit and measurable performance standards focusing on efficiency and efficacy (Hujala et al., 2014), create the conditions for individual practitioners to be blamed. A service user participant linked blame and formal complaints processes:

> I think the culture is very blaming of individuals and that goes from the worker to the service user, so if you put in a complaint they will target that at one particular

> worker, generally speaking, depending how bad the problem was. Yeah, they'll target it and say 'well that particular worker is the problem, they've got to go' … but they don't really get rid of them … or 'they need training or … they need to take some leave or, or actually you [consumer] were really bad and they were responding to you so' … yeah there's this blaming. I think workers feel very unsupported in the wards. (SU15-P)

This participant (SU15-P) emphasised how blaming individuals and protecting the organisation were resulted in a profound lack of safety for practitioners. A feeling of limited support was also noted by several participants and contributed to the defensive practices of risk avoidance discussed in Chapter 4.

Literature supports this finding that practitioners feel unsupported and undervalued (RCVMHS, 2021d). Other studies reported practitioners having limited support to implement specific policy goals, such as eliminating restrictive practices, while simultaneously fearing that they would be blamed for using restrictive practices (Muir-Cochrane, O'Kane et al., 2018). These studies reflect the paradoxical nature of the culture of blame and current policy and organisational environments in which improvements and reform are expected, yet there is inadequate time, skill development and resources to enact such changes. Existing literature and the findings of this research suggest that practitioners' fear of blame is tied to a lack of organisational support and is a characteristic of all service types and professional disciplines.

A culture of blame in which individual practitioners are positioned as being at fault and responsible means that the broader systemic factors constraining and limiting practice are not considered or addressed. For example, systemic issues raised by participants in all groups included limited acute and community services resulting in service users' premature discharge from services. However, if an incident occurred following a person's premature discharge, the blame would be assigned to the discharging practitioner and the intensified context in which practitioners work would not be acknowledged. Limited appropriate referral sources and inadequate organisational support for the practitioner were also highlighted. Additionally, practitioners emphasised having little time to navigate complex systems such as finding accommodation, particularly from the emergency department.

Other symbols of a culture of blame included control mechanisms implemented by administrators. For example, although issues raised by practitioners were often interconnected with other services, they were responded to in a simplistic way focused only on practitioners' actions. A control-based management style was evident in which "communication is quite anaemic, mostly top-down … the focus of employee behaviours is on compliance with procedures, instructions and orders from the top" (Khartri et al., 2009, p. 316). A psychiatrist who worked across public, private and specialist services sought to challenge and provide a counter-narrative to the blame of individual practitioners:

> And then, it gets to the stage where services are blamed, whereas it's bigger than that. The clinicians are doing what they can with the scant resources, um but it's the clinicians who always get the blame. I do a lot of reports for the coroner um and I always try and make it clear that it's the systemic issues which aren't being addressed. If you're a registrar and seeing someone at midnight and they need to go into a bed and there's no beds available, you tend to not admit them because it's too difficult. Um but, it's … all the pressure is on the registrar. And because he doesn't have time or uh … someone to complain to, no one sorts out the problem. (P13)

This psychiatrist's account illustrates the myriad issues affecting practitioners' decision-making and practice. These findings link to practitioner experiences discussed in Chapter 4, where although practitioners were excluded from organisational decision-making, they were left to respond to and implement the outcome of such decisions. Practitioners were also often blamed when incidents occurred.

These experiences of a culture of blame were most dominant for public mental health services practitioners. However, the expansion of the NGO sector is characterised by a transfer of risk from public mental health services to NGOs that have traditionally not been responsible for clinical and specialist services, including the management of crisis and acute episodes of distress (Lemon et al., 2016). Therefore, it is unsurprising that NGO practitioners in this study also feared being blamed for critical incidents. Practitioners across all mental health service delivery sectors believed that they would be blamed if problems arose.

Practitioners were aware that if they highlighted problems (such as constant change and uncertainty) within their organisation this would result in their competence being questioned as they would be constructed as the problem. This finding aligns with Fotaki and Hyde's (2015) observation that blame is "mistakenly and unconsciously attributed to those who identify organisational problems" (p. 446). Such blaming indicates the subtle yet embedded ways a culture of blame operates, resulting in a lack of transparency or opportunity for honesty and openness. Practitioners adapted their practice to try to meet service user and family needs, which sometimes involved going against organisational procedures and policies. This juggling act was a significant theme for practitioners reflecting on the complexity of their experiences and actions. As a psychiatrist explained:

> The whole area of risk assessments is just fraught with difficulty. There's … no evidence that we're any good at it. But you have do it, although if you've done it and then you go to court because something's come undone and you say "I didn't think…" They say "Well, did you do a risk assessment" … "Yes, I did" … "Well, what did you find?" (P11)

This study found that it was uncommon for practitioners to feel supported, with just four reporting experiences that involved administrators being accountable for issues and adverse events. Additionally, two practitioners in NGOs noted having sufficient resources and opportunities for collaboration between teams; and a peer worker talked about feeling supported at the NGO where she worked, stating that her lived experience and role were valued. While a small number reported receiving support from management, they also noted that they were subject to constant organisational change and job insecurity. This discussion now turns to the second sub-theme relating to practitioners' accounts of a culture of blame.

Blame and Competition Between Practitioners and Services

Blame and competition between practitioners and different services was identified as another facet of a culture of blame. Blame between practitioners was explained as parallel processes in which they re-enacted or projected the same practices they experience from the broader organisation and administrative environment onto colleagues. The following account describes psychiatrists' tendency to criticise the practice of other psychiatrists:

> I think one thing that is a big issue … and I did speak about it in my own therapy was this … tendency in our professional body of psychiatrists to criticise other psychiatrist's care of patients and you know to be, you know 'oh that suicide wouldn't have happened to me' … and that sort of thing … it's this, sort of this reflex way of thinking about adverse events. … yeah so I think that's one thing that I'm sorry about that there's a lot of rudeness and conflict in our profession and it's

> fostered by the system because you know … if you really care about a patient and you need them to be looked after in private or community or wherever you have referred the patient in good faith … but there's certain things that just cause people to be excluded like, you know, a history of violence or acts of suicidality or substances and things like that and it's so frustrating when you can't get help for your patient. (P14)

This reflex-blame response, coupled with criticism of and competition between practitioners, mirrored how individuals were blamed for systemic issues. This reflex-blame response was fostered by the organisational and administrative context where policies, procedures, risk management and conflicting demands were significant and increasing for practitioners and a direct consequence of NPM. Participant 14 stated how criticism of other practitioners was fostered by the broader system that responded in reactive and blaming ways, which obscured contextual factors. These reflex and defensive responses also reflected the lack of safety, trust and support experienced by practitioners in their roles.

Blame and tension between services were also created by limited clarity of service responsibilities and a lack of collaboration and communication. Service roles and responsibilities were noted by practitioners as confusing and unclear, contributing to individual services and sectors working in isolation. Participants working in NGOs spoke about a tendency to blame government services for issues, while government services blamed NGOs for poor outcomes or a lack of appropriate services. One NGO practitioner mentioned that "it's so easy to blame someone else" (P7) rather than focusing on the broader organisational issues that hamper communication and perpetuate siloed ways of working.

The lack of organisational responsibility across most mental health services exacerbated these problems. For example, a public service psychiatrist stated that "there should be partnerships between clinical services [and] NGOs, everyone knows that" (P15). However, participants emphasised that there was limited agreement on service roles and pathways, something this psychiatrist (P15) believed was the responsibility of the government and MHC to outline in service contracts. Importantly, practitioners had limited involvement in the service design and delivery of NGOs and funding contracts. These decisions were made by governments and commissioning bodies such as the MHC. As a result, a psychiatrist reported: “[NGOs] get some money … set up their own fiefdoms. So right now we haven’t got any pathways” (P15).

The Productivity Commission (2020c) report stated that partnerships are most effective when there is clarity of responsibility or accountability, and partnerships are likely to break down and result in blame when there is a lack of mutual understanding and shared perspectives. This study’s findings suggest that a lack of partnerships between services, alongside little clarity about service roles and responsibility, creates uncertainty and promotes a blame and competition culture. Additionally, competitive funding models were identified as contributing to blame between service types (e.g., between public inpatient and non-government community services). This blaming can be understood as arising from competitive funding models based on scarce resources leading to fragmentation of services and sector competition rather than collaboration (NHMRC, 2014c; Rosenberg, Hickie & Rock, 2020). Previous inquiries and reviews have also highlighted this issue, noting that market forces, such as the competition for funding underpinned by neoliberalism, can drive services and practitioners apart rather than together, cultivating a competition and blame culture (Groom et al., 2003). Additionally, the SSCMH (2006) noted that “blame shifting” between federal and state governments resulted from a lack of reliable funding streams for community services (p. 218).

Overall, these findings support Cohen’ (2017) and Pope and Burnes’ (2013) contention that competition sits in a context of increasing workplace distrust, rising demands, increasing organisational attention to reputational risk and individual staff seeking to protect their interests in work settings deemed to be unfair and unsafe. Most participants reported a pervasive culture of blame fostered by the organisational and administrative cultural frame and the paradoxical policy and reform context. This study found that service users and families were marginalised due to the blaming and competitive cultures between practitioners and mental health services, although this was not the practitioners’ overt intention.

Conclusion

A culture of blame permeated all areas of mental health services, profoundly impacting all participant groups in this research. This culture operated discursively; it was both tangible in the way that people were directly told they were to blame, and intangible, whereby the organisational and administrative contexts created a culture of blame that was felt, perceived and anticipated. The organisational and administrative context produced a culture of blame via control-based management processes and a preoccupation with risk aversion. Ironically, a culture of blame also reinforced risk aversion.

Service users' experiences of this culture were rooted in biomedical discourse and neoliberal logic, which combined to produce a paradox in which service users were simultaneously responsible for their distress and powerless to change their pathology and genetics. A culture of blame was closely associated with ideas about service users' deservingness of scarce resources; additionally, service users experienced the brunt of pressure experienced by practitioners as blame was displaced onto service users. Displaced blame directly resulted from practitioners lacking the resources and capacities to adequately meet service users' needs. The enduring blame of families due to historical misconceptions and disproved ideas was reported as a deeply entrenched culture and pervasive in families' experiences of mental health services.

Finally, a culture of blame resulted in attributing blame to practitioners with little acknowledgement of the untenable conditions within which they worked. Competition between practitioners and service types manifested as part of a culture of blame and mirrored how individuals were blamed for systemic issues. Overall, in view of the overarching research question, this chapter has clearly identified that a culture of blame mediated reform aspirations at all levels of the mental health sector. The findings support existing literature and add to this body of knowledge by detailing how service users and families also experienced a culture of blame. The next chapter presents the second element of culture produced by the broader cultural frames, a culture of othering.

Chapter 7: A Culture of Othering

A culture of othering is the second key element of culture arising from the cultural frames (see Chapters 4 and 5) experienced by service users and families. The concept of the *other* has been developed and applied across several disciplines, including Simone de Beauvoir's (1949/1997) work, *The Second Sex*, about gender. Postcolonial theorists have engaged extensively with the concept of the other to understand colonial relations and power. For example, Edward Said (1978) exposed how Europe constructed its opposite, the *Oriental other*, for the purpose of domination and its own reproduction. Postmodern theorists have also employed this concept. Foucault (1980) undertook genealogical analysis to examine the language by which the other was represented, explaining how religious, medical or scientific discourses were used to construct the other. Similarly, anti-oppressive theorists have explicated the notion of othering; for example, Dominelli (2002) states that othering is an integral element of the processes of oppression and discrimination.

Othering involves constructing and labelling an individual or group as inferior, deviant, pathological and different (Dominelli, 2002). Othering processes are exclusionary and aim to reproduce relations of dominance (Dominelli, 2002). Notions of other and othering pertaining to mental health settings are particularly evident when considering the history of institutionalisation and psychiatry (see Chapter 5), whereby those deemed Mad and constructed as other were, and continue to be, segregated. Psychiatric discourses construct people as mentally ill, which positions them as others and "relegates them to the position of passive objects of psychiatric knowledge and their own knowledge and experiences are routinely obliterated" (MacCallum, 2002, p. 89).

Othering entails being excluded from "being human, refused reciprocity and excluded from intelligibility … Others have their presentation of self denied. Their competence cannot be validated. They cannot be trusted" (Rawls & David, 2005, p. 494). In this research, service users and families spoke of othering as a core feature of mental health service cultures that positioned them as inferior and inherently different to practitioners. This culture excluded service users and families socially and epistemically.

Participants from all groups spoke of a culture of othering. Othering was also identified across service types; however, it was most pronounced in inpatient settings.

While this element of culture was common to service users' and families' accounts, their experiences and the effects of othering varied. For this reason, service user and family experiences are presented separately, starting with service user experiences. The discrediting and undermining of service users' and families' knowledges are also explored as part of a culture of othering.

Service Users as Other

Othering and dividing practices were identified as pervasive features of service cultures associated with and sustained by biomedical discourse. Discourses that position people who experience mental distress as inherently different and less human were common in service user accounts. A service user-practitioner described mental health services as involving a "real culture of othering" (SU15-P). A key device of othering was binary categorisation such as patient/professional, sane/Mad and us/them. These dichotomies dominate Western constructions of mental distress. Such dichotomies limit space for service users and their families to consider, negotiate or create understandings about themselves on their terms and in ways that reflect their lived experiences and meaning-making. Binary and fixed subject positions of 'service user' and 'practitioner' were evident in terms used by participants such as 'us' and 'we', and 'they' and 'them'. McCallum (2002, p. 88) similarly observed a culture of 'Us' and 'Them' in a psychiatric inpatient ward and explained this as service users and staff inhabiting different worlds. Prejudice and discrimination against service users sustain the us/them binary in mental health services and the continued acceptance of entrenched practices such as coercion and restraint (McSherry, 2020).

A key dimension of othering was the demarcating and differentiating processes evident in practitioners' language, communication and actions, which manifested in service users feeling "less deserving than people within traditional health services" (SU2). Another service user said: "in some places there's less respect and … obviously you're the patient and they're the health professional, they're the doctors or the nurses … it's hard not to feel that divide" (SU12-P). This account reflects many service users' descriptions of othering that was communicated and *felt*. Another service user emphasised the explicit nature of demarcating practices symbolising power and control. She discerned this aspect of the culture from the moment she entered a service; it was reinforced in interactions with staff:

> That was very obvious from the moment I walked in that door … there is a massive divide. It's like we're in charge and you're the crazy person that doesn't matter. It was very energetically, body language-wise, tonal-wise in the way they spoke, very obvious … they think anybody walking in their door, is lower than them … Your needs don't actually matter. (SU1)

This finding is consistent with Dominelli's (2002) contention that othering processes are dehumanising. The effects of these practices were illustrated in the way the service user was made to feel "lower than them" and that she "doesn't matter" (SU1).

Surveillance and monitoring practices demonstrate a culture of othering, where service users spoke about their awareness that everything they did was interpreted through a lens of illness. This illness lens created the conditions for practitioners to construct service users as the other. Therefore, any service user actions or behaviours could be viewed as different, unacceptable or unrelatable:

> It's like anything you do is a bit weird … to me they're acting strange but the thing is, because I'm the one with a diagnosis, like I've got to defend myself just to prove I'm not strange, and they [practitioners] can do whatever the F they want and they get away with it. (SU5)

Practices such as surveillance promote Mad/sane and observer/observed binaries, sustaining the conditions of a culture of othering. Surveillance is an entrenched norm and routine practice in mental health services, particularly in inpatient services, as indicated in Chapter 5 about the legacy of psychiatric institutionalisation. The ongoing use of observation practices has been framed as "defensive and custodial" (Cutcliffe & Stevenson, 2008, p. 943), antithetical to therapeutic relationships and recovery-oriented practices.

The construction of the other as deviant underpins and justifies the need for surveillance, as highlighted in Chapter 4, where risk-averse environments and the focus on controlling risk pervaded mental health services and workforce practices (D. Green, 2007; Webb, 2006). D. Green (2007) asserts that increasing demands for administrative accountability and documentation results in services and practitioners needing to "build conservative, controlling and defensive procedures against risk" (p. 406). While some deem such practices necessary for protection and risk minimisation, Slemon et al. (2017) argue that surveillance and observation are unethical due to the harmful impacts on service users.

Discourses of inherent difference and otherness were represented and reinforced in physical features of services; the “fishbowl” (F6) in inpatient wards and perspex and “bullet proof glass” (SU17-P) at services’ front desks were strong markers of culture. While such features may appear or be interpreted as neutral, pragmatic or risk mitigation strategies by organisations, the meanings ascribed by participants in this research epitomise difference, otherness and power dynamics. In addition to reinforcing perceptions of service users as dangerous, these physical features are cultural artefacts—not only symbols of culture but sustaining cultures of othering and division (Schein, 1992, 2010).

The physical features served as a constant reminder to service users and families of their otherness. Additionally, physical features and the way spaces were negotiated and used by practitioners to physically distance themselves from service users, confirmed and fortified otherness. For example, participants’ accounts in Chapter 5 included descriptions of being ignored or smiled at behind the nursing station glass when trying to communicate with staff. Such actions of diminished and truncated communication, and physical distancing, were potent examples of othering and dehumanisation.

Service users’ experiences of being treated with little respect were synonymous with reducing them to a patient identity—treated as an illness and not as a whole person. Labelling exacerbates power differentials, distances service users from service providers and overrides their self-defined definitions and meaning-making about their experience (MacFarlane, 2009). Bainbridge (1999) and Weis (1995) speak about the way the construction of the other not only “serves to mark and name those thought to be different from oneself but also impacts how practitioners view themselves in relation to the ‘others’…″ (Weis, 1995, p. 18). In the present study, the difference between ‘us’ and ‘them’ was amplified, and the knowledge of those who classify differences was reinforced and confirmed by practitioners who had to uphold their ‘professional’ selves and ‘saneness’. This experience was evident in practitioners’ accounts of feeling unable to share parts of themselves that existed outside their role as a practitioner, nurse, social worker or psychiatrist: “you can’t show any parts of self that reveal your own issues or experiences” (P1). Some psychiatrists also spoke of the stigmatising responses they observed by services and colleagues towards other practitioners experiencing mental distress.

As noted in Chapters 1 and 3, some participants in this research had mixed identities of service user *and* practitioner, or family member *and* practitioner. Some practitioners were in designated peer work roles, while other practitioners stated that they did not feel able to disclose their service use or experiences of mental distress in their workplace:

> Like why is there this separation, I don't understand. I mean I don't go into my job and tell people I've been in a psych ward or whatever. But I just feel that sometimes maybe that would help, I don't know. It's a difficult, yeah … I understand you have to maintain professionalism and self-disclosure is not something that you would do all the time, um but at the same time I feel that it can be quite beneficial for some people. (P4)

Professional discourses rendered self-disclosure problematic as practitioners' sharing their experiences of distress or service use was deemed unsafe, highlighting the demarcation of people based on their experiences, professional privilege and power.

These findings support existing literature. For example, King et al. (2020) argue that a "pervasive culture of nondisclosure" exists in relation to practitioners' sharing their experience of distress or service use (p. 1048). They identified this as both the cause and by-product of stigmatising views held by practitioners about service users. This culture of non-disclosure has been attributed to practitioners' fear of being perceived as "impaired" (Harris et al., 2019, p. 925) if they disclose their lived experiences of distress, service use, or both. These findings demonstrate the embedded nature of an othering culture experienced by those who use and work in services and the presence of iatrogenic stigma (NMHC, 2014c; Sartorius, 2002), whereby practitioners contributed to and reproduced stigma in their practice.

Family Experiences of Othering

Family participants also identified practices of othering and division between themselves and practitioners, as well as between service users and practitioners. This culture was evident in the language used by mental health practitioners to construct service users and families as possessing fixed identities of service user/patient and family member/carer. A family member described being struck by the language used to describe service users and families:

> [Practitioners] talk so badly about people coming in … there's a culture of 'we're [mental health professionals] well and they [service users] are sick … we are good

> and they are bad' … I don't even know what it is, it is like 'we are better than' … but that's what keeps the system in place. (F3)

Discourses of binary systems of sanity and madness are reflected in this account, whereby constructions of the other were deeply rooted in institutional practices centred on segregation, classification and control (Bainbridge, 1999) (also discussed in Chapter 5). Several family member participants similarly noted the cultural artefacts identified by service users, including "glass partitions" (F11), service entrance doors operated by staff who made service users wait until they were observed before allowing entry, and male security guards within services. Physical features in buildings and practices of distancing and surveillance were an extension of the previously mentioned cultural artefacts and key markers of othering culture.

The processes that took place between these physical barriers included witnessing service users' knocking on the "glass fishbowl" and being told by a nurse to "stop doing that [knocking]" (F11), limited engagement or communication from practitioners and being ignored. A mother spoke of arriving at an inpatient ward to visit her son:

> They [staff] would be in the glass cage, all doing administrative stuff. And, not engaging and you'd stand there humiliated, and ashamed, and angry, waiting … One of the people at [advocacy group] mentioned one day that when they were in the hospital they would go up, and she said, "I would rattle on the window because, they would ignore me" and, I thought, well I should have done that. But, I felt like if I got a bad name for myself … you know? (F8)

These experiences (e.g., being made to wait, ignored) indicate mechanisms of a culture that operate to reinforce power relations and the position of service users as the other. These findings suggest that families are also considered the other by association with their loved ones. Families' experiences can be linked to Goffman's (1963) concept of courtesy stigma or stigma by association, whereby families are viewed negatively due to their relationship with the stigmatised individual. This finding is reflected in Chapter 6, where family participants spoke about being blamed for their loved one's distress and feeling that "you have done something wrong for your child to be here" (F3). Another family member participant said the culture felt like "an old boys' club" (F8), signifying exclusion and being made to feel less than and the other. The final manifestation of a culture of othering was discrediting and undermining participants' lived experience knowledges.

Othering and Knowledges

Othering is linked to the construction of knowledge, specifically, the legitimacy and credibility of the other's knowledge. Service users and families widely reported that their lived experiences were ignored, undermined and discredited. Such experiences are interpreted here as a manifestation of othering characterised by the discrediting and dismissal of service user and family knowledges and experiences. Exclusion and marginalisation are rooted in othering (Dominelli, 2002) and constitute a form of epistemic injustice (LeBlanc & Kinsella, 2016). The notion of epistemic injustice conceptualised by Fricker (2007) concerns how social identity and power affect a person's status as a knower. Fricker argues that there is a distinctively epistemic kind of injustice: the harm done to a person specifically in their capacity as a knower, or epistemic agent, because of prejudicial stereotypes. Epistemic injustice involves undermining a person's capacity to engage in epistemic practices such as articulating one's knowledge (testimony) or making sense of or interpreting one's experiences (Crichton et al., 2017; Fricker, 2007). In this study, historical ideas about service users and families that constructed them as others resulted in epistemic injustice in which their testimonies and interpretations were treated as unreliable, and their capacity as knowledge holders was undermined. This construction as other justified service providers excluding them from decision-making about their care and treatment and opportunities to provide testimony about their experiences.

Service users and families referred to this manifestation of othering as "they know best" (F8) culture, meaning that services and practitioners are "embedded in the 'we are the experts'…" (F6) view and consistently positioned as knowing better than service users and families. In contrast to the credibility invested in practitioners, service users were acutely aware of the limited value placed on their knowledge and voice. For example, after detailing experiences of distress and service use in an interview, a service user participant who is also a practitioner said, "so now I've said that, will my voice be as credible as others? I'm not sure" (SU15-P).

Discrediting service users is longstanding and underpinned by the dominance of historical ideologies and biomedical discourses outlined in the historical cultural frame. Biomedical ideas are situated in a scientific paradigm that assumes knowledge lies exclusively in professionals with technical expertise (Bracken & Thomas, 2005, 2017).

Further, significant value is placed on technical expertise within the biomedical paradigm, which marginalises lived experience knowledges (Coles et al., 2013). Consequently, service users' experiences were relegated to patient status and viewed as lacking insight and competence (Hamilton & Roper, 2006). Families, who were othered by association, were conceived as people who lacked valid knowledge. A key difference between service user and family experiences is that service users were positioned as lacking insight and competence due to mental distress. Families were positioned as having insight but lacking competence as parents or carers and were blamed for their loved ones' distress (see the discussion on the blame placed on families earlier in this chapter and Chapter 6).

Service Users' Delegitimised Knowledges

Service users' experience of having their knowledge and voice dismissed or undermined was common across service types; however, the impacts were more significant for those with inpatient experiences. For example, a service user shared an experience where their family called emergency services, claiming the service user was attempting to overdose—a threat the family often used against the service user. When the service user attempted to communicate to practitioners (paramedics, nurses and psychiatrist) that they were not suicidal but experiencing abuse from their family, they were not heard or acknowledged. Instead, they were involuntarily placed in a secure facility.

A 'professional knows best' culture was associated with coercive practices. For example, given that service users are deemed incompetent, they were not asked about their understandings or knowledge of their experiences, and coercive practices were deemed necessary. Differences in the form and use of coercive practices, and dismissal of service user experiences, were identified between private and public services. A service user-practitioner described that while she experienced some differences in private services, a coercive and professional knows best culture remained pervasive:

> And private wards have a lot of programs … even those, they're not voluntary, there's coercion all the time. There's still a lack of listening to the individual and what they need, and you've gotta fit into the program um yeah … there's a culture of we know best and this is what you need. (SU15-P)

This manifestation of a culture of othering was not always explicit and may have been woven into the organisation's ways of operating. Services are designed and operate in ways that are based on practitioner expertise and knowledge.

Madigan’s (1999) contention that people in psychiatric services are discursively embodied and managed as people without knowledge was echoed in many service user accounts: “I think that [there is] the culture of … they [practitioners] have more right. That they have more knowledge, even though it’s my life, that they know more about me and my mental state than I do” (SU2). Another participant described how this deeply embedded assumption that service users hold little or no knowledge and insight about themselves and what they are experiencing was also explicitly enacted:

> In the private clinic when I was there for an eating disorder a psychiatrist sort of, you know, I was telling her that I know myself so I would be able to go home and maintain my recovery. And she was kind of like, "Oh no, I don’t think you can because people don’t just go home and are able to do that”. And I was like, ‘I know myself well enough to know that I am able to do that’. (SU12-P)

This account shows the practitioner discrediting the service users’ testimony and interpretation of the situation; it exemplifies testimonial injustice whereby a person’s knowledge is undermined because of the hearer’s prejudicial ideas (Fricker, 2007). Consequently, the service user was not only silenced and ignored but excluded from treatment decisions made about her. This example shows how the organisational and administrative cultural frame sustains and reproduces epistemic injustice. Given the psychiatrist’s legal responsibility for the service user, the psychiatrist’s response may stem from the risk-averse and compliance-driven environment, which invokes practices to avoid blame.

These findings support the work of Crichton et al. (2017), who suggest that epistemic injustice experienced by service users in psychiatric services is highly prevalent. It is also congruent with LeBlanc and Kinsella’s (2016) work highlighting how experiences and knowledges different from dominant discourses and ideologies are viewed as other, dismissed and ignored.

Families’ Delegitimised Knowledges

Family participants spoke of their experiences of a culture of othering and delegitimised knowledges in relation to themselves and their loved ones. They witnessed their loved ones being excluded from involvement in decision-making and treatment, resulting in their views and knowledge being discounted. There was also a lack of recognition of family members’ experiences and their knowledge was deemed irrelevant: “I think that’s what I found so frustrating was that they were completely dismissing my personal understanding of her as a person … This particular person was very ‘I know best’…” (F2).

Consequently, many family participants said they felt unheard and misunderstood, and the context and circumstances relevant to the service users’ experiences of distress (e.g., intersecting psychosocial and environmental factors) went unacknowledged. Some family members said there were times when they were listened to, but their account was never solicited:

> It really is … the old attitude of they know best … that particular doctor was, there was scepticism [towards me] and it was like ‘hmm, well, you know we’re the doctors and we’ve come to this conclusion’ type of thing … they listened but you just get the impression they think you’re a hysterical mother type thing. They might politely listen but you just get the feeling that they think they know best. (F7)

This description of an ‘old attitude’ suggests that it is an unquestioned feature of mental health service culture, visible in the practitioners’ attitudes, responses and interactions with families. It also signifies that this attitude is longstanding, situated in and linked to the institutional legacy of mental health services where families were not included or heard.

Other family members similarly spoke about being treated with disinterest and suspicion when they tried to communicate with practitioners about their family member’s welfare. The practitioners’ disinterest and suspicion reflect the blaming of families stemming from historical ideas about families as the cause of their loved one’s distress. Consequently, any family knowledge is positioned as illegitimate. These examples illustrate testimonial injustice, where groups or individuals may be listened to, but their accounts are ignored, treated with doubt or not solicited (Crichton et al., 2017; Fricker, 2007).

Other attempts by family members to communicate and be involved in their loved ones’ care were often treated as an annoyance or threat to professional expertise. For example, a service user who obtained her case notes said “derogatory” statements about her partner described him as “interfering” (SU15-P). A family member understood practitioner responses and “hanging onto that [power] so tightly” (F3) as the result of practitioners working in ineffective systems and feeling the need to assert their legitimacy as experts. Some family participants understood their exclusion as embedded in mental health service cultures linked to the dominant biomedical discourses that pathologised service users and viewed families as unimportant to service users' recovery. Instead, families were included only at times deemed necessary to practitioners (e.g., at discharge).

Service user and family participants rejected the notion that they lacked knowledge and understanding about themselves or their loved ones. Service users discussed acts of resistance to practitioners' ideas about their needs. For example, one participant spoke of the importance of "empowering the consumer [because] you always know yourself better":

> Doctors always think they know best but if you kind of learn about what medicines you're taking … you know long-term effects and read up some stories about the people that have been on this stuff long-term and the harm it can do … You know I was like far out I've got to get off this stuff while I'm still alive you know. (SU5)

Importantly, some participants noted individual practitioners who listened to their experiences and deemed their voice and knowledge credible. However, overwhelmingly, service users and families reported genuine valuing and recognition of their expertise and experiences as the exception, rather than a value and practice systematically embedded and enacted throughout mental health services.

Conclusion

All participant groups identified a culture of othering in mental health services. The experiences and impacts of othering culture differed among service users, families and practitioners. Biomedical discourses sustained a culture of othering and were embedded in constructions of service users as inherently different from practitioners and the broader 'sane' members of society. This view can be traced to the segregation of people deemed Mad throughout history and their construction as dangerous and incompetent (as discussed in Chapter 5). The perceived otherness and difference experienced by service users permeated all aspects of services. Service users described their otherness as obvious and consistently felt in practitioners' actions, language and communications. Othering processes dehumanised service users, devalued their personhood and marginalised their self-defined needs.

These findings identified numerous cultural artefacts and physical features in services that signified and amplified service users' otherness and reinforced power asymmetries between service users, families and practitioners. The separation of service users from families and the exclusion of families in mental health services is rooted in the history of segregation and blaming families for causing their loved ones' distress. For families, the culture of othering was experienced as exclusion, blame by services and practitioners, and being made to feel lesser.

Practitioners who were also service users recognised a culture of othering and spoke of their reluctance to disclose their experiences of distress, service use, or both, due to potentially stigmatising responses from their organisation or colleagues. This finding supports previous studies that identified a culture of non-disclosure where practitioners do not feel safe or able to share their own experiences of distress or service use (Harris, et al., 2019; King et al., 2020). However, this study has identified implicit and explicit expectations felt by practitioners to maintain their professional self and saneness.

Finally, service users' knowledge was consistently dismissed or undermined. Families also experienced having their knowledge disregarded and deemed less credible than practitioners. These experiences were captured in the commonly used expression: 'we [practitioners] know best' culture. The findings in this chapter identified that a culture of othering within mental health services significantly mediated reform attempts. Returning to the overarching research question, given this culture's unquestioned status and manifold manifestations (physical, discursive and epistemic), it presented a significant barrier to reform aspirations and activities.

Chapter 8: Discussion

This research sought to answer the question of how do mental health service cultures mediate reform aspirations and activities in Australia? In this chapter, I answer the research question by addressing the four study objectives:

1. To describe how mental health service cultures are understood, experienced, and enacted by service users, families and practitioners
2. To explore how current mental health service cultures mediate and are mediated by the implementation of national and local mental health policies
3. To identify barriers and enablers of cultural change in mental health services.
4. To identify requirements and mechanisms for cultural change in mental health services.

First, I address Objectives 1 and 3 by summarising the key findings concerning how mental health service cultures were understood, experienced and enacted by participants and highlighting key barriers and enablers of cultural change. I revisit Schein's (1992, 2010) layered framework of culture to explain why particular mental health service cultures are unquestioned and legitimised and, therefore, act as a barrier to reform. Next, I address Objective 2 by explaining how culture is a barrier to policy implementation, emphasising how the organisational and administrative context did not allow for policy implementation or create the conditions for adopting new practice approaches. I then argue for reconceptualising mental health service cultures through the lens of a 'wicked problem' and present the implications for policy and practice.

The requirements and mechanism for cultural change (Objective 4) are addressed in the discussion on implications for policy and practice, where I return to the theory of epistemic injustice and argue that existing cultures are produced and reproduced by particular epistemic resources. In doing so, I address the intractable nature of old culture. I identify a number of crucial mechanisms for cultural change including critical examination of administrators' authority and influence within mental health service organisations, addressing the competing demands practitioners face, education of future mental health practitioners, funding and resources, and the importance of policy makers and administrators engaging with the impacts of NPM, including the effects on practitioners' everyday work and service quality. Finally, the study's limitations are outlined, and avenues for future research are presented.

Objectives 1 and 3

I begin this section by presenting three key overall findings related to the experiences and meanings ascribed to mental health service cultures, and the broader cultural frames. I then provide a discussion of each chapter's findings and identify key barriers and possible enablers of cultural change (Objective 3) via an exploration of participants' understandings, experiences and enactments of mental health service cultures (Objective 1).

Based on the literature review in Chapter 2, I expected that the understandings of culture would vary significantly across the three participant groups (service users, families and practitioners). However, I found that there were many points of consensus in how cultures were *understood* across the three groups. Differences in *meanings* and *experiences* ascribed to cultures depended largely on different subject positions. For example, practitioners experienced old culture as limiting their capacity to work in person-centred ways due to biomedical dominance where their core priorities related to assessment, diagnosis and treatment. In contrast, service users experienced old culture as dehumanising, and entrenched practices were punitive, harsh and grounded in paternalism and assumptions about their capability and capacity. Families experienced this culture as exclusionary, with individualistic biomedical discourses devaluing family involvement. Additionally, families' experiences of old culture included witnessing their loved ones treated according to narrow biomedical approaches that communicated a deficit view, void of hope or possibility. This finding is novel as it adds a multi-perspective understanding of service cultures to the existing literature, which has largely focused on the experiences and perspectives of one group (e.g., practitioners). These findings support the literature identified in Chapter 2 and emphasise the importance of cultural change projects incorporating the perspectives and experiences of all stakeholders. This will ensure a more comprehensive understanding of culture is established, leading to more sustained and meaningful change.

Another unexpected finding was that the cultures identified were relevant and significant to all service types, although they manifested differently. For example, all services, whether private, public or NGOs, were compelled by economic priorities and resource issues: public services had an economic rationalist culture focused on cost cutting, private services operated according to an economic imperative focused on profit and NGOs operated according to their contractual funding agreement. Inpatient public services were identified as holding the most visible and entrenched culture of blame; however, practitioners in NGOs also emphasised fear of being blamed for critical incidents, which influenced how they worked with service users. This finding is an important contribution as existing literature has focussed largely on single settings (e.g., inpatient units) or service types. Additionally, this finding emphasises the importance of the broader cultural frames identified in this study, found to shape and sustain existing cultures across the mental health sector.

The historical and organisational and administrative cultural frames are a key finding and contribution of this research. All participants' understandings and experiences of culture sat within or originated from either the organisational and administrative context or the historical context of mental health services. Using the concept of a cultural frame enabled the exploration of the links between the organisational culture and the broader historical, economic, social and political contexts that produce it. Additionally, these two contexts shaped and reinforced cultures of blame and othering, providing insight into why such cultures are complex and seemingly resistant to change. I now turn to a discussion of each chapter's findings, highlighting barriers and enablers of cultural change.

Organisational and Administrative Cultural Frame

The first findings chapter (Chapter 4) identified that mental health service cultures are inextricably tied to and shaped by the influence of neoliberalism and NPM, which permeate mental health services. Although disparate and often competing priorities between practitioners and administrators were central to understanding the experiences and enactments of cultures for all participant groups; this cultural frame was most relevant to practitioners' experiences.

Practitioners highlighted the differences between organisational priorities and their own. Organisational priorities of economic efficiency and effectiveness, compliance and risk aversion adversely impacted service quality and integrity. On the contrary, practitioners' priorities involved providing quality services that met the needs of service users and families. Practitioners noted a desire to be responsive, flexible and person-centred;

however, insufficient resources coupled with organisational priorities limited and constrained their practice. This tension created a sense of disillusionment and frustration for practitioners as their efforts often felt futile and inadequate. A top-down culture of economic rationalism meant that economic priorities were consistently prioritised over service users' and families' priorities and needs at the level of service delivery.

This economic rationalist culture sits at the basic assumption layer of culture as it is an implicit assumption that guides practices at both the administrative and organisational levels (Schein, 1992, 2010). It presents such a significant barrier to cultural change towards recovery-oriented and person-centred practices, as it is inconceivable in the current social, political and economic environment to design services that place person-centred approaches above this tacit economic imperative. Addressing this tension between economic imperatives, which are highly valued by administrators and governments, and the priorities of service users, families and practitioners, poses a significant challenge. This challenge is largely due to the priorities being in conflict when viewed in short-term and narrow ways. For example, additional resources to enable practitioners to provide person-centred support for a service user are likely to result in improved outcomes in the long-term; yet when viewed through the lens of existing organisational priorities, additional resources and time to care for the service user would be viewed as inefficient and ineffective service provision. These findings highlight that the longstanding coexistence of administrative and medical practitioners' authority in healthcare bureaucracies is an ongoing tension, which ultimately shapes culture. These findings are reflected in literature identifying NPM-driven constraints seeking to improve cost efficiency and effectiveness (Gray et al., 2015; Wallace & Pease, 2011). Despite significant impacts on the quality of mental health services and cultures, NPM appeared uncontested and unacknowledged in the broader organisational context of mental health services.

Practitioners perceived administrators as bound by political and economic agendas that were at odds with the needs of service users as well as practitioners' views about what was required and what was 'best practice' (Garelick & Fagin, 2005). These differing pressures on administrators and practitioners caused friction and distrust; the resulting culture of blame is a key barrier to cultural change at the workforce level (Garelick & Fagin, 2005). The different priorities for administrators and practitioners are consistent with P. R. Brown and Calnan's (2016) findings that increasing incompatibilities between the interests of senior managers and practitioners in the UK contributed to the erosion of trust. Addressing this disparity in priorities is a possible enabler of cultural change and may contribute to improved relationships and the development of trust between practitioners and administrators.

One of the most common issues identified by all participants, particularly practitioners, was insufficient funding and resources, specifically in public inpatient and community mental health services. These resource issues were a key feature of the organisational and administrative context, shaping participants' understandings of service cultures. This finding is not new, as underfunding, coupled with inflexible and unreliable funding, was identified in the SSCMH's (2006) report. Adequate and appropriate resourcing is an enduring issue echoed by participants in this research. The RCVMHS (2021a) reported that insufficient resources are "only part of the picture" noting that other issues such as "the system's operation including service planning, design and mix, leadership and governance, and workforce capacity and capability" contribute to these issues (p. 13). These Committee and Commission findings are congruent with the findings in this project, as the need for additional resources was a common feature of participants' experiences, understandings and enactments of culture. The chronic nature of under-resourcing was enmeshed in the culture, normalised and accepted. Practitioners tolerated these issues and worked within the constraints of the organisational environment, and in some cases, used such constraints to justify substandard practice. For example, time and resource scarcity were cited to justify the lack of involvement of families in practice. As such, limited and misallocation of resources were identified as part of the service cultures shaping practice and expected standards of services. These resource issues are a barrier to cultural change, and improvement to the allocation of resources, with such decisions including practitioners, service users and families, may enable cultural change.

Compliance and risk-averse environments were central to practitioners' experiences and understandings of service cultures. Practitioners enacted and reproduced this culture through risk-avoidant practices. Key cultural artefacts were identified in all services and included risk assessment and audits, as well as risk-infused language. These findings are consistent with the literature discussed in Chapter 2, with risk-averse cultures reportedly prevailing in mental health services (Clancy & Happell, 2014; M. Crowe & Carlyle, 2003; Cui et al., 2021; G. Davidson et al., 2016; Felton & Stickley, 2018; Holley et al., 2016; Lemon et al., 2016). Practitioners rejected the belief that standardised assessments and procedures prevent risk and critical incidents. Instead, assessments were identified as having been co-opted by administrators as risk minimisation tools and devices to ensure practitioners' compliance. The RCVMHS (2021d) similarly reported risk-averse cultures as barriers to safe and compassionate service environments.

Risk-averse cultures pose a significant barrier to implementing recovery-oriented culture. These findings highlight how managing risk has become a central tenet of practice in public mental health services and NGOs following the advent of NPM (D. Green, 2007; Lemon et al., 2016; Sawyer, 2009; Wand, 2017). Practitioners may wish to work in recovery-oriented ways; however, this aim is often overshadowed by legislation, policy and organisational mandates to intervene and mitigate risk (Dixon, 2015; Sawyer, 2008; Slemon et al., 2017). A shift away from risk-averse stances pose a significant challenge for mental health organisations. Literature reports that the perceived risk held by practitioners and organisations is often incongruous with the actuality of risk (M. Jones, 2020; Marsh & Kelly, 2018). Thus, a possible enabler of cultural change within individual organisations is critical examination of the effectiveness of existing risk management practices and policies, and the factors, ideas and evidence informing them.

A move to tolerating risk and supporting service users to have the opportunity for the dignity of risk is another possible enabler of cultural change but requires clear direction and leadership support and commitment (Brophy, Fletcher et al., 2020). For dignity of risk approaches to be adopted, organisational leaders must resist monolithic and simplistic approaches to dealing with risk (M. Jones, 2020) and instead accommodate the "ethical complexities" associated with balancing service user and family rights and practitioners' responsibilities (Marsh & Kelly, 2018, p. 305). This requires a coherent organisational approach toward positive risk- taking practices and practical guidance for practitioners to negotiate and tolerate risk (Robertson & Collinson, 2011). Strategies to support dignity of risk approaches in mental health services are identified in the literature and may contribute to cultural change in line with recovery-oriented policy aspirations.

Central to all dignity of risk strategies is the importance of relational and collaborative approaches (Ahmed et al., 2021; M. Jones, 2020; Marsh & Kelly, 2018). One example is shared decision-making which provides opportunity for service users to express their preferences through decision-making, creating space for rich discussions about risk and safety drawing on the expertise of service users and practitioners (Ahmed et al., 2021; Marsh & Kelly, 2018). Another approach that promotes dignity of risk is supported decision-making, which entails the provision of appropriate support and information so that service users can make decisions according to their wishes (Gooding, 2013).

Language was identified in this study as a cultural artefact (Schein, 1992, 2010) which had significant implications for how service users and families were constructed and experienced mental health services. Thus, a shift in the language of risk is an important enabler of cultural change that can influence practice at the individual level. Research identifies that the existing language of risk does not capture or reflect the intricacies of service users' and families' experiences (Clancy et al., 2014; M. Jones, 2020). Additionally, the language of risk excludes service users' knowledge and experiences, and reinforces power asymmetries and a 'professional knows best' stance (Clancy et al., 2014; M. Jones, 2020). Using language that is reflective of the service users' and families' values and beliefs creates the conditions for trusting relationships between service users, families and practitioners and may contribute to cultural change (Clancy et al., 2014; M. Jones, 2020).

Compliance-driven and risk-averse cultures present a key barrier to engendering cultures of honesty, transparency and openness, which are identified in the workforce standards as key elements of quality and safety culture in mental health services (Workforce Australia, 2014). Although a small number of practitioners felt supported by administrators in their role, most identified a silencing culture and lack of leadership in driving safety and supporting transparency. Therefore, current leadership practices marked by a lack of support and limited openness and transparency are key barriers to cultural change. Research in the UK focused on culture in the National Health Service found that due to multiple competing demands, organisations tended to revert to bureaucratised forms of management characterised by rules, regulations and procedures corresponding to externally imposed demands (Dixon-Woods et al., 2014). In the present study, these externally imposed demands value compliance and result in reactive and defensive responses to deeper systemic issues rather than an effort to improve service quality for service users and families. Accordingly, a possible enabler of cultural change involves resisting reactive responses at an organisational level and instead responding in ways that include collaboration with key stakeholders (service users, families, practitioners and administrators) to create sustained and meaningful improvements. Given their power and authority, it is incumbent on administrators and organisational leaders to work to genuinely promote a culture in which dialogue is encouraged by demonstrating a willingness to listen and learn from practitioners (Pope, 2019). This also requires a responsiveness to practitioners', service users' and families' concerns. A dialogic approach should be viewed as enabling cultural change in which honesty, integrity and ethical behaviour from practitioners is valued by leadership (Pope, 2019), rather than positioning practitioners as the 'problem' or 'whistleblowers' when they do speak up.

Practitioners also described a lack of control over their everyday work due to the shift in authority from practitioner knowledge to administrative authority. Marx's (1932/1974) concept of alienation was used to frame practitioners' subjective experiences of feeling disconnected from their work. Practitioners felt demoralised and undervalued, which did not create the conditions or appetite for cultural change or positivity towards their work. These findings are consistent with research conducted with Canadian social workers who described how neoliberalism and NPM narrowed their vision and focus to the organisational demands (Baines, 2006). In the present study, NPM created a preoccupation with organisational priorities and funding, resulting in practitioners being unable to do what they aspired to do if they had more autonomy and fewer strictures placed on them. The literature also reports practitioners experiencing powerlessness about the capacity for change in their service due to service rigidity, structural barriers and limited success when advocating for change to administrators (Dawson et al., 2020). Practitioner alienation was central to practitioners' experiences and understandings of service cultures; their reduced discretion and authority were a substantial barrier to cultural change.

Given the pervasiveness of NPM in mental health services, a possible enabler of cultural change to reduce practitioner alienation is individual services and organisational leaders critically engaging with the impacts of NPM on practitioners' everyday work, and effects on service quality. However, as noted in the previous paragraph, this would require a willingness from organisational leadership to listen to practitioners and promote a culture in which meaningful dialogue across organisational levels is encouraged (Pope, 2019). This is an important implication of this research and is discussed in more detail later in this chapter (see 'Implications for Policy and Practice').

The second theme of the organisational and administrative cultural frame was accountability and responsibility. Administrators' limited accountability and responsibility were key to practitioners' experiences and understandings of service cultures. This finding poses questions about why administrators are not accountable and responsive to practitioners, service users and families, and what cultural conditions are needed for this to occur. Accountability and responsibility have been identified as governance issues previously, with recommendations such as improved monitoring and evaluation of system performance (Productivity Commission, 2020c).

The present study's findings suggest that obscured and unclear governance arrangements shape and sustain a culture of limited accountability at an organisational and relational level, from administrators to practitioners and from practitioners to service users and families. This shortcoming manifested in a culture of complacency, whereby accountability and responsibility dissipated. Consequently, a collective sense of futility and frustration was evident. Practitioners felt unable to create improvements or enact changes, and this perception was central to their understanding of culture. Existing fragmented governance arrangements sustain cultures of complacency where limited accountability is common, expected and impedes cultural change.

Potential enablers of cultural change include improved transparency and clarity regarding responsibilities and lines of accountability. This finding aligns with recommendations from the Productivity Commission (2020c), which identified improved governance arrangements as an enabler of reform. In line with participants' experiences of accountability in this study, the Productivity Commission (2020c) suggested that the funding of services must be linked to policy, adoption of a clear national vision, increased coherence across policy documents and broader engagement with stakeholders, including service users, families and practitioners across sectors.

Historical Cultural Frame

Chapter 5 revealed how mental health service cultures are located in and tied to the history of institutionalisation and psychiatry. While some participants noted changes, overwhelmingly, the legacy of historical ideologies and practices were significant and identified by all participant groups as entrenched and intractable. Key markers of the old culture described by participants included:

- A pervasive biological interpretation of distress that constructs service users as lacking insight and capacity
- Paternalistic, coercive, controlling and dehumanising practices

- The overt and covert power of practitioners positioned within mental health services as experts and ‘knowing best’.

These findings are consistent with the literature (Bee et al., 2015; Bennetts et al., 2011; Black et al., 2021; Byrne, Happell & Reid-Searl, 2016; Piat et al., 2021), and old culture was central to the participants’ understandings, experiences and enactments of service cultures.

Old cultures sustain authoritarian and paternalistic biomedical services and practices (Bee et al., 2015; Byrne, Happell & Reid-Searl, 2016; Gee et al., 2016; Tickle et al., 2014). Medicalising human distress and positioning professionals as expert knowledge holders is central to practice approaches emanating from biomedicine (Scott, 2010). The ‘expert knows best’ stance disempowers service users, contributes to the inability to form meaningful and collaborative partnerships and devalues lived experience (Byrne, Happell & Reid-Searl, 2016; Scott, 2010). Cultures that produce practices that inhibit cultural change and are contradictory to recovery principles have been identified in Australia and internationally (Byrne, Happell & Reid-Searl, 2016; Ning, 2010; Piat et al., 2021).

Most participants spoke of biomedical reductionist approaches that rendered invisible the psychosocial and environmental factors intersecting service user and family experiences. Additionally, service users’ and families’ meaning-making was obscured. Service users and families described hopeless cycles of service use and revolving door experiences. All participant groups emphasised the tendency of individual practitioners to unreflexively centre biological explanations of mental distress that constructed service users in a particular way and underpinned service responses. However, participants also described how mental health services were structured such that clinical practices and understandings were the central way of operating and the authoritative currency. Services were funded and delivered in ways that focused on addressing a clinical problem from a biomedical explanatory framework—assess, diagnose, treat—therefore, practitioners were constrained to operate and practice in such ways. This broader context sustains existing cultures and is a key barrier to cultural change. Recognising and questioning the ways narrow biomedical discourses are embedded in policy, funding arrangements and performance standards may go some way to enabling cultural change.

The elements of old culture sit at the third layer of Schein’s (1992, 2010) framework of culture (basic assumptions) and present a significant barrier to change. Basic assumptions are unquestionable and extremely difficult to change (Schein, 1992, 2010). Elements of this old culture were accepted without question. Schein (1992, 2010) states that the basic assumption layer of culture evolves when ‘solutions’ to a ‘problem’ are perceived to work repeatedly. For example, biomedical practices remain dominant because they are the most familiar and understood approach to responding to mental distress (Tew, 2011).

Consequently, attention to power, valuing service user meaning-making and self-defined needs were rarely encountered by service users or families. As discussed in Chapter 2, culture is a barrier to the implementation of peer work (Gillard et al., 2014; Ibrahim et al., 2020) and the adoption of new practices such as service user involvement (Bennets et al., 2011) and shared decision-making (Kokanović et al., 2018; Shera & Ramon, 2013). Old culture can function as an obscuring and constraining force that limits alternative ways of working (Alvesson, 2002), such as embracing recovery-oriented practice or service user and family involvement (Black et al., 2021; Piat et al., 2010). While practitioners recognised that old ways of working were inadequate and communicated their desire to work in flexible and person-centred ways, enactment of agency within the extant cultures of the mental health sector was difficult.

The types of practices embedded in old culture were familiar to practitioners because they provided a perceived sense of safeguarding. The tendency to retreat to ‘what is known’ or to the ‘dominant culture’ reflects Moth’s (2020) notion of ‘biomedical residualism’ whereby practice is reduced to prescribing and monitoring compliance of medication and brief assessment of signs and symptoms, with limited focus on the person and their self-defined needs. This approach suggests that any attempt to change culture must consider the historical, political and social context in which it is located. Therefore, a possible enabler of changing old culture is an examination of these basic assumptions and how they operate, and interrogating why they are deemed successful, relevant, or both, in existing services. This enabler of cultural change presents an important implication for policy and practice and will be expanded further later in this chapter (see ‘Implications for Policy and Practice’).

Blame

In Chapter 6, my key argument was that a culture of blame is a by-product of the coexistence of the organisational and administrative cultural frame and the historical cultural frame. All participant groups identified a culture of blame as crucial to their understanding and experiences of mental health service cultures. Blame cultures have been documented in the literature for some time (Clancy & Happell, 2014; J. F. Morgan, 2007; Turner et al., 2020; Wand, 2017); however, my findings explain how a culture of blame operates discursively in tangible and intangible ways, impacting practitioners, service users and families. A culture of blame operated at an unconscious level of service culture, ultimately leading to negative and harmful experiences for service users and families. Practitioners consistently talked about how a culture of blame left them feeling unsafe and distrustful. There was an explicit link between the experiences of practitioners and service users in the way that the practitioners' high-pressured environments resulted in them displacing blame onto service users and families. Conceptualising displaced blame as a parallel process is a useful way to draw awareness to such processes which appeared to evolve unconsciously. These findings concur with the work of Bloom and Farragher (2011) who described parallel processes as developing outside of practitioners' awareness. They further argue that systemic issues and pressurised environments, such as the context of mental health services, impact the ability of people working within them to think complexly, leading to rigid thinking and decision-making (Bloom & Farragher, 2011). These ideas bear significant relevance to this study's findings as the organisational and administrative context was identified as producing displaced blame.

Accordingly, a possible enabler of cultural change involves organisational leaders, administrators and practitioners increasing their awareness of these parallel processes, such as displaced blame, through supervision, or creating safe spaces in which practitioners can critically reflect on their practice. Additionally, organisational leaders must identify how they are contributing to parallel processes via promoting a culture of blame. However, as McSherry (2020) has argued, a culture of blame forms part of the "complex dynamic of institutional cultures" (p. 230) and reflects broader societal concerns, risk management and discrimination against service users. Thus, the organisational and administrative and historical contexts create and reproduce a culture of blame. The workings of both contexts are a significant barrier to cultural change. Engaging with these broader contexts, including how they produce the conditions for risk averse and discriminatory practices to be accepted is a first possible step in enabling cultural change.

Othering

In Chapter 7, I used the concept of othering to explain how mental health service cultures position service users and families as inferior to, and inherently different from, practitioners. A culture of othering excluded service users and families socially and epistemically. This culture is rooted in the historical cultural frame, particularly segregation; biomedical discourses have long positioned people deemed Mad as inherently different and unintelligible. Families also experienced an othering culture due to their association with the service user, coined by Goffman (1963) as stigma by association (also referred to as courtesy stigma). Families understood this form of othering as underpinning their exclusion from their loved one's care. Participants who were service user-practitioners also understood the contribution of a culture of othering to their perceived need to uphold their professional selves and 'saneness'. They experienced this culture as a lack of safety around sharing their experiences of service use or distress in the workplace due to how their colleagues and organisation would perceive them.

Given its unquestioned status in mental health services, a culture of othering sits at the level of basic assumptions. However, a culture of othering also manifests in cultural artefacts (Schein, 1992, 2010), which are considered easy to observe but not always easy to decipher. Practitioners did not identify the cultural artefacts of othering culture in the same way service users and families identified them. For example, a service user described the obvious divide she felt between her and the practitioners: "you're the crazy person" (SU1). Additionally, practices of surveilling the service user other, and the physical division made explicit by the nurses' "fish bowl" (F6) were identified as symbols of othering culture. While cultural artefacts are theoretically easy to change, it is unlikely that only changing them will result in long-term cultural change, as they are surface manifestations of the deeper and entrenched cultures outlined in the cultural frames. Thus, sustained cultural change requires addressing the broader cultural frames, particularly old culture, which is addressed in more depth below (see 'Implications for Policy and Practice').

Objective 2

The second objective of this project was to explore how mental health service cultures mediate and are mediated by national and local mental health policies. In Chapter 2 I identified that within national, state and territory policies, culture is presented as both an enabler and barrier to change and improvements in the workforce, developing recovery-oriented services and improving the quality and safety of mental health services (AHMAC, 2013; MHWAC, 2011b). The findings of this study reveal a disjunct between policy aspirations, the organisational and administrative context, and the everyday experiences of practitioners, service users and families.

Broadly, culture was identified as a barrier to policy translation and implementation. Specifically, the organisational and administrative cultural frame impeded rather than enabled policy translation. Practitioners identified that although overarching policy mandates for recovery and person-centred practice were relevant to their practice, they felt limited in their ability to enact the key principles because of the way the organisational and administrative context effected their everyday work and constrained their practice. For example, biomedical dominance and risk-averse cultures shaped their practice in ways that made recovery-oriented practices risky. Thus, positive risk-taking (in line with self-determination and service user choice) was not promoted or supported by the organisational and administrative context. Recovery-oriented and person-centred practice approaches were therefore difficult to implement alongside organisational priorities that emphasise risk aversion, compliance and efficiency. Additionally, in public services, overarching policies related to recovery were not supported at the organisational and administrative level as they did not contribute to achieving organisational priorities such as efficiency, meeting performance indicators, accreditation and outcome measures.

The findings of this study also identified that private services were characterised by a culture focused on profit and within NGOs, a culture which prioritised risk aversion and compliance with the service’s funding and contractual agreement. As a result, overarching policies such as the NFROMHS (AHMAC, 2013) became insignificant and sometimes seemed inapplicable to services’ and practitioners’ everyday work. For example, practitioners said that scarce resources constrained their practice and resulted in limited services without opportunities for recovery. A service user (SU11) described his 10-minute appointment with a psychiatrist in a public outpatient clinic where most of the psychiatrist’s time was spent reading his case notes. It is likely that due to the psychiatrist’s legal responsibilities and workload, medication was all that was offered to this service user.

Under-resourced and compliance-driven environments are inherent to the organisational and administrative cultural frame and inhibited practitioners’ capacity to implement policies such as recovery approaches articulated in the NFROMHS. Stated differently, the organisational and administrative context does not create the conditions for policy implementation. Instead, practitioners understood their mandate, and the focus of their work, as organisational priorities that were misaligned with national and local policy goals.

Culture in mental health services was mediated by policy at the surface and cultural artefact levels. For instance, the use of recovery language was identified by practitioners who were aware that the involvement of service users and families was an articulated policy goal. Additionally, practitioners in NGOs stated that recovery was discussed in their employment orientation and an espoused value of the organisation; however, administrators did not support of value this focus. Instead, meeting the service contract goals was prioritised. One exception to this finding was an NGO where a recovery philosophy underpinned operations since its inception; therefore, the recovery goals articulated in its policy applied to practitioners' everyday work and were supported by the organisation's leaders. However, practitioners stated that the funding contracts continued to shape their practice. That is, the funding contract requirements superseded the needs of service users, families and communities, and the recovery-oriented ethos. To improve the translation and implementation of policy, funding contracts need to align with policy mandates.

The literature and mental health policy describe workforce culture as a barrier to policy implementation. This research challenges this argument, instead highlighting how the organisational context did not allow space for implementing policy at the practice level or create the conditions for taking on new practice approaches. While there may have been ways that practitioners could implement policy objectives into their practice, overall, the structures, processes and demands on practitioners meant that there was limited capacity to enact change beyond their individual practice.

Practitioners reported feeling powerless and alienated from their work and, consequently, had limited willingness to enact frequent changes. These feelings and attitudes were more prominent when policy goals were perceived as distant from the realities of practitioners' everyday practice. However, this does not absolve practitioners of their responsibilities, and practitioners in this study highlighted that the untenable demands in their everyday work did not excuse poor practice.

The organisational and administrative context presents a significant barrier to policy implementation. Top-down priorities imposed upon practitioners by administrators, did not align with the aspirations and activities outlined in government policy. Administrative and organisational demands were often in direct conflict with policy goals. These findings are reflected in the literature in areas such as practitioners being hamstrung in their ability to change and influence practice in order to reflect state and national reform agendas (RCVMHS, 2021d) or overcome "entrenched practices and attitudes, feelings of helplessness and a perceived 'risk averse' and 'blame' culture" (Davison et al., 2013, p. 378).

An Australian study conducted in a private youth mental health service found that the emphasis on economic efficiencies and the dominance of biomedical discourse limited practitioners' ability to implement recovery-oriented practice (Dawson et al., 2020). The researchers stated that the neoliberal philosophy of the "…'best care' must be delivered with the fewest resources and within the shortest amount of time" (Dawson et al., 2020, p. 287) was evident in the service's cultural, economic and political contexts. Although Dawson et al.'s research was conducted in a private service, the findings of practitioners feeling hamstrung by competing demands hold significant relevance to the present study's findings.

At the beginning of this thesis, I established how it is often stated that there is an enduring gap between policy and practice in mental health services and culture has been identified as a barrier to policy implementation (Mendoza et al., 2013; NMHC, 2014a; Rosenberg & Harvey, 2021; RCVMHS, 2021d; G. P. Smith & Williams, 2016). Concerning the uptake of research evidence about social determinants of health in policy, Bacchi (2008) refers to lack of 'fit' rather than a 'gap' between what we 'know' and what we 'do'. Bacchi (2008) examined how the 'problem' of the gap between research uptake by policy makers is understood and represented. Additionally, Bacchi (2008) argues that researchers need to consider how policy questions and proposals frame 'problems' in ways that restrict the policy agenda.

I draw on Bacchi's (2008) framing here and suggest that what is perceived or presented as a gap between policy and practice is better understood as a lack of fit. The present study's findings suggest a lack of fit between mental health policy and the current practice environments, including how services are funded, what resources are available and the extent of support for practitioners. Addressing this lack of fit between the contexts of services and policy visions may begin to address the enduring translation gap. Government officials, organisational leaders and administrators must shift their focus from individual practitioners and the workforce to organisational conditions. Policy implementation should be viewed as a process of continuous collaboration between political, policy-making and administrative stakeholders, in addition to front-line practitioners, service users and families.

A crucial task of implementation involves assessing the existing capacity of practitioners to enact and implement policy aspirations (Hudson et al., 2019). This study identified that practitioners feel they do not have the capacity or support to enact policy within the existing conditions of their organisation. Critical examination of the organisational conditions identified in this study are required if policy is to be implemented. This critical examination will go some way in addressing the existing lack of fit between policy and practice environments, and requires addressing other areas of service cultures identified earlier in this chapter such as silencing culture, the competing demands practitioners face, the disconnect between practitioners and administrators and old culture. Building on this issue of policy implementation and translation as multilayered, the next section discusses the utility of the concept of culture and reconceptualises it through the lens of a wicked problem.

Culture as a Wicked Problem

Attempting to understand mental health service cultures has been an encounter with a world of slippery intangibles, which I have often felt compelled to reduce and tidy into something neat and 'usable' in the positivist sense (i.e., defined and measurable). The complexity and entrenched nature of the issues shaping and sustaining service cultures led me to reconceptualise culture through the lens of a wicked problem. Mental health service cultures are multilayered and difficult to define, seemingly resistant and intractable; therefore, they can be understood as wicked problems (Rittel & Webber, 1973).

Wicked problems are characterised by a lack of definitive formulation (Rittel & Webber, 1973) and "are chronic public policy challenges that are value-laden and contested and that defy a full understanding by definition of their nature and implications" (Danken et al., 2016, p. 28). Understandings and experiences of mental health service cultures varied between participant groups and often depended on subject positioning, power and access to resources. Therefore, there is no conclusive definition of culture and no authoritative or simple solution. Attempting to provide a definitive description would be more unhelpful than helpful as it would obscure the many layers, enactments and functions of culture, leading to an incomplete and simplistic conception and solution.

In contrast to wicked problems, tame problems can be defined and are characterised by stability and a definitive point at which the problem is 'solved'. Additionally, the solutions can be objectively evaluated as positive or not (Rittel & Webber, 1973). Actions can have profound, cumulative consequences for wicked problems, and their interconnectedness means that the range of possible actions in any given circumstance has, potentially, no resolution (Hannigan & Coffey, 2011). A wicked problems lens is useful for framing mental health service cultures as it encapsulates the contradictory, overlapping and multi-perspective characteristics of the cultures identified in this study. When viewing mental health service cultures through the lens of a wicked problem, the many overlapping and interlinked parts can be recognised. For example, formulating mental health service cultures as a problem related to workforce issues is inextricably linked with systemic issues, such as a lack of resources and funding issues across the mental health sector, which overlaps with an economic focus on rationalising and outcome measures, which also conflicts with the goals of national and local policies, which then creates the conditions for blame and othering.

A core characteristic of a wicked problem is a multi-actor environment (Danken et al., 2016). Social complexity is a key feature of multi-actor environments typified by a diversity of stakeholders, worldviews, backgrounds and responsibilities, all of which add to the overwhelming nature of wicked problems. Mental health services can be understood as a multi-actor environment given the varying responsibilities and accountabilities, disparate priorities, and overlapping and contesting views about the best way to provide quality services to service users and families. The divergence and fragmentation in views and experiences are central to understanding the complexity of mental health service cultures and how power operates. For example, the power and authority invested in practitioners contributes to reproducing a 'practitioners as experts' stance, which excludes service users and families practically and epistemically. At the same time, the organisational and administrative context reduces practitioners' discretion and authority in their everyday practice leading to a culture of risk aversion and practitioner alienation.

Mental health service cultures have several wicked problem characteristics as they cannot be easily separated into discrete parts nor managed or fixed with one-dimensional solutions (Conklin, 2006; Grint, 2005). While Schein's (2010) layered culture framework was useful in understanding culture at an organisational level, it was limited as it did not enable a broader linking to the historical, social and political contexts identified as central to understanding mental health service cultures in this study. Therefore, framing mental health service cultures as a wicked problem directs attention to how the broader historical and organisational contexts interconnect with the cultures at the service delivery level and the experiences of service users, families and practitioners. Additionally, given that solution-focused, conventional approaches are unlikely to address wicked problems (Grint, 2005), this framing encourages policymakers and administrators to think differently about approaches to addressing service cultures. Thus, alternative approaches and methods for thinking about and addressing service cultures may transpire (Thomas et al., 2018).

Implications for Policy and Practice

Framing mental health service cultures as a wicked problem leads to a complex space, a space of both/and, where we are forced to move away from the us/them dichotomy into complicated and contradictory ideas, positions and understandings of culture. This framing creates a space beyond binary constructions of the problem, solution and singular actors. It means talking about practitioners' inherent power and privilege and the constraints and limitations in neoliberal systems premised on NPM that control and restrict their professional autonomy and agency. It means reckoning with the past and continued harms and injustices experienced by service users and families. It means asking questions about how we can move beyond—to a space where there is accountability and collective and individual commitment to change towards policy aspirations. In summarising my main arguments, I am cautious about offering any conclusive answers or directions regarding changing culture in mental health services as doing so would be antithetical to addressing culture as a wicked problem and the research findings. However, the findings have several important policy and practice implications. In presenting these implications, I address Objective 4, the requirements and mechanism for cultural change. This discussion builds on some of the enablers of cultural change explicated earlier in this chapter.

First, this study identified that old culture is a significant and intractable part of mental health services. This finding confirmed the well documented limitations of biomedical dominance and the many entrenched practices identified as the legacy of institutionalised practices. The utility and value of such practices and approaches must also be interrogated and unsettled. In considering this finding, two questions emerge that are useful to consider at the policy and practice level:

1. How can the legitimised, familiar, taken-for-granted and accepted practices and ideologies within mental health services become ‘strange’ and unacceptable?
2. How can mental health services reckon with and break away from old culture? What are the mechanisms that can enable this?

At the centre of the entrenched practices and ideologies identified as sustaining and shaping culture are epistemic questions:

- Whose knowledge is included?
- Whose knowledge is excluded?
- Whose knowledge counts?
- Whose knowledge is considered valid?

In this section, I return to the notion of epistemic injustice (Fricker, 2007), particularly hermeneutical injustice, to show how existing cultures within the mental health sector are produced, reproduced and sustained by particular epistemic resources and obstacles (Medina, 2012).

I found that epistemic injustice sustained and reproduced existing cultures. According to Medina (2012), epistemic injustices are “created and maintained through the sustained effort over time across interactions and cannot, therefore, be confined to a single moment of testimonial exchange” (p. 56). Service users and families spoke of established patterns of testimonial injustice—how service users’ and families’ knowledges are given minimal credibility and authority, considered irrelevant and excluded at every level of the service sector. For example, biomedical interpretations of mental distress are structured into and permeate all parts of mental health services, from legislation to funding structures to cultural artefacts such as the physical features of buildings. Biomedical interpretations construct the service user as other, lacking insight and capacity, which justify practices marked by paternalism while sustaining power relations where professionals are experts and, thus, unquestionable. Once cast as a person with mental illness, the individual is ascribed status of reduced credibility; therefore, their testimony is deemed unintelligible or objectifiable. This study also identified that families experienced epistemic injustice due to their position as others by their association with service users.

This construction of service users as other and unintelligible appeared to underpin dehumanising responses to service users, forming the fabric of the mental health service sector. The silencing and suppression of people deemed Mad has been a mainstay of mental health services and psychiatric institutions (Porter, 1987). When asked about culture, service user participants consistently described having their testimony discredited and being declared incompetent or incapable. When participants attempted to draw on their own frameworks of understanding, or hermeneutical resources, to explain their experiences or needs, practitioners usually did not share these resources. This finding is consistent with Crichton et al.'s (2017) argument that epistemic injustice in service delivery contexts results in consequences such that "patients' testimonies and interpretation are not acknowledged as credible, and the patients are thus undermined in their capacity as knowledge holders or contributors to the epistemic effort to reach correct diagnosis and treatment" (p. 65). The relevance of policies centred on recovery philosophy, which position service users as people with expertise, is strikingly inconsistent with the deeply embedded nature of old cultures.

Within any context, there are meanings and interpretations that are widely used and shared (Medina, 2017). This study identified that the meanings and interpretations in the mental health sector most widely shared and mobilised are biomedical conceptions of mental distress, and this was considered part of service cultures. These biomedical conceptions are entrenched and located in history; however, they are also authoritative within the mental health sector and were used to justify various exclusionary practices epistemically and practically. Service users and families experience harms and wrongs because they are subject to biomedical-centric forms of hermeneutical injustice. Such biomedical-centric injustices are produced and sustained by economies of credibility and intelligibility, which are sustained by deeper theoretical conceptions of the nature of mental illness that epistemically privilege the concepts and methods of biomedicine and psychiatric discourses (Crichton et al., 2017; Lakeman, 2010).

Given such complexity in understandings of cultures, simply urging people to think differently or practice in recovery-oriented ways is unlikely to lead to a shift in the complex social forces that shape culture (H. Davies & Mannion, 2013). Additionally, there has been minimal engagement with the complexity of service cultures contributing to the lack of change in accord with policy aspirations. One of the key implications that can be drawn from this research is that the understandings of mental distress that conjure ideas about service users as lacking knowledge and legitimacy require critical engagement and interrogation at every level of the service sector. While this is unlikely to lead to widespread cultural change, it may influence practices at the individual level. Practitioners must reflect on professional privilege at a minimum. While practitioners feel disempowered and demoralised, they continue to hold authority and responsibility, and the implications of their decisions and actions have lasting and sometimes irreversible impacts on the lives of service users and families.

Practitioners consistently identified a lack of support or spaces to critically reflect on their decision-making, practice or experiences working in intensified environments, a key implication of NPM. They often felt unsupported and hamstrung by competing demands. Considering these deeply entrenched practices and beliefs as a problematic part of the culture, administrators and organisations could enable change by facilitating critical engagements with professional power and engendering spaces of reflection and support for staff. However, the power, influence and position of administrators must be included, as administrators contributed to practitioners feeling constrained and overwhelmed by the demands of their organisation and were unable to adequately listen to and address service users’ and families’ wishes and needs. Practitioners in Moth’s (2019) study referred to this provision as “breathing space” in which opportunities to reflect on their decision-making and practice were extremely limited in a culture driven by administrators’ priorities for KPIs and outcome targets (p. 143). The findings of the present research support Moth’s (2019) findings and other authors’ assertions that NPM constrains spaces for relationship-based practice and generates a tendency for risk-averse practices, which reinforce narrow biomedical interventions (C. Brown et al., 2022; Moth, 2020). These factors must be incorporated into any efforts to improve workforce cultures and implement approaches such as recovery-oriented practice.

Practitioner education could also encourage this critical engagement with epistemic questions. Education is a powerful tool as it can teach, develop and nurture the attitudes and cultures needed in mental health services. Research suggests that practitioners’ values and professional identity are shaped during their education, including practicums, and there have been calls for critical examination of professional cultures, including how education shapes professional attitudes and practices (MHWAC, 2011b; Norton, 2019; Sommerseth & Dysvik, 2008). Therefore, a possible avenue to address old culture could be tertiary education of practitioners. Practice approaches mandated in policy, such as recovery-oriented practice and service user involvement, should be embedded in practitioner education to challenge old culture and position entrenched practices as unacceptable, problematic and often harmful. Critical interrogation of power and epistemic injustice as part of education is essential.

Research evidence suggests that new workers in mental health services are enculturated into pre-existing practices and dominant ritualistic culture (Bee et al., 2015; Berlin & Carlström, 2015). The *National Mental Health Workforce Strategy* (MHWAC, 2011) emphasised that the attitudes and values within the existing workforce have a powerful influence in shaping the attitudes of entry-level workers. Education and support of new workers may help shift the hierarchical culture among professional disciplines that pervade mental health services. Education could also involve formalised education from service users and families, for example, establishing ongoing, sustainable service user or lived experience academic positions (Happell, Pinikahana, 2003; Happell & Roper, 2009; Happell, Scholz et al., 2019; Happell et al., 2022).

The positive impacts of lived experience education on social work, nursing, occupational therapy and clinical psychology students are well documented and include promoting critical engagement with dominant ideas about mental distress, challenging negative attitudes and improving understandings of personal recovery, voice hearing and the value of lived experience in practice (Arblaster et al., 2018; Happell, Byrne et al., 2014; Happell et al., 2020; Happell et al., 2021; Horgan et al., 2018; Newman et al., 2019; Ridley et al., 2016; Taylor & Gordon, 2022). Service user-led education programs aimed at improving positive attitudes towards recovery and reduced stigma towards people experiencing mental distress have been implemented with medical students in New Zealand (Newton-Howes et al., 2021). This education program significantly improved medical students' attitudes towards recovery; however, it had less effect in facilitating a reduction in stigmatising attitudes. In contrast, a recent study reported that lived experience education resulted in significantly improved attitudes and reduced stigma among clinical psychology students (Taylor & Gordon, 2022). Similarly, international research in the nursing field highlighted the positive impacts of lived experience education on students citing increased understanding, curiosity and improved attitudes toward service users and mental health nursing (Happell et al., 2020; Happell et al., 2021). These studies highlight that lived experience education is a powerful pedagogical practice and strategy to facilitate improved understandings and attitudinal change in future mental health practitioners.

A central feature of all practitioners’ accounts when speaking about culture was the sense of feeling constrained. For most practitioners, these conditions seemed insurmountable in their everyday work. The findings identified how practitioners are constrained by the cultures in which they exist and actively reproduce the culture through their everyday practices. This highlights an inherent tension in thinking about culture and structure (Alvesson; 2002). Cultural change efforts have been directed at the workforce, particularly in policies (Meadows et al., 2007; MHWAC, 2011; South Australian Government, 2020). However, this study’s findings and Alvesson’s (2002) work unsettles the assumption in policy direction and the literature that positions practitioners—the workforce—as the focus of cultural change goals.

A key implication from this project is that any effort at cultural change at the workforce level is simplistic and obscures contexts that shape and inform practitioners’ work, actions and responses to service users and families. Practitioners described their awareness of reproducing cultures alongside attempting to resist culture in subtle ways. All practitioners in this research indicated that they support cultural change and improvement in the mental health sector but felt they had limited capacity to enact change. Practitioners need to be supported to implement change. The RCVMHS (2021d) also noted that practitioners who contributed to the inquiry described an appetite for change but did not feel they had the necessary support to manage the changes that would affect their role. Practitioners identified factors that would support them in preparing for change. The most important factors were: clear communication and being kept informed, having the opportunity to contribute to proposed changes, access to resources and training and professional development (RCVMHS, 2021d). However, for practitioners to enact changes in their everyday practices, they must have some autonomy and discretion restored, and critical conversations regarding the factors constraining their practice, and administrators’ authority, are required.

One of the most commonly identified issues of service cultures was insufficient funding and resources in all parts of the sector, particularly in public inpatient and community mental health services. Under-resourcing was identified as a significant barrier to cultural change. The lack of funding was perceived to result in gaps in mental health services, particularly for service users experiencing complex and multiple unmet needs. Resource pressure experienced by the mental health sector meant that services and practitioners were forced to focus on acute responses, with community care also becoming a place of responding only to acuity. Resource constraints affect services' and practitioners' abilities to respond effectively to service users and families. Any effort to enact cultural change must consider this context. This resource issue is relevant to the translation of policy aspirations and activities such as recovery-oriented practice that appeared tacked on to existing services or funding contractual agreements, resulting in only surface-level changes to the cultures of mental health services.

It is important to note that existing strategies to improve mental health service cultures have provided promising results; however, the long-term impacts are unknown (Fletcher et al., 2019; Miller, 2015). Studies have largely focused on specific areas such as singular services or inpatient wards. Efforts to address culture more broadly need to consider the cultural frames identified in this research, as these contexts sustain, reinforce and shape the cultures of mental health services. While NPM is likely to continue to pervade services, critical engagement with the workings of NPM must consider its effect on practitioners' everyday work and service quality. For example, NPM-driven changes have been criticised for causing an 'audit society' whereby the preoccupation with target-setting and assessment related to performance indicators is said to inadvertently compromise, rather than enhance, the quality of services (Common, 2004; Grace et al., 2017; Lapsley, 2009). This critique of NPM has key implications for policymakers and administrators.

One example of where the impacts of NPM could be addressed is in the accreditation of services. Accreditation is vital to monitor compliance with the *National Standards for Mental Health Services 2010* (Australian Government, 2010). The standards describe the type of care that should be delivered in accordance with nine domains of the *Key Performance Indicators for Australian Public Mental Health Services* (National Mental Health Performance Subcommittee, 2013), including effectiveness, meaning that "care, intervention or action achieves desired outcome in an appropriate timeframe"; and efficiency, that is, "achieving the desired results with the most cost-effective use of resources" (Australian Government, 2010, p. 5). These standards reveal the influence of NPM logic in how mental health services are delivered and measured; therefore, they determine the driving priorities for administrators. The standards raise questions about the alignment of safety and quality with accountability in service delivery and the current focus on cost-effectiveness and efficiency. Addressing the wicked problem of mental health service cultures requires rethinking these accreditation processes and ensuring they align with policy. At a minimum, the multiple and often conflicting accreditation, policy and organisational demands practitioners have to negotiate in their work should be reduced.

Limitations and Future Research

This section focuses on this study's limitations and possible avenues for future research. The first limitation relates to the sample of participants. Most participants resided in Western Australia, and while there were no significant differences in the data collected from people residing in other states and territories, the findings could be specific to the Western Australian context. The lack of diverse experiences is a significant limitation. While some participants identified as living in rural areas, Aboriginal and Torres Strait Islander, or as part of the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning (LGBTIQ+) community, demographic information was not collected. Therefore, the lack of focus on recruiting diverse voices means that the findings may not reflect or be relevant to these groups. Future research needs to explore these diverse experiences and perspectives of mental health service cultures.

I experienced difficulty recruiting family participants, as discussed in Chapter 3. Therefore, the number of family interviews was approximately half that of the practitioner and service user groups. While I did not seek to produce findings that were representative of all discipline groups and experiences, the psychiatric and social work disciplines formed most of the practitioner participant group. Therefore, the findings may be specific to these disciplines.

Finally, it is important to note that people with negative experiences of using and working in mental health services may have been more motivated to participate in the project. While positive experiences are noted, the project may be more representative of negative experiences, leading to a particular view of service cultures. The absence of the voices of administrators, policymakers and other senior officials in the mental health sector is a limitation. It only became apparent during data analysis that the voices of these stakeholders were relevant. Due to the absence of their viewpoints, a full picture of culture from all perspectives was not achieved. Additionally, critical approaches to researching organisations have been critiqued for othering administrators and management, framing managers as a function within an organisational hierarchy (Wray-Bliss, 2009). However, careful attention was paid to considering multiple perspectives and the experiences of administrators and senior managers through reflexive conversations with my supervisory team and LECs.

The findings are tied to context, so the meanings I constructed in this project are limited by my subjective position as participants were not involved in the data analysis once I completed member checking. The involvement of an LES on my supervisory panel and LECs provided invaluable contributions to this project and have increased the quality of the research, particularly its rigour, credibility and meaningful coherence (Tracy, 2010). However, there were several limitations to LEC and LES involvement. First, the small number of meetings and, secondly, as this was a PhD project, there were restrictions on the LECs and the LES's level of involvement and decision-making (Coupe & Mathieson, 2020). These limitations undoubtedly inhibited the potential for deeper and more meaningful involvement (N. Jones et al., 2021).

There are several potential avenues for future research based on this study's findings. Research could explore administrators' perspectives of culture, considering how they fit with service users', families' and practitioners' views as identified in this research. This addition would create an even deeper understanding of culture from multiple perspectives.

The conceptualisation of culture as a wicked problem could be explored, including possible 'solutions' or ways forward. Additionally, researchers could explore small-scale cultural change projects and determine whether the broader historical, social and economic contexts suggested as important in this project are relevant to such projects.

This study has identified several avenues that need to be considered by administrators and organisations regarding supporting their workforce to provide quality services to mental health service users and families. Further research could be conducted to explore the effectiveness of these factors or how they could be implemented into practice.

Finally, future research could explore the long-term impacts of lived experience education on practitioners in various disciplines and the implications for cultural change in mental health services.

Chapter 9: Conclusion

In concluding this project, I return to the overarching research question, outline the key contributions to knowledge and provide my final reflections.

Overarching Research Question

The broad research question guiding this study was how do mental health service cultures mediate reform aspirations and activities in the Australian mental health sector? In answering this question, this study has identified that mental health service cultures inhibit reform aspirations and activities. The broader historical, social, political and economic contexts that shape and sustain existing cultures were most important in this regard. The two key contexts of mental health services, the organisational and administrative context and the historical context, need to be addressed if reform aspirations are to be realised.

This research suggests that culture describes what is unquestioned and accepted. A critical and deconstructive stance towards what is 'actually going on' in mental health services is often avoided, particularly concerning power and knowledge. The research findings illustrate the multiple ways culture is understood and experienced by mental health service users, families and practitioners. Exploring mental health service cultures from multiple perspectives allowed new understandings to emerge. While culture can and does change, it is unlikely to occur predictably via policy or managerial interventions (Davies, Nutley et al., 2000). Focusing on culture in an exploratory way has provided an avenue to explore the unspoken and hidden issues and dominant discourses within mental health services.

Contribution to Knowledge

This research makes two distinct contributions to knowledge. First, the methodology enabled a multi-perspective understanding of culture from three participant groups: service users, families and practitioners. There were many points of consensus across the participant groups in how culture was understood, and divergence in the meanings and experiences ascribed to cultures often depended on subject positions. This multi-perspective approach allowed for an exploration of different perspectives and conceptualisations of culture and makes a novel contribution to the wider literature.

Additionally, unlike previous research, this study was able to draw together these multiple perspectives to inform proposed enablers of cultural change.

Second, the findings demonstrated the importance of the broader historical, social, economic and political contexts in understanding mental health service cultures, including how practitioners are constrained by and reproduce culture in their everyday practices. Analysing this broader context produced a more responsive way of theorising and understanding mental health service cultures. This orientation which focussed on the broader contexts of organisational culture is less common in the wider literature and has implications for how researchers, educators, mental health administrators and practitioners can approach cultural change. This approach identified the deeper layers of culture which sit at the basic assumption level of Schein's (1992, 2010) framework, demonstrating why service cultures are so complex and resistant to policy and structural changes.

Addressing the wicked problem of mental health service cultures requires a questioning of old culture; the taken-for-granted and accepted practices and ideologies within mental health services, at of the centre of which are epistemic questions that must be addressed. Although practitioners viewed existing policy aspirations as important, the organisational context that fostered and reinforced entrenched practices meant that the policies became insignificant compared with organisational priorities centred on economic imperatives, risk aversion and accountability. Thus, while individual practitioners adopted recovery-oriented approaches in their practice, forming patches or sites of change, the overarching culture with its entrenched historical practices coupled with the constraints of NPM limited sustained and meaningful change efforts. Therefore, this research argues for critical engagement with these historical, social, economic and political contexts, including the impact on practitioners' everyday work and service users' and families' experiences.

Research Reflections and Concluding Statement

This project has undergone several changes since its original conception. Due to issues gaining ethics approval, the project design and setting were changed so that DoH HREC approval was no longer required. My experience with the DoH's HREC signified mental health service cultures I would later identify as part of this research—although I did not realise this then.

“How Do You Expect Mental Health Patients to Understand Culture?”

To conclude this thesis, I return to an early stage of this project sitting at a table in a room with approximately 15 DoH HREC members as I was required to present my research and respond to questions in an allocated 10 minutes. The question: “How do you expect mental health patients to understand culture?” was asked by an HREC member, and another member scoffed and said “Yes”, affirming the legitimacy of the question. The HREC members seemed to question my assumption that “mental health patients” would understand a complex topic such as service culture. I had spent considerable time thinking and planning how to operationalise this concept in the project with all participants before the interviews. As noted throughout this thesis, culture is regarded in the literature as a complex and multilayered concept that is variously defined. I responded to the question, stating that I had prepared a preamble in interview guides, including a description of my understanding of culture, inviting participants to share how my understanding resonated with theirs. I also explained that I planned to discuss the preamble and my definition of culture with my LECs following ethics approval.[3] I expressed that I was interested in understanding how participants made sense of culture, as it was frequently used in various contexts.

There was no response from the HREC members to my statements. Perhaps this was usual practice: a committee member asks a question, the researcher answers, next question. It seemed like my response did not address their question or the issues they were raising. I remember thinking that I had not been clear in my response, or perhaps I did not understand their questions. It felt like there was a communication gap between what the committee members were asking and what I was trying to articulate—a gap in what we were trying to convey to each other. Upon reflection, which I did not comprehend fully at that time, the committee members seemed to be questioning how “mental health patients” had the knowledge, capacity or insight to comprehend, understand and speak about a complex subject like mental health service cultures and, therefore, contribute to valid knowledge generation on the topic. This response reflects the findings of this research, particularly old culture, the culture of othering and constructions of service users’ knowledge as lacking credibility and legitimacy.

---

[3] As mentioned in Chapter 3, I was unable to include LECs prior to ethics approval.

An additional issue raised by the HREC was my providing a gift voucher to service user and family participants to recognise the contribution of their expertise, knowledge and time, as stated in my research information sheet. One HREC member flagged this process and the wording I used, stating: “we don’t give handouts”. Following the meeting, I received the application review document from the HREC noting that my remuneration statement to participants must be deleted and replaced with “patients will be reimbursed for costs of up to $20”. This statement was contrary to the NHMRC’s (2016) *Statement on Consumer and Community Involvement in Health and Medical Research*, which specifies that research institutions “should have planned budget strategies and allocate funds to support, implement, and acknowledge consumer and community involvement [which may include] honoraria and payments for consumers and community members” (p. 11). The HREC instructions were contrary to the NHMRC statement and reinforced the notion that mental health patients’ knowledge and expertise were not valued.

Whistleblowers

The HREC members also asked questions about the practitioners’ participating in the research: “How will you know they are telling the truth?” and “How will you protect the practitioners who speak out given how whistleblowers have been treated in the past?” The questions seemed contradictory at the time—questioning the reliability or ‘truth’ in what practitioners would say alongside concern for practitioners speaking the truth and the consequences for them as whistleblowers. Whistleblowers within health care are victimised and ostracised for raising concerns (Mannion & Davies, 2015). Therefore, this question was useful for thinking through my procedures to ensure practitioners’ anonymity. Participants in the research spoke of the tacit knowing that whistleblowers experience consequences and that the silencing culture sustained practitioners’ fear of speaking out. I outlined to the HREC how I would ensure the anonymity of practitioners. Again, there was minimal response from the HREC members. I was perplexed by the questioning of whether practitioners would tell the truth. ‘Whose truth and in relation to what?’ I wondered. I left this meeting feeling confused. I questioned whether my proposed research was unethical and ill-conceived, and I was almost certain that the HREC would not approve it.

Concluding Statement

Having concluded this research, I now see the questions and issues raised by the HREC members as indicative of the cultures of mental health services. They were powerful markers for what was to come in this research. At the heart of these statements are questions about types of knowledge and whose knowledge counts. A key feature of the findings of this research is the diminished credibility given to service users' and families' testimonies. The discursive construction of service users as 'people without knowledge' permeated mental health service cultures. Thus, the beliefs evident in the HREC members' statements and questions reveal underpinning ideas that create and perpetuate old culture and epistemic injustice. Due to prejudice and discrimination, mental health service users are viewed as unintelligible and wronged in their capacity as knowers (Fricker, 2007; LeBlanc & Kinsella, 2016).

The HREC members questioned whether practitioners would speak the truth and provide factual accounts of culture. This speaks to many of the practitioners' experiences in this research of feeling controlled and silenced by the organisational and administrative contexts within which they worked. The truth within an organisation is "what passes for common sense custom and practice" (Higgins & Reitz, 2019, p. 453). Therefore, the truth is treated unproblematically, as normal and accepted. These truths were treated in this project as sitting at the basic assumptions level of culture; that is, they are unquestioned elements of a culture sitting below consciousness (Schein, 1992, 2010). The findings of this research reveal some of these accepted and unproblematic truths within mental health services, shedding light on power and hierarchies, and the conflicting and competing priorities, worldviews and values that exist between service users, families, practitioners and administrators.

It is my hope that this thesis 'speaks back' to the HREC members' questioning of practitioners' truth and of service users' understanding of mental health service cultures. People who use mental health services and their families know and understand the many ways in which culture manifests and operates, the markers and artefacts of culture, the way culture feels, and how extant cultures are sustained and reinforced. Service users, families and practitioners hold vital knowledge in understanding mental health service cultures and possible ways forward.

References

Ahmed, N., Barlow, S., Reynolds, L., Drey, N., Begum, F., Tuudah, E., & Simpson, A. (2021). Mental health professionals' perceived barriers and enablers to shared decision-making in risk assessment and risk management: A qualitative systematic review. *BMC Psychiatry, 21*(1), 594. https://doi.org/10.1186/s12888-021-03304-0

Alakus, C. & Petrakis, M. (2020). The social worker's role within an adult mental health interprofessional collaborative team. In M. Petrakis (Ed.), *Social work practice in health* (pp. 116–134). Routledge.

Allan, J. (2009). Theorising new developments in critical social work. In J. Allan, L. Briskman & B. Pease (Eds.), *Critical social work* (2nd ed., pp. 30–44). Allen & Unwin.

Aluwihare-Samaranayake, D. (2012). Ethics in qualitative research: A view of the participants' and researchers' world from a critical standpoint. *International Journal of Qualitative Methods*, *11*(2), 64–81. https://doi.org/10.1177/160940691201100208

Alvesson, M. (1987). *Organization theory and technocratic consciousness: Rationality, ideology, and quality of work*. de Gruyter.

Alvesson, M. (2002). *Understanding organizational culture*. SAGE Publications. https://dx.doi.org/10.4135/9781446280072

Alvesson, M. & Ashcraft, K. L. (2009). Critical methodology in management and organization research. In D. A. Buchanan & A. Bryman (Eds.), *The SAGE handbook of organizational research methods* (pp. 61–77). SAGE Publications.

Alvesson, M. & Deetz, S. (2000). *Doing critical management research*. SAGE Publications.

Alvesson, M. & Willmott, H. (2012). *Making sense of management: A critical introduction*. SAGE Publications. https://dx.doi.org/10.4135/9781446251782

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*. American Psychiatric Publishing.

Andreasson, J., Ljungar, E., Ahlstrom, L., Hermansson, J. & Dellve, L. (2018). Professional bureaucracy and health care managers' planned change strategies: Governance in Swedish health care. *Nordic Journal of Working Life Studies*, *8*(1). https://doi.org/10.18291/njwls.v8i1.104849

Antonio, R. J. (1981). Immanent critique as the core of critical theory: Its origins and developments in Hegel, Marx and contemporary thought. *The British Journal of Sociology*, *32*(3), 330–345. https://doi.org/10.2307/589281

Arksey, H. & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International journal of social research methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Australian Association of Social Workers. (2020). *Australian Association of Social Workers code of ethics 2020*. https://www.aasw.asn.au/document/item/92

Australian Commission on Safety and Quality in Health Care. (2018). *National safety and quality health service standards: User guide for health service providing care for people with mental health issues*. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-health-services-providing-care-people-mental-health-issues

Australian Government. (2010). *National standards for mental health services 2010*. Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-standards-for-mental-health-services-2010-and-implementation-guidelines

Australian Health Ministers' Advisory Council. (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Commonwealth of Australia. https://www.health.gov.au/resources/publications/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers

Australian Health Ministers' Conference. (2009a). *Fourth National Mental Health Plan: An agenda for collaborative action in mental health 2009-2014*. Commonwealth of Australia. https://www.health.qld.gov.au/__data/assets/pdf_file/0026/366119/fourth_nat_mh_plan.pdf

Australian Health Ministers' Conference. (2009b). *National mental health policy 2008*. Commonwealth of Australia. https://www.health.gov.au/resources/publications/national-mental-health-policy-2008

Australian Institute of Health and Welfare. (2019). *Mental health services: In brief 2019* (Cat. No. HSE 228). https://www.aihw.gov.au/getmedia/f7395726-55e6-4e0a-9c1c-01f3ab67c193/aihw-hse-228-in-brief.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2014). *Australia's health 2014* (Cat. No. AUS 178). https://www.aihw.gov.au/reports/australias-health/australias-health-2014

Australian Institute of Health and Welfare. (2022, 17 May). *Mental health services in Australia*. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

Bacchi, C. (2008). The politics of research management: Reflections on the gap between what we 'know' (about SDH) and what we do. *Health Sociology Review*, *17*(2), 165–176. https://doi.org/10.5172/hesr.451.17.2.165

Bach-Mortensen, A. M. & Barlow, J. (2021). Outsourced austerity or improved services? A systematic review and thematic synthesis of the experiences of social care providers and commissioners in quasi-markets. *Social Science & Medicine*, *276*, Article 113844. https://doi.org/https://doi.org/10.1016/j.socscimed.2021.113844

Bainbridge, L. (1999). Competing paradigms in mental health practice and. In B. Pease & J. Fook (Eds.), *Transforming social work practice: Postmodern critical perspectives* (pp. 179–194). Allen & Unwin.

Baines, D. (2006). 'If you could change one thing': Social service workers and restructuring. *Australian Social Work*, *59*(1), 20–34. https://doi.org/10.1080/03124070500449754

Bakker, A. B., Le Blanc, P. M. & Schaufeli, W. B. (2005). Burnout contagion among intensive care nurses. *Journal of advanced nursing*, *51*(3), 276–287. https://doi.org/10.1111/j.1365-2648.2005.03494.x

Barker, J. R. (1993). Tightening the iron cage: Concertive control in self-managing teams. *Administrative Science Quarterly*, *38*(3), 408–437. https://doi.org/10.2307/2393374

Barnes, C. (2003). What a difference a decade makes: Reflections on doing 'emancipatory' disability research. *Disability & Society*, *18*(1), 3–17. https://doi.org/10.1080/713662197

Bates, L. & Stickley, T. (2013). Confronting Goffman: How can mental health nurses effectively challenge stigma? A critical review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *20*(7), 569–575. https://doi.org/https://doi.org/10.1111/j.1365-2850.2012.01957.x

Beckett, P., Field, J., Molloy, L., Yu, N., Holmes, D. & Pile, E. (2013). Practice what you preach: Developing person-centred culture in inpatient mental health settings through strengths-based, transformational leadership. *Issues in Mental Health Nursing*, *34*(8), 595–601. https://doi.org/10.3109/01612840.2013.790524

Bee, P., Brooks, H., Fraser, C. & Lovell, K. (2015). Professional perspectives on service user and carer involvement in mental health care planning: A qualitative study. *International Journal of Nursing Studies*, *52*(12), 1834–1845. https://doi.org/10.1016/j.ijnurstu.2015.07.008

Bell, K. (2011). Participants' motivations and co-construction of the qualitative research process. *Qualitative Social Work*, *12*(4), 523–539. https://doi.org/10.1177/1473325011429020

Bennetts, W., Cross, W. & Bloomer, M. (2011). Understanding consumer participation in mental health: Issues of power and change. *International Journal of Mental Health Nursing*, *20*(3), 155–164. http://dx.doi.org/10.1111/j.1447-0349.2010.00719.x

Beresford, P. (2016). The role of survivor knowledge in creating alternatives to psychiatry. In J. Russo & A. Sweeney (Eds.), *Searching for a rose garden: Challenging psychiatry, fostering mad studies* (pp. 25–35). PCCS Books.

Beresford, P. (2020). 'Mad', mad studies and advancing inclusive resistance. *Disability & Society*, *35*(8), 1337–1342. https://doi.org/10.1080/09687599.2019.1692168

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Berlin, J. M. & Carlström, E. D. (2015). Cultural camouflage—A critical study of how artefacts are camouflaged and mental health policy subverted. *The International Journal of Health Planning and Management*, *30*(2), 111–126. https://doi.org/https://doi.org/10.1002/hpm.2210

Bessant, J., Watts, R., Dalton, T. & Smyth, P. (2020). *Talking policy: How social policy is made*. Routledge.

Black, J., Ramos, J. & Glover, H. (2021). *Queensland alliance for mental health: Wellbeing first*. https://www.qamh.org.au/wp-content/uploads/EMBARGOED-Copy-Wellbeing-First-Report-DIGITAL.pdf

Bland, R. (1998). Understanding grief and guilt as common themes in family response to mental illness: Implications for social work practice. *Australian Social Work*, *51*(4), 27–34. https://doi.org/10.1080/03124079808411241

Bland, R., Drake, G. A. & Drayton, J. A. (2021). *Social work practice in mental health: An introduction.* (3rd ed.). Routledge.

Bland, R. & Foster, M. (2012). Families and mental illness: Contested perspectives and implications for practice and policy. *Australian Social Work*, *65*(4), 517–534. https://doi.org/10.1080/0312407X.2011.646281

Bland, R., Renouf, N. & Tullgren, A. (2015). *Social work practice in mental health: An introduction* (2nd ed.). Routledge. https://doi.org/10.4324/9781003117308

Blauner, R. (1964). *Alienation and freedom: The factory worker and his industry*. Chicago University Press.

Bloom, S. L. (2006). *Organizational stress as a barrier to trauma-sensitive change and system transformation.* National Technical Assistance Center for State Mental Health Planning Publications and Reports. http://www.nasmhpd.org/sites/default/files/Organizational%20Stress%202010%20formatted%20NTAC(1).pdf

Bloom, S. L. & Farragher, B. (2011). *Destroying sanctuary: The crisis in human service delivery systems*. Oxford University Press.

Boardman, J., & Shepherd, J. (2011). Putting recovery into practice: organisational change and commissioning. *The Journal of Mental Health Training, Education and Practice*, 6(1), 7–16. https://doi.org/10.1108/17556221111136125

Bogg, D. (2011). Leadership for social care outcomes in mental health provision. *International Journal of Leadership in Public Services*, *7*(1), 32–47. https://doi.org/10.5042/ijlps.2011.0091

Boxall, K. & Beresford, P. (2013). Service user research in social work and disability studies in the United Kingdom. *Disability & Society*, *28*(5), 587–600. https://doi.org/10.1080/09687599.2012.717876

Boyett, I. & Finlay, D. (1995). The quasi-market, the entrepreneur and the effectiveness of the NHS business manager. *Public Administration*, *73*(3), 393–411. https://doi.org/10.1111/j.1467-9299.1995.tb00835.x

Boyle, M. (2013). The persistence of medicalisation: Is the presentation of alternative part of the problem? In S. Coles, S. Keenan & B. Diamond (Eds.), *Madness contested: Power and practice* (pp. 3–22). PCCS Books.

Bracken, P. & Thomas, P. (2005). *Postpsychiatry: Mental health in a postmodern world*. Oxford University Press.

Bracken, P. & Thomas, P. (2017). Reflections on critical psychiatry. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 98–106). Routledge. https://doi.org/10.4324/9781315399584

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N. & Double, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, *201*(6), 430–434. https://doi.org/10.1192/bjp.bp.112.109447

Bradbury, H. & Lichtenstein, B. M. B. (2000). Relationality in organizational research: exploring the space between. *Organization Science*, *11*(5), 551–564. https://www.jstor.org/stable/2640345

Braithwaite, J. (2002). *Restorative justice and responsive regulation*. Oxford University Press.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE Publications.

Braun, V. & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., Clarke, V., Hayfield, N. & Terry, G. (2019). Thematic analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences* (pp. 843–860). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_103

Briskman, L., Pease, B. & Allan, J. (2009). Introducing critical theories for social work in a neo-liberal context. In J. Allan, L. Briskman & B. Pease (Eds.), *Critical social work: Theories and practices for a socially just world* (pp. 3–14). Allen & Unwin.

Brophy, L., Fletcher, J. & Hamilton, B. (2020). Being recovery-oriented and reducing the use of restrictive interventions in mental health care: The challenges in achieving transformation. In B. McSherry & Y. Maker (Eds.), *Restrictive practices in health care and disability settings* (pp. 236–256). Routledge. https://doi.org/10.4324/9780429355219

Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J. & McSherry, B. M. (2016). Consumers and their supporters' perspectives on poor practice and the use of seclusion and restraint in mental health settings: Results from Australian focus groups. *International Journal of Mental Health Systems*, *10*, Article 6. https://doi.org/10.1186%2Fs13033-016-0038-x

Brown, C. (2021). Critical clinical social work and the neoliberal constraints on social justice in mental health. *Research on Social Work Practice*, *31*(6), 644–652. https://doi.org/10.1177/1049731520984531

Brown, C., Johnstone, M., Ross, N. & Doll, K. (2022). Challenging the constraints of neoliberalism and biomedicalism: Repositioning social work in mental health. *Qualitative Health Research*, *32*(5), 771–787. https://doi.org/10.1177/10497323211069681

Brown, P. R. & Calnan, M. W. (2016). Chains of (dis)trust: Exploring the underpinnings of knowledge-sharing and quality care across mental health services. *Sociology of Health & Illness*, *38*(2), 286–305. https://doi.org/10.1111/1467-9566.12369

Burdekin, B. (1993). *Human rights and mental illness: Report of the national inquiry into the human rights of people with mental illness*. Human Rights and Equal Opportunity Commission. https://apo.org.au/sites/default/files/resource-files/1993-10/apo-nid29708_1.pdf

Bury, M. & Taylor, D. (2008). Towards a theory of care transition: From medical dominance to managed consumerism. *Social Theory & Health*, *6*(3), 201–219. https://doi.org/10.1057/sth.2008.9

Busfield, J. (2013). The pharmaceutical industry and mental disorder. In S. Coles, S. Keenan & B. Diamond (Eds.), *Madness contested: Power and practice* (pp. 90–110). PCCS Books.

Byrne, L., Happell, B. & Reid-Searl, K. (2015). Recovery as a lived experience discipline: A grounded theory study. *Issues Mental Health Nursing*, *36*(12), 935–943. https://doi.org/10.3109/01612840.2015.1076548

Byrne, L., Happell, B. & Reid-Searl, K. (2016). Lived experience practitioners and the medical model: World's colliding? *Journal of Mental Health*, *25*(3), 217–223.

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L. & Saunders, M. (2021). *National lived experience workforce guidelines*. National Mental Health Commission. https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines

Byrne, L., Wilson, M., Burke, K. J., Gaskin, C. J. & Happell, B. (2014). Mental health service delivery: A profile of mental health non-government organisations in south-east Queensland, Australia. *Australian Health Review*, *38*(2), 202–207. https://doi.org/10.1071/ah13208

Byrne, L. & Wykes, T. (2020). A role for lived experience mental health leadership in the age of Covid-19. *Journal of Mental Health*, *29*(3), 243–246. https://doi.org/10.1080/09638237.2020.1766002

Cameron, K. & Freeman, S. (1991). Culture, congruence, strength and type: Relationship to effectiveness. *Research in Organizational Change and Development*, *5*, 23–58. https://webuser.bus.umich.edu/cameronk/PDFs/Organizational%20Culture/Cultural%20Congruence.pdf

Capital Health Network. (2020). *Australian Capital Territory mental health and suicide prevention plan 2019–2024. (Part B: Implementation plan. Part C: Performance & monitoring plan)*. https://www.chnact.org.au/wp-content/uploads/2020/08/CHN-Mental-Health-and-Suicide-Prevention-Plan-PartsBC.pdf

Carey, G., Malbon, E., Green, C., Reeders, D. & Marjolin, A. (2020). Quasi-market shaping, stewarding and steering in personalization: The need for practice-orientated empirical evidence. *Policy Design and Practice*, *3*(1), 30–44. https://doi.org/10.1080/25741292.2019.1704985

Carney, T. (2008). The mental health service crisis of neoliberalism—An antipodean perspective. *International Journal of Law and Psychiatry*, *31*(2), 101–115. https://doi.org/https://doi.org/10.1016/j.ijlp.2008.02.001

Carr, S. (2016). *Position paper: Are mainstream mental health services ready to progress transformative co-production?* National Development Team for Inclusion. https://www.ndti.org.uk/assets/files/MH_Coproduction_position_paper.pdf

Carter, S. M. & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, *17*(10), 1316–1328. https://doi.org/10.1177/1049732307306927https://doi.org/10.1177/1049732307306927

Chamberlin, J. (1990). The ex-patients' movement: Where we've been and where we're going. *The Journal of Mind and Behavior*, *11*(3/4), 323–336. http://www.jstor.org/stable/43854095

Chow, W. S. & Priebe, S. (2013). Understanding psychiatric institutionalization: A conceptual review. *BMC Psychiatry*, 13, Article 169. https://doi.org/10.1186/1471-244X-13-169

Christakis, N. A. (2008). Don't just blame the system. *British Medical Journal*, *336*(7647), 747. https://doi.org/10.1136/bmj.39534.461134.59

Clancy, L., Happell, B., & Moxham, L. (2014). The Language of Risk: Common Understanding or Diverse Perspectives? *Issues in Mental Health Nursing, 35*(7), 551–557. https://doi.org/10.3109/01612840.2014.880139

Clancy, L. & Happell, B. (2014). Tensions of difference: Reconciling organisational imperatives for risk management with consumer-focused care from the perspectives of clinicians and managers. *Journal of Clinical Nursing*, *23*(21–22), 3177–3187. https://doi.org/10.1111/jocn.12564

Clarke, V., Braun, V. & Hayfield, N. (2015). Thematic analysis. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed., pp. 222–248). SAGE Publications.

Coburn, D. (2006). Medical dominance then and now: Critical reflections. *Health Sociology Review*, *15*(5), 432–443. https://doi.org/10.5172/hesr.2006.15.5.432

Cockerham, W. C. (2015). Max Weber: Bureaucracy, formal rationality and the modern hospital. In F. Collyer (Ed.), *The Palgrave handbook of social theory in health, illness and medicine* (pp. 124–138). Palgrave Macmillan.

Cohen, M. (2017). A systemic approach to understanding mental health and services. *Social Science & Medicine, 191*, 1–8. https://doi.org/10.1016/j.socscimed.2017.08.037

Coleman, E. (2008). The politics of rationality. In K. Philip & B. da Costa (Eds.), *Tactical biopolitics: Art, activism, and technoscience* (pp. 341–364). MIT Press. https://doi.org/10.7551/mitpress/9780262042499.003.0020

Coleman, R. (2011). R*ecovery: An alien concept* (3rd ed.). P&P Press.

Conklin, J. (2006). Dialogue *m*apping: Building *s*hared *u*nderstanding of *w*icked *p*roblems. Wiley.

Common, R. (2004). Organisational learning in a political environment. *Policy Studies*, *25*(1), 35–49. https://doi.org/10.1080/0144287042000208224

Connell, R., Fawcett, B. & Meagher, G. (2009). Neoliberalism, New Public Management and the human service professions: Introduction to the special issue. *Journal of Sociology*, *45*(4), 331–338. https://doi.org/10.1177/1440783309346472

Corlett, S. (2014). Francis, Berwick and culture change–An opportunity to engage patients and increase transparency in mental health. *Mental Health and Social Inclusion*, *18*(1), 13–16. https://doi.org/10.1108/MHSI-10-2013-0034

Costa, L., Voronka, J., Landry, D., Reid, J., Mcfarlane, B., Reville, D. & Church, K. (2012). 'Recovering our stories': A small act of resistance. *Studies in Social Justice*, *6*(1), 85–101. https://doi.org/10.26522/ssj.v6i1.1070

Council of Australian Governments Health Council. (2017). *The fifth national mental health and suicide prevention plan*. Department of Health, Australian Government. https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan.pdf

Coupe, N. & Mathieson, A. (2020). Patient and public involvement in doctoral research: Impact, resources and recommendations. *Health Expectations*, *23*(1), 125–136. https://doi.org/https://doi.org/10.1111/hex.12976

Creed, W. E. D., Langstraat, J. A., & Scully, M. A. (2002). A Picture of the Frame: Frame Analysis as Technique and as Politics. Organizational Research Methods, 5(1), 34–55. https://doi.org/10.1177/1094428102051004

Cresswell, M. & Spandler, H. (2016). Solidarities and tensions in mental health politics: Mad studies and psychopolitics. *Critical and Radical Social Work*, *4*(3), 357–373. https://doi.org/10.1332/204986016x14739257401605

Crichton, P., Carel, H. & Kidd, I. (2017). Epistemic injustice in psychiatry. *BJPsych Bulletin*, *41*(2), 65–70. https://doi.org/10.1192/pb.bp.115.050682

Crowe, J. (2017). Reform, revolution and disruption in mental health care: A consumer's perspective. *Public Health Research & Practice, 27*(2), 1–4. https://www.phrp.com.au/issues/april-2017-volume-27-issue-2/reform-revolution-and-disruption-in-mental-health-care-a-consumers-perspective/

Crowe, M. & Carlyle, D. (2003). Deconstructing risk assessment and management in mental health nursing. *Journal of Advanced Nursing*, *43*(1), 19–27. https://doi.org/https://doi.org/10.1046/j.1365-2648.2003.02669.x

Cui, J., Mao, L., Newman, C. E., Kwan, C. K. & Lancaster, K. (2021). Managing risk in the pro-empowerment era of mental health care: A cross-cultural study of social work perspectives in Hong Kong and Sydney. *The British Journal of Social Work*, *51*(3), 831–848. https://doi.org/10.1093/bjsw/bcaa232

Cutcliffe, J. R. & Stevenson, C. (2008). Feeling our way in the dark: The psychiatric nursing care of suicidal people-a literature review. *International Journal of Nursing Studies*, *45*(6), 942–953. https://doi.org/10.1016/j.ijnurstu.2007.02.002

Cutler, N. A., Moxham, L. & Stephens, M. (2015). The meaning of safety in an acute mental health inpatient services. *Australian Nursing and Midwifery Journal*, *22*(8), 39. https://search.informit.org/doi/10.3316/informit.968383965400116

Danken, T., Dribbisch, K. & Lange, A. (2016). Studying wicked problems forty years on: Towards a synthesis of a fragmented debate. *der moderne staat, 9*(1), 5–6. https://elibrary.utb.de/doi/abs/10.3224/dms.v9i1.23638

Dark, F., Whiteford, H., Ashkanasy, N. M., Harvey, C., Harris, M., Crompton, D., & Newman, E. (2017). The impact of organisational change and fiscal restraint on organisational culture. *International Journal of Mental Health Systems*, 11(1), 11. https://doi.org/10.1186/s13033-016-0116-0

Davidson, G., Brophy, L. & Campbell, J. (2016). Risk, recovery and capacity: Competing or complementary approaches to mental health social work. *Australian Social Work*, *69*(2), 158–168. https://doi.org/10.1080/0312407X.2015.1126752

Davidson, L. (2005). Recovery, self management and the expert patient—Changing the culture of mental health from a UK perspective. *Journal of Mental Health*, *14*(1), 25–35. https://doi.org/10.1080/09638230500047968

Davies, H. & Mannion, R. (2013). Will prescriptions for cultural change improve the NHS? *BMJ*, *346*(7900), 19–21. https://doi.org/10.1136/bmj.f1305

Davies, H., Mannion, R., Jacobs, R., Powell, A. & Marshall, M. (2007). Exploring the relationship between senior management team culture and hospital performance. *Medical Care Research and Review*, *64*(1), 46–65. https://doi.org/10.1177/1077558706296240

Davies, H., Nutley, S. M., & Mannion, R. (2000). Organisational culture and quality of health care. Quality in Health Care, 9(2), 111-119. https://doi.org/10.1136/qhc.9.2.111

Davies, K. & Gray, M. (2015). Mental health service users' aspirations for recovery: Examining the gaps between what policy promises and practice delivers. *The British Journal of Social Work*, *45*(suppl. 1), i45–i61. https://doi.org/10.1093/bjsw/bcv089

Davis, R. T. (2010). Constructing a profession of social work: The role of social work supervision. *Revista de Asistenta Sociala*, (1), 20–30.

Davison, S., Hauck, Y., Martyr, P. & Rock, D. (2013). How mental health clinicians want to evaluate the care they give: A Western Australian study. *Australian Health Review*, *37*(3), 375–380. https://doi.org/https://doi.org/10.1071/AH12171

Dawson, L., River, J., McCloughen, A. & Buus, N. (2020). 'Every single minute and hour is scrutinised': Neoliberalism and Australian private mental health care. *Sociology of Health & Illness*, *42*(2), 277–292. https://doi.org/10.1111/1467-9566.13009

Day, K. & Petrakis, M. (2018). Early intervention in mental health: Opportunities and challenges. In M. Petrakis (Ed.), *Social work practice in health: An introduction to contexts, theories and skills* (pp. 100–115). Allen & Unwin.

Daya, I., Hamilton, B. & Roper, C. (2020). Authentic engagement: A conceptual model for welcoming diverse and challenging consumer and survivor views in mental health research, policy, and practice. *International Journal of Mental Health Nursing*, *29*(2), 299–311. https://doi.org/10.1111/inm.12653

D'Cruz, H., Gillingham, P. & Melendez, S. (2007). Reflexivity, its meanings and relevance for social work: A critical review of the literature. *The British Journal of Social Work,* 37(1), 73–90. http://www.jstor.org/stable/23721231

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, *33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

de Beauvoir, S. (1997). *The second sex* (H. M. Parshley, Ed. and Trans.). Vintage. (Original work published 1949)

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, *19*(3), 91–97. https://doi.org/10.1037/h0101301

Deetz, S. A. (1982). Critical interpretive research in organizational communication. *Western Journal of Speech Communication*, *46*(2), 131–149. https://doi.org/10.1080/10570318209374073

Dej, E. (2016). Psychocentrism and Homelessness: The pathologization/responsibilization paradox. *Studies in Social Justice*, *10*, 117–135. https://doi.org/10.26522/ssj.v10i1.1349

Denborough, D. (2021). Moral injury and moral repair: The possibilities of narrative practice. *International Journal of Narrative Therapy & Community Work*, (4), 24–58. https://dulwichcentre.com.au/product/moral-injury-and-moral-repair-the-possibilities-of-narrative-practice-david-denborough/

Denzin, N. K. (2017). Critical qualitative inquiry. *Qualitative Inquiry*, *23*(1), 8–16. https://doi.org/10.1177/1077800416681864

Denzin, N. K. & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 1–32). Sage Publications.

Denzin, N. K. & Lincoln, Y. S. (2008). Introduction: The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The landscape of qualitative research* (3rd ed., pp. 1–44). Sage Publications.

Department of Health. (2005). *Submission to the Senate Select Committee on Mental Health: Overview of mental health policy and reform 1990–2005*. Government of Western Australia. https://www.aph.gov.au/~/media/wopapub/senate/committee/mentalhealth_ctte/submissions/sub376_pdf.ashx

Department of Health NSW. (1983). *Inquiry into health services for the psychiatrically ill and developmentally disabled*. https://www.nswmentalhealthcommission.com.au/content/richmond-report

Dickinson, H., Bismark, M., Phelps, G. & Loh, E. (2016). Future of medical engagement. *Australian Health Review*, *40*(4), 443–446. https://doi.org/10.1071/ah14204

Dickinson, H., Snelling, I., Ham, C. & Spurgeon, P. C. (2017). Are we nearly there yet? A study of the English National Health Service as professional bureaucracies. *Journal of Health Organization and Management*, *31*(4), 430–444. https://doi.org/10.1108/JHOM-01-2017-0023

Dickson-Swift, V., James, E. L., Kippen, S. & Liamputtong, P. (2007). Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research*, *7*(3), 327–353. https://doi.org/10.1177/1468794107078515

Dietz, C. A. (2000). Responding to oppression and abuse: A feminist challenge to clinical social work. *Affilia*, *15*(3), 369–389. https://doi.org/10.1177/08861090022094001

Dillon, J. (2011). The personal is the political. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 141–157). Palgrave Macmillan UK. https://doi.org/10.1057/9780230342507_11

Diminic, S., Hielscher, E., Lee, Y. Y., Harris, M., Schess, J., Kealton, J. & Whiteford, H. (2016). *The economic value of informal mental health caring in Australia*. The University of Queensland. http://helpingminds.org.au/wp-content/uploads/2017/03/Mind_Value-of-Informal-MH-Caring_Full-Report_v7.pdf

Dixon, J. (2015). Balancing risk and recovery in mental health: An analysis of the way in which policy objectives around risk and recovery affect professional practice in England. In J. M. Chamberlain (Ed.), Medicine, Risk, Discourse and Power (pp. 120-140). Taylor and Francis.

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P. & West, M. (2014). Culture and behaviour in the English National Health Service: Overview of lessons from a large multimethod study. *BMJ Quality & Safety*, *23*(2), 106–115. https://doi.org/10.1136/bmjqs-2013-001947

Doherty, M., McGuire, A., Martin, R. & Gillieatt, S. (2021). Disrupting ‘expertise’: Learnings from a grassroots lived experience and social work academic partnership. *Advances in Social Work and Welfare Education*, *22*(2), 39–55. https://search.informit.org/doi/10.3316/informit.683643734089810

Dominelli, L. (2002). *Anti-oppressive social work theory and practice*. Palgrave Macmillan.

Dorozenko, K. & Martin, R. (2017). *A critical literature review of the direct, adverse effects of neuroleptics: Essential information for mental health consumers, carers, families, supporters and clinicians* (Working Paper). School of Occupational Therapy, Social Work and Speech Pathology, Curtin University. http://hdl.handle.net/20.500.11937/67535

Dorozenko, K., Ridley, S., Martin, R. & Mahboub, L. (2016). A journey of embedding mental health lived experience in social work education. *Social Work Education*, *35*(8), 905–917. https://doi.org/10.1080/02615479.2016.1214255

Dotson, K. (2011). Tracking epistemic violence, tracking practices of silencing. Hypatia, 26(2), 236–257. http://www.jstor.org/stable/23016544

Double D. B. (2019). Twenty years of the Critical Psychiatry Network. *The British Journal of Psychiatry*, 214(2), 61–62. https://doi.org/10.1192/bjp.2018.181

Duthie, E. A., Fischer, I. C. & Frankel, R. M. (2020). Blame and its consequences for healthcare professionals: Response to Tigard. *Journal of Medical Ethics*, *46*, 339–341. http://dx.doi.org/10.1136/medethics-2019-105525

Edwards, M., Halligan, J., Horrigan, B. & Nicoll, G. (2012). *Public sector governance in Australia*. ANU Press. http://www.jstor.org/stable/j.ctt24h92b

Egan, R. (2012). Australian social work supervision practice in 2007. *Australian Social Work*, *65*(2), 171–184. https://doi.org/10.1080/0312407X.2011.653575

Egan, R., Maidment, J. & Connolly, M. (2017). Trust, power and safety in the social work supervisory relationship: Results from Australian research. *Journal of Social Work Practice*, *31*(3), 307–321. https://doi.org/10.1080/02650533.2016.1261279

Emanuel, E. J. & Emanuel, L. L. (1996). What is accountability in health care? *Annals of Internal Medicine*, *124*(2), 229–239. https://doi.org/10.7326/0003-4819-124-2-199601150-00007 %m 8533999

Engel, R. J. & Schutt, R. K. (2013). *The practice of research in social work* (3rd ed.). Sage Publications.

Epstein, M. (2012). Mental health consumer movement. In G. Meadows, J. Farhall, E. Fossey, M. Grigg, F. McDermott & B. Singh (Eds.), *Mental health in Australia: Collaborative community practice* (3rd ed., pp. 7–8). Oxford University Press.

Epstein, M. (2013). *The consumer movement in Australia: A memoir of an old campaigner*. Our Consumer Place. https://www.ourcommunity.com.au/files/OCP/HistoryOfConsumerMovement.pdf

Faulkner, A. (2017). Survivor research and mad studies: The role and value of experiential knowledge in mental health research. *Disability & Society*, *32*(4), 500–520. https://doi.org/10.1080/09687599.2017.1302320

Fawcett, B. (2012). Mental health. In M. Gray, J. Midgley & S. A. Webb (Eds.), *The Sage handbook of social work* (pp. 515–530). SAGE Publications. http://dx.doi.org/10.4135/9781446247648.n34

Felton, A. & Stickley, T. (2018). Rethinking risk: A narrative approach. *The Journal of Mental Health Training, Education and Practice*, *13*(1), 54–62. https://doi.org/10.1108/JMHTEP-06-2017-0043

Fine, M. (2016). Just methods in revolting times. *Qualitative Research in Psychology*, *13*(4), 347–365. https://doi.org/10.1080/14780887.2016.1219800

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209–230. https://doi.org/10.1177/146879410200200205

Fireman, B., Gamson, W., Rytina, S. & Taylor, B. (1984). Encounters with unjust authority. *Contemporary Sociology*, *13*. https://doi.org/10.2307/2578884

Fletcher, J., Hamilton, B., Kinner, S. A. & Brophy, L. (2019). Safewards impact in inpatient mental health units in Victoria, Australia: Staff perspectives. *Frontiers in Psychiatry*, *10*, 462. https://doi.org/10.3389/fpsyt.2019.00462

Fook, J. & Pease, B. (1999). Emancipatory social work for a postmodern age. In B. Pease & J. Fook (Eds.), *Transforming social work practice: Postmodern critical perspectives* (pp. 224–229). Allen & Unwin.

Fossey, E., Harvey, C., Mcdermott, F. & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian & New Zealand Journal of Psychiatry*, *36*(6), 717–732. https://doi.org/10.1046/j.1440-1614.2002.01100.x

Fotaki, M. & Hyde, P. (2015). Organizational blind spots: Splitting, blame and idealization in the National Health Service. *Human Relations, 68*(3), 441–462. https://doi.org/10.1177/0018726714530012

Foucault, M. (1973). *Madness and civilization: A history of insanity in the Age of Reason* (R. Howard, Trans.). Vintage Books. (Original work published 1961)

Foucault, M. (1976). *The birth of the clinic* (A. M. Sheridan, Trans.). Routledge. https://doi.org/10.4324/9780203406373 (Original work published 1963)

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings 1972–1977* (C. Gordon, L. Marshall, J. Mepham & K. Soper, Trans.; C. Gordon, Ed.). The Harvester Press. (Original work published 1980)

Foucault, M. (2006). *Michel Foucault: Psychiatric power: Lectures at the Collège de France* (G. Burchell, Trans.; J. Lagrange, Ed.). Palgrave Macmillan. (Original work published 1974)

Francis, R. (2013). *Report of Mid Staffordshire NHS Foundation Trust public inquiry: Executive summary*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

Freeman, A. R., McWilliam, C. L., MacKinnon, J. R., DeLuca, S. & Rappolt, S. G. (2009). Health professionals' enactment of their accountability obligations: Doing the best they can. *Social Science & Medicine*, *69*(7), 1063–1071. https://doi.org/10.1016/j.socscimed.2009.07.025

Frese, F. J. & Davis, W. W. (1997). The consumer–survivor movement, recovery, and consumer professionals. *Professional Psychology: Research and Practice*, *28*(3), 243–245. https://doi.org/10.1037/0735-7028.28.3.243

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.

Gale, T. (1999). Policy trajectories: Treading the discursive path of policy analysis. *Discourse: Studies in the Cultural Politics of Education*, *20*(3), 393–407. https://doi.org/10.1080/0159630990200304

Garelick, A. I. & Fagin, L. (2005). The doctor–manager relationship. *Advances in Psychiatric Treatment*, *11*, 241–250. https://doi.org/10.1192/apt.11.4.241

Garton, S. (2003). Asylum histories: Reconsidering Australia's lunatic past. In C. Coleborne & D. MacKinnon (Eds.), *Madness in Australia: Histories, heritage and the asylum* (pp. 121–134). University of Queensland Press.

Gee, A., McGarty, C. & Banfield, M. (2016). Barriers to genuine consumer and carer participation from the perspective of Australian systemic mental health advocates. *Journal of Mental Health*, *25*(3), 231–237. https://doi.org/10.3109/09638237.2015.1124383

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, *40*(3), 266–275. https://doi.org/10.1037/0003-066X.40.3.266

Germov, J. (2005). Managerialism in the Australian public health sector: Towards the hyper-rationalisation of professional bureaucracies. *Sociology of health & illness*, *27*(6), 738–758. https://doi.org/10.1111/j.1467-9566.2005.00472.x

Germov, J. (2013). *Second opinion: An introduction to health sociology*. Oxford University Press.

Gerrand, V. (2005). Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia. *Health Sociology Review*, *14*(3), 255–271. https://doi.org/10.5172/hesr.14.3.255

Gerrand, V., Singh, B., Nagel, T., Ash, D., Turnbull, C., Meadows, G., Fossey, E., Grigg, M., Rosen, A., Weir, W. & Benson, A. (2012). Mental health services in Australia. In G. Meadows, M. Grigg, J. Farhall, F. McDermott, E. Fossey & B. Singh (Eds.), *Mental health in Australia: Collaborative community practice* (pp. 69–117). Oxford University Press.

Gillard, S., Edwards, C., Gibson, S., Holley, J. & Owen, K. (2014). New ways of working in mental health services: A qualitative, comparative case study assessing and informing the emergence of new peer worker roles in mental health services in England. *Health Services and Delivery Research*, *2*(19). https://doi.org/10.3310/hsdr02190

Glisson, C., & James, L. R. (2002), The cross-level effects of culture and climate in human service teams. *Journal of Organizational Behavior*, 23, 767–794. https://doi.org/10.1002/job.162

Godin, P. (2004). ‘You don’t tick boxes on a form’: A study of how community mental health nurses assess and manage risk. *Health, Risk & Society*, *6*(4), 347–360. https://doi.org/10.1080/13698570412331323234

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Penguin UK.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Gomory, T. & Dunleavy, D. J. (2017). Madness: A critical history of 'mental health care' in the United States. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 117–125). Routledge. https://doi.org/10.4324/9781315399584

Gooding, P. (2016). From deinstitutionalisation to consumer empowerment: Mental health policy, neoliberal restructuring and the closure of the 'Big bins' in Victoria. *Health Sociology Review*, *25*(1), 33–47. https://doi.org/10.1080/14461242.2015.1134261

Gooding, P., McSherry, B., Roper, C. & Grey, F. (2018). *Alternatives to coercion in mental health settings: A literature review*. Melbourne Social Equity Institute, University of Melbourne. https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf

Gooding, P. (2013). Supported Decision-Making: A Rights-Based Disability Concept and its Implications for Mental Health Law. *Psychiatry, Psychology and Law*, 20(3), 431–451. https://doi.org/10.1080/13218719.2012.711683

Gordon, K., Hairston, D., Miller, S., Legha, R. & Starks, S. (2019). Origins of racism in American medicine and psychiatry: Contemporary issues and interventions. In M. M. Medlock, D. Shtasel, N. T. Trinh & D. R. Williams (Eds.), *Racism and psychiatry: Contemporary issues and interventions* (pp. 3–19). https://doi.org/10.1007/978-3-319-90197-8_1

Government of South Australia. (2020). *Mental health services plan 2020–2025*. https://www.sahealth.sa.gov.au/wps/wcm/connect/8520124e-0250-4393-819e-71bca0db4ad9/19032.2+MHSP-report-web-no+watermark.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-8520124e-0250-4393-819e-71bca0db4ad9-nwLp6cp

Grace, F. C., Meurk, C. S., Head, B. W., Hall, W. D., Harris, M. G. & Whiteford, H. A. (2017). An analysis of policy success and failure in formal evaluations of Australia's national mental health strategy (1992–2012). *BMC Health Services Research*, *17*(1), Article 374. https://doi.org/10.1186/s12913-017-2309-x

Gray, M., Dean, M., Agllias, K., Howard, A. & Schubert, L. (2015). Perspectives on neoliberalism for human service professionals. *Social Service Review*, *89*(2), 368–392. https://doi.org/10.1086/681644

Greckhamer, T. (2017). Critical approaches to qualitative research. In R. Mir & S. Jain (Eds.), *The Routledge companion to qualitative research in organization studies* (pp. 40–55). Routledge.

Green, B. (2005). Unfinished business: Subjectivity and supervision. *Higher Education Research and Development*, *24*(2), 151–163. https://doi.org/10.1080/07294360500062953

Green, D. (2007). Risk and social work practice. *Australian Social Work*, *60*(4), 395–409. https://doi.org/10.1080/03124070701671131

Grint, K. (2005). Problems, problems, problems: The social construction of 'leadership'. *Human Relations*, *58*(11), 1467–94. https://doi.org/10.1177/0018726705061314

Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research.* (pp. 105–117). SAGE Publications.

Guillemin, M. & Gillam, L. (2004). Ethics, reflexivity, and 'ethically important moments' in research. *Qualitative Inquiry*, *10*(2), 261–280. https://doi.org/10.1177/1077800403262360

Guishard, M. A., Halkovic, A., Galletta, A. & Li, P. (2018). Toward epistemological ethics: Centering communities and social justice in qualitative research. *Qualitative Social Research*, *19*(3). https://doi.org/10.17169/fqs-19.3.3145

Habibis, D. (2005). Epilogue: The mental health reform cakewalk: Moving forwards backwards. *Health Sociology Review*, *14*(3), 306–312. https://search.informit.org/doi/10.3316/informit.636248104386652

Haigh, F., Kemp, L., Bazeley, P., & Haigh, N. (2019). Developing a critical realist informed framework to explain how the human rights and social determinants of health relationship works. *BMC Public Health, 19*(1), 1571. https://doi.org/10.1186/s12889-019-7760-7

Haines, A., Perkins, E., Evans, E. A. & McCabe, R. (2018). Multidisciplinary team functioning and decision making within forensic mental health. *Mental Health Review Journal*, *23*(3), 185–196. https://doi.org/10.1108/MHRJ-01-2018-0001

Halligan, M. & Zecevic, A. (2011). Safety culture in healthcare: A review of concepts, dimensions, measures and progress. *BMJ Quality & Safety Journal*, *20*(4), 338–343. https://doi.org/10.1136/bmjqs.2010.040964

Hamilton, B., & Roper, C. (2006). Troubling ‘insight’: power and possibilities in mental health care. *Journal of Psychiatric and Mental Health Nursing, 13*(4), 416–422. https://doi.org/https://doi.org/10.1111/j.1365-2850.2006.00997.x

Hamilton, M. (2010). People with complex needs and the criminal justice system. *Current Issues in Criminal Justice*, *22*(2), 307–324. https://doi.org/10.1080/10345329.2010.12035888

Hanley, B., Scott, H. & Priest, H. (2017). The impact of organisational change on professionals working within a Community Mental Health Team (CMHT): A psychodynamic perspective. *Psychoanalytic Psychotherapy*, *31*(2), 176–194. https://doi.org/10.1080/02668734.2017.1315338

Hannigan, B. & Coffey, M. (2011). Where the wicked problems are: The case of mental health. *Health Policy*, *101*(3), 220–227. https://doi.org/10.1016/j.healthpol.2010.11.002

Happell, B., Byrne, L., McAllister, M., Lampshire, D., Roper, C., Gaskin, C. J., Martin, G., Wynaden, D., McKenna, B., Lakeman, R., Platania-Phung, C., & Hamer, H. (2014). Consumer involvement in the tertiary-level education of mental health professionals: A systematic review. *International Journal of Mental Health Nursing, 23*(1), 3–16. https://doi.org/https://doi.org/10.1111/inm.12021

Happell, B., Pinikahana, J., & Roper, C. (2003). Changing attitudes: the role of a consumer academic in the education of postgraduate psychiatric nursing students. *Archives of psychiatric nursing*, *17*(2), 67–76. https://doi.org/10.1053/apnu.2003.00008

Happell, B., & Roper, C. (2009). Promoting genuine consumer participation in mental health education: A consumer academic role. Nurse Education Today, 29(6), 575–579. https://doi.org/https://doi.org/10.1016/j.nedt.2008.01.004

Happell, B. & Roper, C. (2009). Promoting genuine consumer participation in mental health education: A consumer academic role. *Nurse Education Today*, *29*(6), 575–579. https://doi.org/10.1016/j.nedt.2008.01.004

Happell, B. & Roper, C. (2006). The myth of representation: The case for consumer leadership. *Australian e-Journal for the Advancement of Mental Health*, *5*(3), 177–184. https://doi.org/10.5172/jamh.5.3.177

Happell, B., Scholz, B., Bocking, J., & Platania-Phung, C. (2019). Promoting the value of mental health nursing: The contribution of a consumer academic. *Issues in Mental Health Nursing, 40*(2), 140–147. https://doi.org/10.1080/01612840.2018.1490834

Happell, B., Sharrock, J., Warner, T., O'Donovan, A., Hurley, E. & Gordon, S. (2022). Changing 'the world for the better': Motivations of mental health academics for supporting expert by experience roles in mental health education. *Journal of Mental Health*, 1–8. https://doi.org/10.1080/09638237.2022.2091759

Happell, B., Waks, S., Bocking, J., Horgan, A., Manning, F., Greaney, S., Goodwin, J., Scholz, B., van der Vaart, K. J., Allon, J., Hals, E., Granerud, A., Doody, R., Chan, S. W.-C., Lahti, M., Ellilä, H., Pulli, J., Vatula, A., Platania-Phung, C., … Biering, P. (2021). "But I'm not going to be a mental health nurse": Nursing students' perceptions of the influence of experts by experience on their attitudes to mental health nursing. *Journal of Mental Health, 30*(5), 556-563. https://doi.org/10.1080/09638237.2019.1677872

Happell, B., Waks, S., Horgan, A., Greaney, S., Manning, F., Goodwin, J., Bocking, J., Scholz, B., Hals, E., Granerud, A., Doody, R., Platania-Phung, C., Griffin, M., Russell, S., MacGabhann, L., Pulli, J., Vatula, A., Browne, G., van der Vaart, K. J., Allon, J., … Biering, P. (2020). "It is much more real when it comes from them": The role of experts by experience in the integration of mental health nursing theory and practice. *Perspectives in Psychiatric Care, 56*(4), 811-819. https://doi.org/https://doi.org/10.1111/ppc.12496

Harber, B. & Ball, T. (2003, November). From the blame game to accountability in healthcare. *Policy Options*, 48–54. https://policyoptions.irpp.org/wp-content/uploads/sites/2/assets/po/corporate-governance/harber.pdf

Harding, S. (1986). *The science question in feminism.* Cornell University Press.

Harding, S. (1987). *Feminism and methodology.* Indiana University Press.

Harding, S. (1991). *Whose science? Whose knowledge?: Thinking from women's lives*. Cornell University Press.

Harper, D. & Speed, E. (2012). Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice*, *6*(1), 9–25. http://hdl.handle.net/10552/1634

Harrington, A. (2012). The fall of the schizophrenogenic mother. *The Lancet*, *379*(9823), 1292–1293. https://doi.org/10.1016/S0140-6736(12)60546-7

Harris, J. I., Leskela, J., Lakhan, S., Usset, T., DeVries, M., Mittal, D. & Boyd, J. (2019). Developing organizational interventions to address stigma among mental health providers: A pilot study. *Community Mental Health Journal*, *55*(6), 924–931. https://doi.org/10.1007/s10597-019-00393-w

Health Workforce Australia. (2014). *National mental health core capabilities.* Department of Health.

Healy, K. (2012). Critical perspectives. In M. Gray, J. Midgley & S. A. Webb (Eds.), *The SAGE handbook of social work* (pp. 191–206). SAGE Publications. https://doi.org/10.4135/9781446247648

Helfrich, C. D., Li, Y.-F., Mohr, D. C., Meterko, M. & Sales, A. E. (2007). Assessing an organizational culture instrument based on the Competing Values Framework: Exploratory and confirmatory factor analyses. *Implementation Science*, *2*(1), 13. https://doi.org/10.1186/1748-5908-2-13

Henderson, J. (2005). Neo-liberalism, community care and Australian mental health policy. *Health Sociology Review*, *14*(3), 242–254. https://doi.org/10.5172/hesr.14.3.242

Henderson, J. (2013). How the tidal model was used to overcome a risk-averse ward culture. *Mental Health Practice*, *17*(1), 34–37. https://journals.rcni.com/mental-health-practice/how-the-tidal-model-was-used-to-overcome-a-riskaverse-ward-culture-mhp2013.09.17.1.34.e811

Hensley, M. A. (2006). Why I am not a "mental health consumer". *Psychiatric Rehabilitation Journal*, 30(1), 67–69. https://doi.org/10.2975/30.2006.67.69

Higgins, J. & Reitz, M. (2019). If whistleblowing is the answer, ask a better question. *Journal of the Royal Society of Medicine*, *112*(11), 453–455. https://doi.org/10.1177/0141076819864522

Hill Collins, P. (2019). *Intersectionality as critical social theory*. Duke University Press.

Hilton, T. P., Fawson, P. R., Sullivan, T. J. & DeJong, C. R. (2020). *Applied social research* (10th ed.). Springer Publishing Company. https://doi.org/10.1891/9780826172846

Hodgson, D. & Watts, L. (2017). *Key concepts and theory in social work*. Bloomsbury Publishing.

Hogden, A., Churruca, K., & Bierbaum, M. (2017). *Safety culture assessment in health care: A review of the literature on safety culture assessment modes*. Australian Commission on Safety and Quality in Health Care. https://www.safetyandquality.gov.au/sites/default/files/migrated/Safety-Culture-Assessment-in-Health-Care-A-review-of-the-literature-on-safety-culture-assessment-modes.pdf

Holley, J., Chambers, M. & Gillard, S. (2016). The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: A qualitative investigation. *Journal of Mental Health*, *25*(4), 315–322. https://doi.org/10.3109/09638237.2015.1124402

Holmqvist, R. & Jeanneau, M. (2006). Burnout and psychiatric staff's feelings towards patients. *Psychiatry Research*, *145*(2), 207–213. https://doi.org/10.1016/j.psychres.2004.08.012

Hood, C. (1991). A public management for all seasons? Public Administration, 69(1), 3–19. https://doi.org/10.1111/j.1467-9299.1991.tb00779.x

Horgan, A., Manning, F., Bocking, J., Happell, B., Lahti, M., Doody, R., Griffin, M., Bradley, S. K., Russell, S., Bjornsson, E., O'Donovan, M., MacGabhann, L., Savage, E., Pulli, J., Goodwin, J., van der Vaart, K. J., O'Sullivan, H., Dorrity, C., Ellila, H., … Biering, P. (2018). 'To be treated as a human': Using co-production to explore experts by experience involvement in mental health nursing education—The COMMUNE project. *International Journal of Mental Health Nursing*, *27*(4), 1282–1291. https://doi.org/https://doi.org/10.1111/inm.12435

Hudson, B., Hunter, D., & Peckham, S. (2019). Policy failure and the policy-implementation gap: can policy support programs help? *Policy Design and Practice*, 2(1), 1–14. https://doi.org/10.1080/25741292.2018.1540378

Hujala, A., Laulainen, S. & Lindberg, K. (2014). Powerless positions, silenced voices?—Critical views on health and social care management. *Journal of Health Organization and Management*, *28*(5), 590–601. https://doi.org/10.1108/JHOM-06-2014-0106

Hungerford, C., Hungerford, A., Fox, C. & Cleary, M. (2016). Recovery, non-profit organisations and mental health services: 'Hit and miss' or 'dump and run'? *International Journal of Social Psychiatry*, *62*(4), 350–360. https://doi.org/10.1177/0020764016634384

Ibrahim, N., Thompson, D., Nixdorf, R., Kalha, J., Mpango, R., Moran, G., Mueller-Stierlin, A., Ryan, G., Mahlke, C., Donat, S., Puschner, B., Repper, J. & Slade, M. (2020). A systematic review of influences on implementation of peer support work for adults with mental health problems. *Social Psychiatry and Psychiatric Epidemiology*, *55*(3), 285–293. http://dx.doi.org/10.1007/s00127-019-01739-1

Ife, J. (1999). Postmodernism, critical theory and social work. In B. Pease & J. Fook (Eds.), *Transforming social work* (pp. 211–223). Allen & Unwin.

Jacobson, N. & Farah, D. (2012). Recovery through the lens of cultural diversity. *Psychiatric Rehabilitation Journal*, *35*(4), 333–335. https://doi.org/10.2975/35.4.2012.333.335

Jaiswal, A., Carmichael, K., Gupta, S., Siemens, T., Crowley, P., Carlsson, A., Unsworth, G., Landry, T. & Brown, N. (2020). Essential elements that contribute to the recovery of persons with severe mental illness: A systematic scoping study. *Frontiers in Psychiatry*, *11*, Article 586230. https://doi.org/10.3389/fpsyt.2020.586230

Janićijević, N. (2011). Methodological approaches in the research of organizational culture. *Economic Annals*, *56*(189), 69–99. https://EconPapers.repec.org/RePEc:beo:journl:v:56:y:2011:i:189:p:69-100

Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*. Routledge.

Jones, M. (2020). Risk: A Conversation Worth Having in Mental Health Care? *Journal of Psychosocial Rehabilitation and Mental Health*, 7(1), 97–101. https://doi.org/10.1007/s40737-019-00154-8

Jones, N., K, A., Byrne, L., Carras, M., Brown, M. & Phalen, P. (2021). Lived experience, research leadership, and the transformation of mental health services: Building a researcher pipeline. *Psychiatric Services*, *72*(5), 591–593. https://doi.org/10.1176/appi.ps.202000468

Jordahl, H. (2019). Perspectives on public sector outsourcing: Quasi-markets and prices. *CESifo Economic Studies*, *65*(4), 343–348. https://doi.org/10.1093/cesifo/ifz015

Kafai, S. (2013). The mad border body: A political in-betweeneess. *Disability Studies Quarterly*, *33*(1). https://dsq-sds.org/article/view/3438/3199

Kärreman, D. & Alvesson, M. (2004). Cages in tandem: Management control, social identity, and identification in a knowledge-intensive firm. *Organization*, 11(1), 149–175. https://doi.org/10.1177/1350508404039662

Kelly, S. E. (2010). Qualitative interviewing techniques and styles. In I. Bourgeault, R. Dingwall & R. De Vries (Eds.), *The SAGE handbook of qualitative methods in health research*. SAGE Publications. https://doi.org/10.4135/9781446268247

Kezelman, C. & Stavropoulos, P. (2012). *'The last frontier'—practice guidelines for treatment of complex trauma and trauma informed care and service delivery.* Adults Surviving Child Abuse. https://apo.org.au/sites/default/files/resource-files/2012-09/apo-nid31272.pdf

Khalil, H., Peters, M. D. J., Tricco, A. C., Pollock, D., Alexander, L., McInerney, P., Godfrey, C. M. & Munn, Z. (2021). Conducting high quality scoping reviews-challenges and solutions. *Journal of Clinical Epidemiology*, *130*, 156–160. https://doi.org/10.1016/j.jclinepi.2020.10.009

Khatri, N., Brown, G. D. & Hicks, L. L. (2009). From a blame culture to a just culture in health care. *Health Care Management Review*, *34*(4), 312–322. https://doi.org/10.1097/HMR.0b013e3181a3b709

Khoo, J., Hasan, H. & Eagar, K. (2019). Utilisation patterns of privately funded mental health services in Australia. *Journal of* Health *Organization* Management, *33*(1), 5–17. https://doi.org/10.1108/jhom-02-2018-0062

King, A. J., Brophy, L. M., Fortune, T. L. & Byrne, L. (2020). Factors affecting mental health professionals' sharing of their lived experience in the workplace: A scoping review. *Psychiatric Services*, *71*(10), 1047–1064. https://doi.org/10.1176/appi.ps.201900606

King, C. (2016). Whiteness in psychiatry: The madness of European misdiagnosis. In J. Russo & A. Sweeney (Eds.), *Searching for a rose garden: Challenging psychiatry, fostering mad studies* (pp. 69-76). PCCS Books.

Kinner, S. A., Harvey, C., Hamilton, B., Brophy, L., Roper, C., McSherry, B. & Young, J. T. (2017). Attitudes towards seclusion and restraint in mental health settings: Findings from a large, community-based survey of consumers, carers and mental health professionals. *Epidemiology & Psychiatric Sciences*, *26*(5), 535–544. https://doi.org/10.1017/s2045796016000585

Kitchener, M. (2002). Mobilizing the logic of managerialism in professional fields: The case of academic health centre mergers. *Organization Studies*, *23*(3), 391–420. https://doi.org/10.1177/0170840602233004

Kitchener, M. & Thomas, R. (2016). The critical health care management domain. In F. Ferlie, K. Montgomery & A. R. Pedersen (Eds.), *The Oxford handbook of health care management* (pp. 117–140). Oxford University Press.

Kohn, L. T., Corrigan, J. M. & Donaldson, M. S. (Eds.). (2000). *To err is human: Building a safer health system*. National Academies Press. https://doi.org/10.17226/9728

Kokanović, R., Brophy, L., McSherry, B., Flore, J., Moeller-Saxone, K. & Herrman, H. (2018). Supported decision-making from the perspectives of mental health service users, family members supporting them and mental health practitioners. *Australian & New Zealand Journal of Psychiatry*, *52*(9), 826–833. https://doi.org/10.1177/0004867418784177

Lakeman, R. (2010). Epistemic injustice and the mental health service user. *International Journal of Mental Health Nursing*, *19*(3), 151–153. https://doi.org/10.1111/j.1447-0349.2010.00680.x

Lakeman, R. (2013). Talking science and wishing for miracles: Understanding cultures of mental health practice. *International Journal of Mental Health Nursing*, *22*(2), 106–115. https://doi.org/https://doi.org/10.1111/j.1447-0349.2012.00847.x

Lapsley, I. (2009). New Public Management: The cruellest invention of the human spirit? *Abacus*, *45*(1), 1–21. https://doi.org/10.1111/j.1467-6281.2009.00275.x

Large, M., Ryan, C. & Nielssen, O. (2011). The validity and utility of risk assessment for inpatient suicide. *Australasian Psychiatry*, *19*(6), 507–512. https://doi.org/10.3109/10398562.2011.610505

Leamy, M., Bird, V., Boutillier, C. L., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

LeBlanc, S. & Kinsella, E. A. (2016). Toward epistemic justice: A critically reflexive examination of ‘sanism’ and implications for knowledge generation. *Studies in Social Justice*, *10*(10), 59–78. https://doi.org/10.26522/ssj.v10i1.1324

Le Boutillier, C., Chevalier, A., Lawrence, V., Leamy, M., Bird, V. J., Macpherson, R., Williams, J. & Slade, M. (2015). Staff understanding of recovery-orientated mental health practice: A systematic review and narrative synthesis. *Implementation Science*, *10*(1), 87. https://doi.org/10.1186/s13012-015-0275-4

Le Boutillier, C. & Croucher, A. (2010). Social inclusion and mental health. *British Journal of Occupational Therapy*, *73*(3), 136–139.

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J. & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services*, *62*(12), 1470–1476. https://doi.org/10.1176/appi.ps.001312011

Lee, E., Tsang, A. K. T., Bogo, M., Johnstone, M., Herschman, J. & Ryan, M. (2019). Honoring the voice of the client in clinical social work practice: Negotiating with epistemic injustice. *Social work*, *64*(1), 29–40. https://doi.org/10.1093/sw/swy050

Lemon, G., Stanford, S. & Sawyer, A. (2016). Trust and the dilemmas of suicide risk assessment in non-government mental health services. *Australian Social Work*, *69*(2), 145–157. https://doi.org/10.1080/0312407X.2015.1131843

Lewis, J.M., O'Flynn, J. & Sullivan, H. (2014), Accountability: To whom, in relation to what, and why? *Australian Journal of Public Administration*, *73*(4), 401–407. https://doi.org/10.1111/1467-8500.12104

Liamputtong, P. (2012). *Qualitative research methods* (4th ed.). Oxford University Press.

Liff, R. & Andersson, T. (2013). The multi-professional team as a post NPM control regime. Can it integrate competing control regimes in healthcare? *Scandinavian Journal of Public Administration*, *16*(2), 45–68. https://ojs.ub.gu.se/index.php/sjpa/article/view/1678

MacCallum, E. J. (2002), Othering and psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing*, *9*(1), 87–94. https://doi.org/10.1046/j.1351-0126.2001.00449.x

Macfarlane, S. (2009). Opening spaces for alternative understandings in mental health practice. In J. Allan, L. Briskman & B. Pease (Eds.), *Critical social work: Theories and practices for a socially just world* (2nd ed., pp. 201–213). Allen & Unwin.

Maddock, A. (2015). Consensus or contention: An exploration of multidisciplinary team functioning in an Irish mental health context. *European Journal of Social Work*, *18*(2), 246–261. https://doi.org/10.1080/13691457.2014.885884

Madigan, S. (1999). Inscription, description and deciphering chronic identities. In I. Parker (Ed.), *Deconstructing psychotherapy* (pp. 150–163). SAGE Publications.

Maguire, M. & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, *9*(3), 3351–1156. https://ojs.aishe.org/index.php/aishe-j/article/view/335

Manley, K., Jackson, C. & Mckenzie, C. (2019). Microsystems culture change: A refined theory for developing person-centred, safe and effective workplaces based on strategies that embed a safety culture. *International Practice Development Journal*. *9*(2), Article 4. https://doi.org/10.19043/ipdj.92.004

Mannion, R. & Davies, H. T. (2015). Cultures of silence and cultures of voice: The role of whistleblowing in healthcare organisations. *International Journal of Health Policy and Management*, *4*(8), 503–505. https://doi.org/10.15171/ijhpm.2015.120

Mannion, R. & Davies, H. T. (2018). Understanding organisational culture for healthcare quality improvement. *BMJ: British Medical Journal*, *363*, Article k4907. https://doi.org/http://dx.doi.org/10.1136/bmj.k4907

Mantzoukas, S. (2004). Issues of representation within qualitative inquiry. *Qualitative Health Research*, *14*(7), 994–1007. https://doi.org/10.1177/1049732304265959

Marlowe, J. (2010). *Using a narrative approach of double-listening in research contexts*. Dulwich Centre Publications. https://doi.org/10.3316/informit.496830527242665

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice*, *13*(6), 522–526. https://doi.org/10.1093/fampra/13.6.522

Marsh, P., & Kelly, L. (2018). Dignity of risk in the community: a review of and reflections on the literature. *Health, Risk & Society*, 20(5–6), 297–311. https://doi.org/10.1080/13698575.2018.1519115

Martin, J. (1992). *Cultures in organizations: Three perspectives*. Oxford University Press.

Martin, R. M., Ridley, S. C. & Gillieatt, S. J. (2017). Family inclusion in mental health services: Reality or rhetoric? *International Journal of Social Psychiatry*, *63*(6), 480–487. https://doi.org/10.1177/0020764017716695

Marx, K. (1974). *Economic and philosophic manuscripts of 1844* (M. Milligan, Trans.; D. J Struik, Ed.). Progress. (Original work published 1932)

Mascie-Taylor, H. & Hoddinott, J. (2017). *Review of safety and quality in the WA health system: A strategy for continuous improvement*. https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Review-of-Safety-and-Quality/Review-of-safety-and-quality.pdf

Mauthner, N. S. & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, *37*(3), 413–431. https://doi.org/10.1177/00380385030373002

McDonald, C. (2006). *Challenging social work: The institutional context of practice*. Palgrave Macmillan.

McKellar, D., & Hanson, J. (2020). Codesigned framework for organisational culture reform in South Australian older persons' mental health services after the Oakden Report. *Australian Health Review*, 44(6), 862–866. https://doi.org/10.1071/ah18211

McKellar, D., Renner, D., Gower, A., O Brien, S., Stevens, A., & DiNiro, A. (2020). Everyone matters; everyone contributes; everyone grows: A pilot project cultivating psychological safety to promote growth-oriented service culture after the Oakden Report. *Australian Health Review*, *44*(6), 867–872. https://doi.org/10.1071/ah20156

McKenna, B., Furness, T., Dhital, D., Ennis, G., Houghton, J., Lupson, C. & Toomey, N. (2014). Recovery-oriented care in acute inpatient mental health settings: An exploratory study. *Issues in Mental Health Nursing*, *35*(7), 526–532.

McLaughlin, H. (2007). *Understanding social work research.* Sage Publications.

McLaughlin, H. (2008). What’s in a name: ‘Client’, ‘patient’, ‘customer’, ‘consumer’, ‘expert by experience’, ‘service user’—What’s next? The British Journal of Social Work, 39(6), 1101–1117. https://doi.org/10.1093/bjsw/bcm155

McMillan, J., Lawn, S. & Delany-Crowe, T. (2019). Trust and community treatment orders. Frontiers in Psychiatry, 10, Article 349. https://doi.org/10.3389/fpsyt.2019.00349

McSherry, B. (2020). The intractable use of restraint, organisational culture and ‘othering’: Lessons from the Oakden scandal. In B. McSherry & Y. Maker (Eds.), Restrictive practices in health care and disability settings: Legal, policy and practical responses (pp. 219–235). Routledge. https://doi.org/10.4324/9780429355219

McSherry, B. & Maker, Y. (2020). Restrictive practices: Options and opportunities. In B. McSherry & Y. Maker (Eds.), Restrictive practices in health care and disability settings: Legal, policy and practical responses (pp. 3–15). Routledge. https://doi.org/10.4324/9780429355219

McWade, B. (2016). Recovery-as-policy as a form of neoliberal state making. Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 5(3), 62–81. https://journals.library.mun.ca/ojs/index.php/IJ/article/view/1602

Medina, J. (2012). The epistemology of resistance: Gender and racial oppression, epistemic injustice, and resistant imaginations. Oxford University Press.

Medina, J. (2017). Varieties of hermeneutical injustice 1. In I. J. Kidd, J. Medina & G. Pohlhaus (Eds.), The Routledge handbook of epistemic Injustice (pp. 41–52). Routledge. https://doi.org/10.4324/9781315212043

Medlock, M., Weissman, A., Wong, S. S. & Carlo, A. D. (2016). Addressing the legacy of racism in psychiatric training. American Journal of Psychiatry Residents' Journal, 11(2), 13–13. https://doi.org/10.1176/appi.ajp-rj.2016.110206

Mendoza, J., Bresnan, A., Rosenberg, S., Elson, A., Gilbert, Y., Long, P., Wilson, K. & Hopkins, J. (2013). Obsessive hope disorder: Reflections on 30 years of mental health reform in Australia and visions for the future. ConNetica Consulting.

Mental Health Commission. (2017). Community treatment orders. https://www.mhc.wa.gov.au/media/1409/community_treatment_orders-2017.pdf

Mental Health Commission. (2020). Mental health, alcohol and other drug workforce strategic framework: 2020–2025. https://www.mhc.wa.gov.au/media/3423/workforce-strategic-framework-final-04-08-20.pdf

Mental Health Commission. (2022). Consumer, family, carer and community paid partnership policy. Government of Western Australia. https://www.mhc.wa.gov.au/about-us/lived-experience/

Mental Health Commission of NSW. (2014). Living well: A strategic plan for mental health in NSW 2014–2024. https://www.nswmentalhealthcommission.com.au/sites/default/files/old/Living%20Well%20-%20A%20Strategic%20Plan%20full%20version.pdf

Mental Health Council of Australia. (2005). Not for service: Experiences of injustice and despair in mental health care in Australia. https://humanrights.gov.au/sites/default/files/content/disability_rights/notforservice/documents/NFS_Finaldoc.pdf

Mental Health Workforce Advisory Committee. (2011a). National mental health workforce plan. Department of Health, Victorian Government. https://www.aihw.gov.au/getmedia/402bfe45-5fd2-49e2-9d30-3f9561db6f44/National-mental-health-workforce-plan-2011.pdf.aspx

Mental Health Workforce Advisory Committee. (2011b). The national mental health workforce strategy. Department of Health, Victorian Government. https://www.aihw.gov.au/getmedia/f7a2eaf1-1e9e-43f8-8f03-b705ce38f272/National-mental-health-workforce-strategy-2011.pdf.aspx

Menzies, R., LeFrançois, B. A. & Reaume, G. (2013). Introducing mad studies. In B. A. LeFrançois, R. Menzies & G. Reaume (Eds.), Mad matters: A critical reader in Canadian mad studies. (pp. 1–22). Canadian Scholars' Press.

Miller, R. (2015). Changing organisational culture: Another role for self-advocacy? Tizard Learning Disability Review, 20(2), 69–76. http://dx.doi.org/10.1108/TLDR-08-2014-0026

Mintzberg, H. (1979). The five basic parts of the organization. Classics of Organization Theory, 4, 232–244.

Misselbrook, D. (2013). Foucault. British Journal of General Practice, 63(611), 312–312. https://doi.org/10.3399/bjgp13X668249

Moncrieff, J. (2013). Magic bullets for mental disorders: The emergence of the concept of an 'antipsychotic' drug. Journal of the History of the Neurosciences, 22(1), 30–46. https://doi.org/10.1080/0964704x.2012.664847

Morant, N., Kaminskiy, E. & Ramon, S. (2016). Shared decision making for psychiatric medication management: Beyond the micro-social. Health Expectations, 19(5), 1002–1014. https://doi.org/10.1111/hex.12392

Morgan, J. F. (2007). 'Giving up the culture of blame': Risk assessment and management in psychiatric practice (Briefing document). Royal College of Psychiatrists. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.424.4677&rep=rep1&type=pdf

Morgan, P. I. & Ogbonna, E. (2008). Subcultural dynamics in transformation: A multi-perspective study of healthcare professionals. Human Relations, 61(1), 39–65. https://doi.org/10.1177/0018726707085945

Morley, C. (2003). Towards critical social work practice in mental health. Journal of Progressive Human Services, 14(1), 61–84. https://doi.org/10.1300/J059v14n01_05

Morrison, E. W. & Milliken, F. J. (2000). Organizational silence: A barrier to change and development in a pluralistic world. The Academy of Management Review, 25(4), 706–725. https://doi.org/10.2307/259200

Morse, J. M. (1995a). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp. 220–35). Sage.

Morse, J. M. (1995b). The significance of saturation. Qualitative Health Research, 5(2), 147–149. https://doi.org/10.1177/104973239500500201

Moth, R. (2020). 'The business end': Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. Competition & Change, 24(2), 133–153. https://doi.org/10.1177/1024529418813833

Muir-Cochrane, E., Gerace, A., Mosel, K., O'Kane, D., Barkway, P., Curren, D. & Oster, C. (2011). Managing risk: Clinical decision-making in mental health services. Issues in Mental Health Nursing, 32(12), 726–734. https://doi.org/10.3109/01612840.2011.603880

Muir-Cochrane, E., O'Kane, D. & Oster, C. (2018). Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint. International Journal of Mental Health Nursing, 27(5), 1511–1521. https://doi.org/10.1111/inm.12451

Mulgan, R. (2000). 'Accountability': An ever-expanding concept? Public Administration, 78(3), 555–573. https://doi.org/10.1111/1467-9299.00218

Muls, A., Dougherty, L., Doyle, N., Shaw, C., Soanes, L. & Stevens, A. M. (2015). Influencing organisational culture: A leadership challenge. British Journal of Nursing, 24(12), 633–638. https://doi.org/10.12968/bjon.2015.24.12.633

Murphy, T. & Bennington-Davis, M. (2005). Restraint and seclusion: The model for eliminating their use in healthcare. HCPro.

National Health and Medical Research Council. (2016). Statement on consumer and community involvement in health and medical research. Consumer Health Forum of Australia. https://www.nhmrc.gov.au/about-us/publications/statement-consumer-and-community-involvement-health-and-medical-research#block-views-block-file-attachments-content-block-1

National Health and Medical Research Council. (2018). National statement on ethical conduct in human research. https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018

National Health Workforce Planning Research Collaboration. (2011). *Mental health non-government organisation workforce project: Final report*. Health Workforce Australia.

National Mental Health Commission. (2014a). Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Volume 1. https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports

National Mental Health Commission. (2014b). Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Volume 2. https://mhfa.com.au/sites/default/files/vol2-review-mh-programmes-services.pdf

National Mental Health Commission. (2014c). Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Volume 3. https://mhfa.com.au/sites/default/files/vol3-review-mh-programmes-services.pdf

National Mental Health Commission. (2015). A case for change: Position paper on seclusion, restraint and restrictive practices in mental health services. https://www.mentalhealthcommission.gov.au/getmedia/63e1d2e6-79fe-45ea-aeab-145f1d9b269a/Position-paper-on-seclusion-and-restraint

National Mental Health Commission. (2019). Monitoring mental health and suicide prevention reform: National report 2019. https://www.mentalhealthcommission.gov.au/getmedia/f7af1cdb-d767-4e22-8e46-de09b654072f/2019-national-report

National Mental Health Performance Subcommittee. (2013). Key performance *indicators for Australian public mental health services* (3rd ed.). https://www.aihw.gov.au/getmedia/f9bb1a07-a43b-458a-9b73-64ef19d8aedd/Key-Performance-Indicators-for-Australian-Public-Mental-Health-Services-Third-Edition.pdf.aspx

Newman, S. & Lawler, J. (2009). Managing health care under New Public Management: A Sisyphean challenge for nursing. *Journal of Sociology*, *45*(4), 419–432. https://doi.org/10.1177/1440783309346477

Newnes, C. (2008). Histories of psychiatry. In C. Newnes, G. Holmes & D. Cailzie (Eds.), *This is madness: A critical look at psychiatry and the future of mental health services* (pp. 7–28). PCCS Books.

Nicholls, E. & Pernice, R. (2009). Perceptions of the relationship between mental health professionals and family caregivers: Has there been any change? *Issues in Mental Health Nursing*, *30*(8), 474–481. https://doi.org/10.1080/01612840802601408

Nightingale, A. (2018). Developing the organisational culture in a healthcare setting. *Nursing Standard*, *32*(21), 53–63. http://dx.doi.org/10.7748/ns.2018.e11021

Ning, L. (2010). Building a ‘user driven’ mental health system. *Advances in Mental Health*, *9*(2), 112–115. https://doi.org/10.5172/jamh.9.2.112

Nolan, D. & Quinn, N. (2012). The context of risk management in mental health social work. *Practice*, *24*(3), 175–188. https://doi.org/10.1080/09503153.2012.679257

Norton, M. (2019). Implementing co-production in traditional statutory mental health services. *Mental Health Practice*, *33*, Article e1304. https://doi.org/10.7748/mhp.2019.e1304

NSW Ministry of Health. (2018). *NSW strategic framework and workforce plan for mental health: A framework and workforce plan for NSW health services*. https://www.health.nsw.gov.au/mentalhealth/resources/Pages/mh-strategic-framework.aspx

O’Callaghan, A. K. (2021). ‘The medical gaze’: Foucault, anthropology and contemporary psychiatry in Ireland. *Irish Journal of Medical Science (1971–).* Advance online publication. https://doi.org/10.1007/s11845-021-02725-w

O’Connor, N., Kotze, B. & Wright, M. (2011). Blame and accountability 2: On being accountable. *Australasian Psychiatry*, *19*(2), 119–124. https://doi.org/10.3109/10398562.2011.562293

O’Flynn, J. (2007). From New Public Management to public value: Paradigmatic change and managerial implications. *Australian Journal of Public Administration*, *66*(3), 353–366. https://doi.org/10.1111/j.1467-8500.2007.00545.x

O’Grady, C. P. & Skinner, W. J. W. (2012). Journey as destination: A recovery model for families affected by concurrent disorders. *Qualitative Health Research*, *22*(8), 1047–1062. https://doi.org/10.1177/1049732312443736

O’Hagan, M., Reynolds, P. & Smith, C. (2012). Recovery in New Zealand: An evolving concept? *International Review of Psychiatry*, *24*(1), 56–63. https://doi.org/10.3109/09540261.2011.651447

Oliver, M. (1992). Changing the social relations of research production? *Disability, Handicap & Society*, *7*(2), 101–114. https://doi.org/10.1080/02674649266780141

O’Neill, D., De Vries, J. & Comiskey, C. M. (2021). Leadership and community healthcare reform: A study using the Competing Values Framework (CVF). *Leadership in Health Services*, *34*(4), 485–498. https://doi.org/10.1108/LHS-01-2021-0007

O’Reilly, M. & Lester, J. N. (2017). *Examining mental health through social constructionism: The language of mental health*. Springer International Publishing AG.

O’Reilly, M. & Parker, N. (2013). ‘Unsatisfactory saturation’: A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, *13*(2), 190–197. https://doi.org/10.1177/1468794112446106

Paradis, E., Nimmon, L., Wondimagegn, D. & Whitehead, C. R. (2020). Critical theory: Broadening our thinking to explore the structural factors at play in health professions education. *Academic Medicine*, *95*(6), 842–845. https://doi.org/10.1097/acm.0000000000003108

Park, M. M., Zafran, H., Stewart, J., Salsberg, J., Ells, C., Rouleau, S., Estein, O. & Valente, T. W. (2014). Transforming mental health services: A participatory mixed methods study to promote and evaluate the implementation of recovery-oriented services. *Implementation Science*, *9*(1), 119. https://doi.org/10.1186/s13012-014-0119-7

Pascale, C. (2010). *Cartographies of knowledge: Exploring qualitative epistemologies*. Sage Publications.

Pearce, P., Phillips, B., Dawson, M. & Leggat, S. G. (2013). Content of clinical supervision sessions for nurses and allied health professionals. *Clinical Governance: An International Journal*, *18*(2), 139–154. https://doi.org/10.1108/14777271311317927

Pease, B. (2009). From evidence-based practice to critical knowledge in post-positivist social work. In J. Allan, L. Briskman & B. Pease (Eds.), *Critical social work* (2nd ed., pp. 45–57). Allen & Unwin.

Pease, B. (2010). Challenging the dominant paradigm: Social work research, social justice and social change. In I. Shaw, K. Briar-Lawson, J. Orme & R. Ruckdeschel (Eds.), *The Sage handbook of social work research* (pp. 98–112). Sage Publications.

Perkins, E., Prosser, H., Riley, D. & Whittington, R. (2012). Physical restraint in a therapeutic setting; a necessary evil? *International Journal of Law and Psychiatry*, *35*(1), 43–49. https://doi.org/10.1016/j.ijlp.2011.11.008

Peters, M. D., Godfrey, C. M., Khalil, H., McInerney, P., Baldini Soares, C. & Parker, D. (2015). *The Joanna Briggs Institute reviewers' manual 2015: Methodology for JBI scoping reviews*. The Joanna Briggs Institute. https://nursing.lsuhsc.edu/JBI/docs/ReviewersManuals/Scoping-.pdf

Peters, M. D. J., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., McInerney, P., Godfrey, C. M. & Khalil, H. (2021). Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Implementation*, *19*(1), 3–10. https://doi.org/10.1097/xeb.0000000000000277

Petersen, E. B. (2007). Negotiating academicity: Postgraduate research supervision as category boundary work. *Studies in Higher Education*, *32*(4), 475–487. https://doi.org/10.1080/03075070701476167

Piat, M. Sabetti, J. & Bloom, D. (2010). The transformation of mental health services to a recovery-orientated system of care: Canadian decision maker perspectives. *International Journal of Social Psychiatry*, *56*(2), 168–177. https://doi.org/10.1177/0020764008100801

Piat, M., Wainwright, M., Sofouli, E., Vachon, B., Deslauriers, T., Préfontaine, C. & Frati, F. (2021). Factors influencing the implementation of mental health recovery into services: A systematic mixed studies review. *Systematic Reviews*, *10*(1), 1–21. https://doi.org/10.1186/s13643-021-01646-0

Pilgrim, D. (2008). 'Recovery' and current mental health policy. *Chronic Illness*, *4*(4), 295–304. https://journals.sagepub.com/doi/abs/10.1177/1742395308097863

Pilgrim, D. & Rogers, A. (2009). Survival and its discontents: The case of British psychiatry. *Sociology of Health and Illness*, *31*(7), 947–961. https://doi.org/10.1111/j.1467-9566.2009.01166.x

Dunlop, R., & Pols, H. (2022). Deinstitutionalisation and mental health activism in Australia: emerging voices of individuals with lived experience of severe mental distress, 1975–1985. *History Australia*. https://doi.org/10.1080/14490854.2022.2028559

Pope, R. & Burnes, B. (2013). A model of organisational dysfunction in the NHS. *Journal of Health Organization and Management*, *27*(6), 676–697. https://doi.org/10.1108/JHOM-10-2012-0207

Pope, R. (2019). Organizational Silence in the NHS: ‘Hear no, See no, Speak no’. *Journal of Change Management, 19*(1), 45–66. https://doi.org/10.1080/14697017.2018.1513055

Porter, R. (1987). *A social history of madness: Stories of the insane*. Weidenfeld and Nicolson.

Porter, R. (2002). *Madness: A brief history*. Oxford University Press.

Power, M. K. 1997. *The audit society*. Oxford University Press.

Price-Robertson, R., Obradovic, A. & Morgan, B. (2017). Relational recovery: Beyond individualism in the recovery approach. *Advances in Mental Health*, *15*(2), 108–120. https://doi.org/10.1080/18387357.2016.1243014

Prodromou, M. & Papageorgiou, G. (2021). Assessing organizational culture in public mental healthcare service organizations. *Journal of Health Organization and Management*. *36*(1), 24–37. https://doi.org/10.1108/JHOM-06-2020-0230

Productivity Commission. (2020a). *Mental health. Productivity Commission inquiry report. Volume 1* (No. 95). https://www.pc.gov.au/inquiries/completed/mental-health/report

Productivity Commission. (2020b). *Mental health. Productivity Commission inquiry report. Volume 2* (No. 95). https://www.pc.gov.au/inquiries/completed/mental-health/report

Productivity Commission. (2020c). *Mental health. Productivity Commission inquiry report. Volume 3* (No. 95). https://www.pc.gov.au/inquiries/completed/mental-health/report

Queensland Government. (2016). *Connecting care to recovery 2016–2021: A plan for Queensland’s State-funded mental health, alcohol and other drug services*. https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465131/connecting-care.pdf

Ramon, S. (2008). Neoliberalism and its implications for mental health in the UK. *International Journal of Law and Psychiatry*, *31*(2), 116–125. https://doi.org/10.1016/j.ijlp.2008.02.006

Rawls, A. W. & David, G. (2005). Accountably other: Trust, reciprocity and exclusion in a context of situated practice. *Human Studies*, *28*(4), 469–497. http://www.jstor.org/stable/27642729

Read, J. (2013). A history of madness. In J. Read & J. Dillon (Eds.), *Models of madness: Psychological, and biological approaches to psychosis*. Routledge. https://doi.org/10.4324/9780203527160

Read, J. & Sanders, P. (2010). *A straight-talking introduction to the causes of mental health problem*. PCCS Books.

Reay, T., Goodrick, E. & Hinings, B. (2016). Institutionalization and professionalization. In E. Ferlie, K. Montgomery & A. R. Pedersen (Eds.), *The Oxford handbook of health care management* (pp. 25–44). Oxford University Press.

Recovery in the Bin, Edwards, B. M., Burgess, R. & Thomas, E. (2019). *Neorecovery: A survivor led conceptualisation and critique* [Keynote presentation]. 25th International Mental Health Nursing Research Conference, London, United Kingdom. https://recoveryinthebin.org/neorecovery-a-survivor-led-conceptualisation-and-critique-mhrn2019/

Renouf, N. (2016). Beyond the dominant approach to mental health practice. In B. Pease, S. Goldingay, N. Hosken & S. Nipperess (Eds.), *Doing critical social work: Transformative practices for social justice* (pp. 123–135). Allen & Unwin.

Reynolds, V. (2012). An ethical stance for justice-doing in community work and therapy. *Journal of Systemic Therapies*, *31*(4), 18–33. https://vikkireynoldsdotca.files.wordpress.com/2017/12/reynoldsandpolancoethicsstanceforjusticedoing2012jst.pdf

Rittel, H. W. & Webber, M. M. (1973). Dilemmas in a general theory of planning. *Policy Sciences*, *4*(2), 155–169. https://doi.org/10.1007/BF01405730

Roberts, G. & Boardman, J. (2014). Becoming a recovery-oriented practitioner. Advances in Psychiatric Treatment, 20(1), 37–47. https://doi.org/10.1192/apt.bp.112.010652

Roberts, G., Good, J., Wooldridge, J., & Baker, E. (2011). Steps towards "putting recovery at the heart of all we do": workforce development and the contribution of "lived experience". *The Journal of Mental Health Training, Education and Practice, 6*(1), 17–28. https://doi.org/10.1108/17556221111136134

Roberts, G. & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment*, *10*(1), 37–48. https://doi.org/10.1192/apt.10.1.37

Robertson, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society, 13*(2), 147–164. https://doi.org/10.1080/13698575.2011.556185

Roper, C., Grey, F. & Cadogan, E. (2018). *Co-production: Putting principles into practice in mental health contexts.* https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf

Roper, C., O'Hagan, M., Kennedy, H. & Roennfeldt, H. (2020). Ending restraint: An insider view. In B. McSherry & Y. Maker (Eds.), *Restrictive practices in health care and disability settings: Legal, policy and practical responses* (pp. 16–38). Routledge.

Rose, D., Fleischmann, P., Tonkiss, F., Campbell, P., & Wykes, T. (2003). *User and Carer Involvement in Change Management in a Mental Health Context: Review of the Literature.* National Coordinating Centre for the Service Delivery and Organisation.

Rose, D. (2014). The mainstreaming of recovery. *Journal of Mental Health*, *23*(5), 217–218. https://doi.org/10.3109/09638237.2014.928406

Rose, D. & Kalathil, J. (2019). Power, privilege and knowledge: The untenable promise of co-production in mental 'health'. *Frontiers in Sociology*, *4*, Article 57. https://doi.org/10.3389/fsoc.2019.00057

Rosen, A. (2006). Australia's national mental health strategy in historical perspective: Beyond the frontier. *International Psychiatry*, *3*(4), 19–21. https://doi.org/10.1192/S1749367600004987

Rosenberg, S. & Harvey, C. (2021). Mental health in Australia and the challenge of community mental health reform. *Consortium Psychiatricum*, *2*(1), 40–46. https://doi.org/10.17816/cp44

Rosenberg, S. & Hickie, I. (2013). Managing madness: Mental health and complexity in public policy. *Evidence Base: A Journal of Evidence Reviews in Key Policy Areas*, (3), 1–19.

Rosenberg, S., Hickie, I. & Rock, D. (2020). *Rethinking mental health in Australia: Adapting to the challenges of COVID-19 and planning for a brighter future*. Brain and Mind Centre, The University of Sydney. https://www.sydney.edu.au/content/dam/corporate/documents/brain-and-mind-centre/youthe/rethinking-the-mental-health-of-australia.pdf

Rosenberg, S., Salvador-Carulla, L., Meadows, G. & Hickie, I. (2022). Fit for purpose—Re-designing Australia's mental health information system. *International Journal of Environmental Research and Public Health*, *19*(8), Article 4808. https://www.mdpi.com/1660-4601/19/8/4808

Ross, D., Campbell, J. & Dyer, A. (2014). Fostering trauma-free mental health workplace cultures and reducing seclusion and restraint. *Social Alternatives*, *33*(3), 37–45. https://search.informit.org/doi/10.3316/INFORMIT.854909170437678

Rossiter, A., de Boer, C., Narayan, J., Razack, N., Scollay, V. & Willette, C. (1998). Toward an alternative account of feminist practice ethics in mental health. *Affilia*, *13*(1), 9–30. https://doi.org/10.1177/088610999801300102

Rowe, J. (2012), Great expectations: A systematic review of the literature on the role of family carers in severe mental illness, and their relationships and engagement with professionals. *Journal of Psychiatric and Mental Health Nursing*, *19*(1), 70–82. https://doi.org/10.1111/j.1365-2850.2011.01756.x

Royal Commission into Victoria's Mental Health System. (2021a). *Final report: Royal Commission into Victoria's mental health system: Volume 1: A new approach to mental health and wellbeing in Victoria*. https://finalreport.rcvmhs.vic.gov.au/download-report/

Royal Commission into Victoria's Mental Health System. (2021b). *Final Report: Royal Commission into Victoria's mental health system: Volume 2: Collaboration to support good mental health and* wellbeing. https://finalreport.rcvmhs.vic.gov.au/download-report/

Royal Commission into Victoria’s Mental Health System. (2021c). *Final Report: Royal Commission into Victoria’s mental health system: Volume 3: Promoting inclusion and addressing* inequities. https://finalreport.rcvmhs.vic.gov.au/download-report/

Royal Commission into Victoria’s Mental Health System. (2021d). *Final Report: Royal Commission into Victoria’s mental health system: Volume 4: The fundamentals for enduring* reform. https://finalreport.rcvmhs.vic.gov.au/download-report/

Royal Commission into Victoria’s Mental Health System. (2021e). *Final Report: Royal Commission into Victoria’s mental health system: Volume 5: Transforming the system—Innovation and implementation*. https://finalreport.rcvmhs.vic.gov.au/download-report/

Runciman, W. B., Merry, A. F. & Tito, F. (2003). Error, blame, and the law in health care—An antipodean perspective. *Annals of Internal Medicine*, *138*(12), 974–979. https://doi.org/10.7326/0003-4819-138-12-200306170-00009

Russo, A. (2019). *Feminist accountability: Disrupting violence and transforming power*. NYU Press.

Saab, M. M., Murphy, M., Meehan, E., Dillon, C. B., O’Connell, S., Hegarty, J., Heffernan, S., Greaney, S., Kilty, C., Goodwin, J., Hartigan, I., O’Brien, M., Chambers, D., Twomey, U. & O’Donovan, A. (2021). Suicide and self-harm risk assessment: A systematic review of prospective research. *Archives of Suicide Research*. Advance online publication. https://doi.org/10.1080/13811118.2021.1938321

Safety and Quality Partnership Standing Committee. (2013). *National practice standards for the mental health workforce*. Department of Health, Victorian Government. https://www.health.gov.au/resources/publications/national-practice-standards-for-the-mental-health-workforce-2013

Said, E. W. (1978). *Orientalism*. Vintage.

Samele, C., Lawton-Smith, S., Warner, L. & Mariathasan, J. (2007). Patient choice in psychiatry. *British Journal of Psychiatry*, *191*(1), 1–2. https://doi.org/10.1192/bjp.bp.106.031799

Samson, C. (1995). The fracturing of medical dominance in British psychiatry? *Sociology of Health & Illness*, *17*(2), 245–268. https://doi.org/10.1111/1467-9566.ep10933403

Sandhu, B. (2017). *The value of lived experience in social change: The need for leadership and organisational development in the social sector*. https://knowledgeequity.org/wp-content/uploads/2021/06/The-Value-of-Lived-Experience-in-Social-Change.pdf

Sartorius, N. (2002). Iatrogenic stigma of mental illness. *BMJ: British Medical Journal*, *324*(7352), 1470–1471. https://doi.org/10.1136/bmj.324.7352.1470

Savy, P. (2005). Outcry and silence: The social implications of asylum closure in Australia. *Health Sociology Review*, *14*(3), 205–214. https://doi.org/10.5172/hesr.14.3.205

Sawyer, A. (2005). From therapy to administration: Deinstitutionalisation and the ascendancy of psychiatric 'risk thinking'. *Health Sociology Review*, *14*(3), 283–296. https://doi.org/10.5172/hesr.14.3.283

Sawyer, A. (2008). Risk and new exclusions in community mental health practice. *Australian Social Work*, *61*(4), 327–341. https://doi.org/10.1080/03124070802428183

Sawyer, A. (2009). Mental health workers negotiating risk on the frontline. *Australian Social Work*, *62*(4), 441–459. https://doi.org/10.1080/03124070903265724

Sawyer, A. (2011). Introduction. *Health Sociology Review*, *20*(2), 114–119. https://doi.org/10.1080/14421242.2011.11003075

Sawyer, A. (2018). Mental illness: Understandings, experience, and service provision In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (6th ed.). Oxford University Press.

Sayce, L. (2001). Social inclusion and mental health. *Psychiatric Bulletin*, *25*(4), 121–123. https://doi.org/10.1192/pb.25.4.121

Schein, E. H. (1992). *Organizational culture and leadership* (2nd ed.). Jossey-Bass.

Schein, E. H. (2010). *Organizational culture and leadership* (4th ed.). Jossey-Bass.

Schein, E. H., Costas, J., Kunda, G., Schultz, M., Connolly, T. H., Wright, S., Hofstede, G. J. & Wah, D. W. H. (2015). Opinions: All about culture. *Journal of Business Anthropology*, *4*(1), 106–150. https://doi.org/10.22439/jba.v4i1.4792

Scherer, A. G. (2009). Critical theory and its contribution to critical management studies. In M. Alvesson, H. Willmott & T. Bridgman (Eds.), *The Oxford handbook of critical management studies* (pp. 29–51). Oxford University Press.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics and social constructionism. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research: Themes and issues* (2nd ed., pp. 189–213). Sage Publishing.

Schwandt, T. A. (2007). *The SAGE dictionary of qualitative inquiry* (3rd ed.). SAGE Publications. https://dx.doi.org/10.4135/9781412986281

Scott, H. (2010). The medical model: The right approach to service provision? *Mental Health Practice*, *13*(5), 27–30. https://www.proquest.com/scholarly-journals/medical-model-right-approach-service-provision/docview/217225142/se-2

Senate Select Committee on Mental Health. (2006). *A national approach to mental health—From crisis to community. First report*. Commonwealth of Australia. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/index

Senneseth, M., Pollak, C., Urheim, R., Logan, C. & Palmstierna, T. (2022). Personal recovery and its challenges in forensic mental health: Systematic review and thematic synthesis of the qualitative literature. *BJPsych Open*, *8*(1), 17. https://doi.org/10.1192/bjo.2021.1068

Sewpaul, V., Ntini, T., Mkhize, Z. & Zandamela, S. (2015). Emancipatory social work education and community empowerment. *International Journal of Social Work and Human Services Practice*, *3*(2), 55–62. https://www.hrpub.org/download/20150620/IJRH1-19290348.pdf

Shera, W., & Ramon, S. (2013). Challenges in the Implementation of Recovery-Oriented Mental Health Policies and Services. *International Journal of Mental Health, 42*(2–3), 17–42. https://doi.org/10.2753/IMH0020-7411420202

Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac.* John Wiley & Sons.

Singh, B. (2012). The twentieth century to the 1990s. In G. Meadows, J. Farhall, E. Fossey, M. Grigg, F. McDermott & B. Singh (Eds.), *Mental health in Australia: Collaborative community practice* (3rd ed., pp. 72–75). Oxford University Press.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge University Press. https://doi.org/10.1017/CBO9780511581649

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. & Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12–20. https://doi.org/10.1002/wps.20084

Slemon, A., Jenkins, E. & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, *24*(4), Article e12199. https://doi.org/10.1111/nin.12199

Smircich, L. (1983). Concepts of culture and organizational analysis. *Administration Science Quarterly 28*, 339–358. https://doi.org/10.2307/2392246

Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. AltaMira Press.

Smith, G. P. & Williams, T. M. (2016). You can lead a horse to water … What self-determination theory can contribute to our understanding of clinical policy implementation. *Journal of Health Services Research & Policy*. Advance online publication. https://doi.org/10.1177/1355819616652922

Sommerseth, R. & Dysvik, E. (2008). Health professionals' experiences of person-centered collaboration in mental health care. *Patient Preference and Adherence*, *2*, 259–269. https://doi.org/10.2147/ppa.s3988

Sommers-Flanagan, J. & Shaw, S. L. (2017). Suicide risk assessment: What psychologists should know. *Professional Psychology: Research and Practice*, *48*(2), 98–106. https://doi.org/10.1037/pro0000106

Speed, E. E., Moncrieff, J. E. & Rapley, M. E. (2014). *De-medicalizing misery II: Society, politics and the mental health industry*. Palgrave Macmillan.

Stanbridge, R. & Burbach, F. (2007). Developing family-inclusive mainstream mental health services. *Journal of Family Therapy*, *29*(1), 21–43. https://doi.org/10.1111/j.1467-6427.2007.00367.x

Standing Council on Health. (2012). *Mental health statement of rights and responsibilities*. Department of Health and Aged Care. https://www.health.gov.au/resources/publications/mental-health-statement-of-rights-and-responsibilities-2012

Stanley, L. & Wise, S. (1993). *Breaking out again: Feminist ontology and epistemology* (2nd ed.). Routledge.

Stanley, T. & Lincoln, H. (2016). Improving organisational culture—The practice gains. *Practice*, *28*(3), 199–212. https://doi.org/10.1080/09503153.2015.1087491

Stepney, P. & Rostila, I. (2011). Towards an integrated model of practice evaluation balancing accountability, critical knowledge and developmental perspectives. *Health Sociology Review*, *20*(2), 133–146. https://doi.org/10.5172/hesr.2011.20.2.133

Stoker, G. (2006). Public value management: A new narrative for networked governance? *The American Review of Public Administration*, *36*(1), 41–57. https://doi.org/10.1177/0275074005282583

Street, B. V. (1993). Culture is a verb: Anthropological aspects of language and cultural. In D. Graddol, L. Thompson & M. Byram (Eds.), *Language and culture: Papers from the annual meeting of the British Association of Applied Linguistics held at Trevelyan College, University of Durham, September 1991* (pp. 23–43). British Association of Applied Linguistics in association with Multilingual Matters.

Strega, S. (2005). The view from the poststructural margins: Epistemology and methodology reconsidered. In L. Brown & S. Strega (Eds.), *Research as resistance: Critical, indigenous and anti-oppressive approaches* (pp. 199–236). Canadian Scholars' Press.

Sweeney, A. (2016). The transformative potential of survivor research. In J. Russo & A. Sweeney (Eds.), *Searching for a rose garden: Challenging psychiatry, fostering mad studies* (pp. 49–57). PCCS Books.

Taylor, J. E., & Gordon, S. E. (2022). Evaluating service user-led teaching of mental health recovery concepts in clinical psychology training. *Training and Education in Professional Psychology*, 16(4), 385–393. https://doi.org/10.1037/tep0000377

Terry, G., Hayfield, N., Clarke, V. & Braun, V. (2017). Thematic analysis. In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (2nd ed., pp. 17–37). SAGE Publications. https://dx.doi.org/10.4135/9781526405555.n2

Tew, J. (2011). *Social* approaches *to mental distress*. Palgrave Macmillan.

Thomas, W., Hujala, A., Laulainen, S. & McMurray, R. (2018). *The management of wicked problems in health and social care*. Routledge.

Tickle, A., Brown, D. & Hayward, M. (2014). Can we risk recovery? A grounded theory of clinical psychologists' perceptions of risk and recovery-oriented mental health services. The British Psychological Society, *87*(1), 96–110. https://doi.org/10.1111/j.2044-8341.2012.02079.x

Tracy, S. J. (2010). Qualitative quality: Eight ‘big-tent’ criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837–851. https://doi.org/10.1177/1077800410383121

Tse, S. & Ng, R. M. K. (2014). Applying a mental health recovery approach for people from diverse backgrounds: The case of collectivism and individualism paradigms. *Journal of Psychosocial Rehabilitation and Mental Health*, *1*(1), 7–13. https://doi.org/10.1007/s40737-014-0010-5

Tse, S., Siu, B. W. M. & Kan, A. (2013). Can recovery-oriented mental health services be created in Hong Kong? Struggles and strategies. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(3), 155–158. https://doi.org/10.1007/s10488-011-0391-7

Turner, K., Stapelberg, N. J., Sveticic, J. & Dekker, S. W. (2020). Inconvenient truths in suicide prevention: Why a restorative just culture should be implemented alongside a zero suicide framework. *Australian & New Zealand Journal of Psychiatry*, *54*(6), 571–581. https://doi.org/10.1177/0004867420918659

Van Der Linden, D., Ger, K. P. J., Eling, P. & Van Schaijk, R. (2005). Work stress and attentional difficulties: An initial study on burnout and cognitive failures. *Work & Stress*, *19*(1), 23–36. https://doi.org/10.1080/02678370500065275

Vranbæk, K. & Byrkjeflot, H. (2016). Accountability in healthcare. In E. Ferlie, K. Montgomery & A. R. Pedersen (Eds.), *The Oxford handbook of health care management* (pp. 481–495). Oxford University Press.

Vrklevski, L. P., McKechnie, L. & O’Connor, N. (2018). The causes of their death appear (unto our shame perpetual): Why root cause analysis is not the best model for error investigation in mental health services. *Journal of Patient Safety*, *14*(1), 41–48. https://doi.org/10.1097/pts.0000000000000169

Wallace, J. & Pease, B. (2011). Neoliberalism and Australian social work: Accommodation or resistance? *Journal of Social Work*, *11*(2), 132–142. https://doi.org/10.1177/1468017310387318

Wallcraft, J. (2010). The service user as a person in health care—service users organising for self empowerment. *International Journal of Integrated Care*, *10*(5). http://doi.org/10.5334/ijic.501

Wand, T. (2017). Considering the culture of blame in mental health care and service delivery. *International Journal of Mental Health Nursing*, *26*(1), 3–4. https://doi.org/10.1111/inm.12258

Waters, R. A. & Buchanan, A. (2017). An exploration of person-centred concepts in human services: A thematic analysis of the literature. *Health Policy*, *121*(10), 1031–1039. https://doi.org/10.1016/j.healthpol.2017.09.003

Webb, S. A. (2006). *Social work in a risk society: Social and political perspectives*. Palgrave Macmillan.

Weber, M. (1962). *Basic concepts in sociology* (H.P. Secher, Trans.). Peter Owen. (Original work published 1922)

Weis, L. (1995). Identity formation and the processes of 'othering': Unravelling sexual threads. *The Journal of Educational Foundations*, *9*(1), 17–33.

Whitaker, L., Smith, F. L., Brasier, C., Petrakis, M. & Brophy, L. (2021). Engaging with transformative paradigms in mental health. *International Journal of Environmental Research and Public Health*, *18*(18), 9504. https://www.mdpi.com/1660-4601/18/18/9504

Whiteford, H., Buckingham, B. & Manderscheid, R. (2002). Australia's national mental health strategy. *The British Journal of Psychiatry*, *180*(3), 210–215. https://doi.org/10.1192/bjp.180.3.210

Whiteford, H., McKeon, G., Harris, M., Diminic, S., Siskind, D. & Scheurer, R. (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review. *Australian and New Zealand Journal of Psychiatry*, *48*(10), 895–906. https://doi.org/10.1177/0004867414541683

Whiteford, H. A. & Buckingham, W. J. (2005). Ten years of mental health service reform in Australia: Are we getting it right? *Medical Journal of Australia*, *182*(8), 396–400. https://doi.org/https://doi.org/10.5694/j.1326-5377.2005.tb06758.x

Willis, E. (1989). *Medical dominance: The division of labour in Australian health care*. Routledge. https://doi.org/10.4324/9781003134343

Willis, E. (2005). The variable impact of New Public Management and budget cuts on the work intensification of nurses and doctors in one public hospital in South Australia between 1994 and 2000. *Australian Bulletin of Labour*, *31*(3), 255–269. https://search.informit.org/doi/10.3316/informit.010651780582721

Willis, E. (2006). Introduction: Taking stock of medical dominance. *Health Sociology Review*, *15*(5), 421–431. https://doi.org/10.5172/hesr.2006.15.5.421

Wilson, A. & Beresford, P. (2000). "Anti-oppressive practice": Emancipation or appropriation? *The British Journal of Social Work*, *30*(5), 553–573. http://www.jstor.org/stable/23716169

Wilson, E. (2003). Psychiatric abuse at Chelmsford Private Hospital, New South Wales, 1960s–1980s. In C. Coleborne & D. MacKinnon (Eds.), *Madness in Australia: Histories, heritage and the asylum* (pp. 121–134). University of Queensland Press.

World Health Organization. (2022). *The International Classification of Diseases 11th Revision: The global standard for diagnostic health information*. https://www.who.int/standards/classifications/classification-of-diseases

Wray-Bliss, E. (2009). Ethics: Critique, ambivalence and infinite responsibilities (Unmet). In M. Alvesson, T. Bridgman & H. Willmott (Eds.), *The Oxford handbook of critical management studies* (pp. 267–285). Oxford University Press.

Wright, M., Crowe, J., Huckshorn, K., Lenihan, K., Mooney, J. & Shields, R. (2017). *Review of seclusion, restraint and observation of consumers with a mental illness in NSW health facilities.* NSW Ministry of Health. https://www.health.nsw.gov.au/mentalhealth/reviews/seclusionprevention/Pages/about.aspx

Wright, S. (1994). 'Culture' in anthropology and organizational studies. In S. Wright (Ed.), *Anthropology of organizations* (pp. 1–34). Routledge.

Wright, S. (1998). The politicization of 'culture'. *Anthropology Today*, *14*(1), 7–15. https://doi.org/10.2307/2783092

Wyder, M., Barratt, J., Jonas, R. & Bland, R. (2021). Relational recovery for mental health carers and family: Relationships, complexity and possibilities. *The British Journal of Social Work*, *52*(3), 1325–1340. https://doi.org/10.1093/bjsw/bcab149

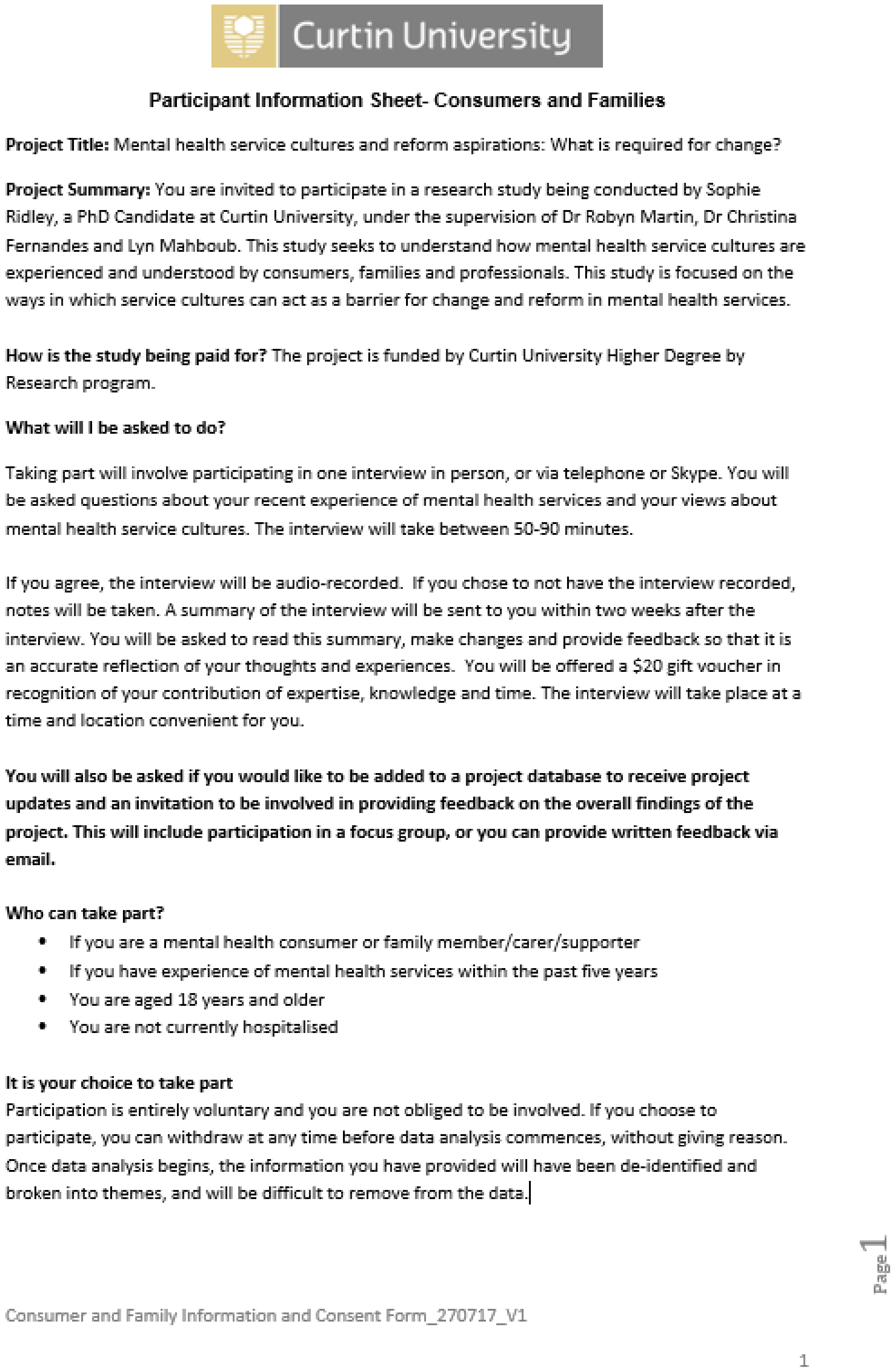
Wyder, M. & Bland, R. (2014). The recovery framework as a way of understanding families' responses to mental illness: Balancing different needs and recovery journeys. *Australian Social Work*, *67*(2), 179–196. https://doi.org/10.1080/0312407X.2013.875580

Yanow, D. & Ybema, S. (2009). Interpretivism in organizational research: On elephants and blind researchers. In D. Buchanan & A. Bryman (Eds.), *The SAGE handbook of organizational research methods* (pp. 39–60). SAGE Publications.

Zeng, G., Chung, D. & McNamara, B. (2020). Organisational contexts and practice developments in mental health peer provision in Western Australia. *Journal of Health Organization and Management*, *34*(5), 569–585. https://doi.org/10.1108/JHOM-09-2019-0281

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

Appendix A: Participant Information Sheets and Consent Form



Curtin University

Participant Information Sheet- Consumers and Families

Project Title: Mental health service cultures and reform aspirations: What is required for change?

Project Summary: You are invited to participate in a research study being conducted by Sophie Ridley, a PhD Candidate at Curtin University, under the supervision of Dr Robyn Martin, Dr Christina Fernandes and Lyn Mahboub. This study seeks to understand how mental health service cultures are experienced and understood by consumers, families and professionals. This study is focused on the ways in which service cultures can act as a barrier for change and reform in mental health services.

How is the study being paid for? The project is funded by Curtin University Higher Degree by Research program.

What will I be asked to do?

Taking part will involve participating in one interview in person, or via telephone or Skype. You will be asked questions about your recent experience of mental health services and your views about mental health service cultures. The interview will take between 50-90 minutes.

If you agree, the interview will be audio-recorded. If you chose to not have the interview recorded, notes will be taken. A summary of the interview will be sent to you within two weeks after the interview. You will be asked to read this summary, make changes and provide feedback so that it is an accurate reflection of your thoughts and experiences. You will be offered a $20 gift voucher in recognition of your contribution of expertise, knowledge and time. The interview will take place at a time and location convenient for you.

You will also be asked if you would like to be added to a project database to receive project updates and an invitation to be involved in providing feedback on the overall findings of the project. This will include participation in a focus group, or you can provide written feedback via email.

Who can take part?

- If you are a mental health consumer or family member/carer/supporter
- If you have experience of mental health services within the past five years
- You are aged 18 years and older
- You are not currently hospitalised

It is your choice to take part

Participation is entirely voluntary and you are not obliged to be involved. If you choose to participate, you can withdraw at any time before data analysis commences, without giving reason. Once data analysis begins, the information you have provided will have been de-identified and broken into themes, and will be difficult to remove from the data.

If you do decide to withdraw, simply contact the researcher by telephone or email and say that you would like to withdraw. Any information that you have supplied will be deleted: this includes the audio-recording and the written interview transcript.

Your participation will be anonymous
This research is anonymous. The researchers are the only people who will have access to the research notes and transcripts from interviews. All results will be de-identified. This means that no information that identifies you will be written in results or publications.

How will the information be used?
The information collected in interviews will be combined with information collected from other participants, such as professionals, and used to produce research findings. These research findings will be written into a thesis and published in academic articles. Quotes from the interview may be used when the findings are published but they will be presented in a way that does not identify you. The results will also be written into summary sheets to enable people who are not researchers to read and know about the study. These results will also be presented at public presentations. If you decide to be added to the project database, you will be invited to discuss how best to share the research findings.

How will your information be stored?
During the study data will be stored on a password protected computer at Curtin University that only the researchers can access. After the study is completed, electronic data will be stored in a secure file on a password locked computer and locked cabinet in the research supervisor's office at Curtin University, Perth. This data will be kept for seven years and will then be destroyed.

Are there any risks to taking part?
It is possible that you may become distressed during an interview. You can choose to stop or take a break. You may also choose to skip any questions you do not want to answer. If you do become distressed, the interviewer will ask if you would like to continue. The researcher will also follow up and check in with you the next day by phone. At this time, the researcher will discuss contacting your support network for further support.

What happens next and who can I contact about the research?
If you would like to participate in this research please contact:
Sophie Ridley
Email: sophie.ridley@postgard.curtin.edu.au
Phone: 0439 933 468

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. The information sheet is for you to keep and the consent form is retained by the researcher/s.

Can I tell other people about the study?

Yes, you can tell other people about the study by showing them the advertisements, or by providing the researcher's contact details. They can contact the researcher by email on sophie.ridley@postgard.curtin.edu.au or phone 0439 933 468 to discuss their participation in the research project and obtain a copy of the information sheet.

What if I have a complaint?

If you have any complaints or reservations about the ethical conduct of this research, you may contact the a Curtin University Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Researcher contact details

Sophie Ridley PhD Candidate School of Occupational Therapy and Social Work Faculty of Health Sciences Curtin University Mobile |0439 933 468 Email| Sophie.ridley@postgrad.curtin.edu.au	**Dr Robyn Martin** Director of Research Training and Research Strategy; Senior Lecturer School of Occupational Therapy and Social Work Faculty of Health Sciences Curtin University Tel | +61 8 92662756 Email | r.martin@curtin.edu.au
Dr Tina Fernandes Course Coordinator and Lecturer Department of Social Work School of Occupational Therapy and Social Work Faculty of Health Sciences Curtin University Tel | +61 8 9266 7330 Email | c.fernandes@curtin.edu.au	

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2017-0654). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Curtin University

Participant Information Sheet- Mental Health Professionals

Project Title: Mental health service cultures and reform aspirations: What is required for change?

Project Summary: You are invited to participate in a research study being conducted by Sophie Ridley, a PhD Candidate at Curtin University, under the supervision of Dr Robyn Martin, Dr Christina Fernandes and Lyn Mahboub. This study seeks to understand how mental health service cultures are experienced and understood by consumers, families and professionals. This study is focused on the ways in which service cultures can act as a barrier for change and reform in mental health services.

You are invited to participate in the research as an individual – not an organisational representative. While your responses will be based on your professional experience, this may span work in a number of mental health organisations and programs. The research is not examining specific organisational cultures; rather mental health service cultures in a general and broad sense.

How is the study being paid for? The project is funded by Curtin University Higher Degree by Research program and supported by an Australian Government Research Training Program Scholarship.

What will I be asked to do?
Taking part will involve participating in one interview in person, or via telephone or Skype. You will be asked questions about your recent experiences of mental health services and your views about mental health service cultures. The interview will take between 50-90 minutes.

If you agree, the interview will be audio-recorded. If you chose to not have the interview recorded, notes will be taken. A summary of the interview will be sent to you within two weeks after the interview. You are invited to make changes and provide feedback so that it is an accurate reflection of your thoughts and experiences. The interview will take place at a time and location convenient for you.

You will also be asked if you would like to be added to a project database to receive project updates and an invitation to be involved in providing feedback on the overall findings of the project. This will include participation in a focus group, or you can provide written feedback via email.

Who can take part?

- If you are a mental health professional, including managers working in inpatient or community services (government or non-government or other mental health specific services such as residential, legal, psychosocial).
- If you have experience working in mental health services within the past five years
- You are aged 18 years and older

It is your choice to take part
Participation is entirely voluntary and you are not obliged to be involved. If you choose to participate, you can withdraw at any time before data analysis commences, without giving reason.

Once data analysis begins, the information you have provided will have been de-identified and broken into themes, and will be difficult to remove from the data.

If you do decide to withdraw, simply contact the researcher by telephone or email and say that you would like to withdraw. Any information that you have supplied will be deleted: this includes the audio-recording and the written interview transcript.

Your participation will be anonymous
This research is anonymous. The researchers are the only people who will have access to the research notes and transcripts from interviews. All results will be de-identified. This means that no information that identifies you will be included in results or publications.

How will the information be used?
The information collected in interviews will be combined with information collected from other participants, such as consumers and families, and used to produce research findings. These research findings will be written into a thesis and published in academic articles. Quotes from the interview may be used when the findings are published but they will be presented in a way that does not identify you. The results will also be written into summary sheets to enable people who are not researchers to read and know about the study. These results will also be presented at public presentations. If you decide to be added to the project database, you will be invited to discuss how best to share the research findings.

How will your information be stored?
During the study data will be stored on a password protected computer at Curtin University that only the researchers can access. After the study is completed, electronic data will be stored in a secure file on a password locked computer and locked cabinet in the research supervisor's office at Curtin University, Perth. This data will be kept for seven years and will then be destroyed.

Are there any risks to taking part?
The researcher conducting interviews has a strong commitment to partnering with professionals, and understanding the experiences and contexts in which you work. It is acknowledged that interviews about mental health service culture may evoke contentious discussions and have the potential to result in professionals feeling vulnerable and exposed in relation to what you share. The researcher will ensure anonymity and privacy throughout all data collection activities and attention will be given to ensuring the research process is open and transparent, and based on a partnership. As mentioned above, you will be sent a summary of the interview in which you will be invited to provide feedback or amendments to the researcher interpretations of the interview. Results will be reported carefully to ensure individuals will not be identifiable within any research findings or publication.

What happens next and who can I contact about the research?
If you would like to participate in this research please contact:
Sophie Ridley
Email: sophie.ridley@postgard.curtin.edu.au
Phone: 0439 933 468

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. The information sheet is for you to keep and the consent form is retained by the researcher/s.

Can I tell other people about the study?

Yes, you can tell other people about the study by showing them the advertisements, or by providing the researcher's contact details. They can contact the researcher by email on sophie.ridley@postgard.curtin.edu.au or phone 0439 933 468 to discuss their participation in the research project and obtain a copy of the information sheet.

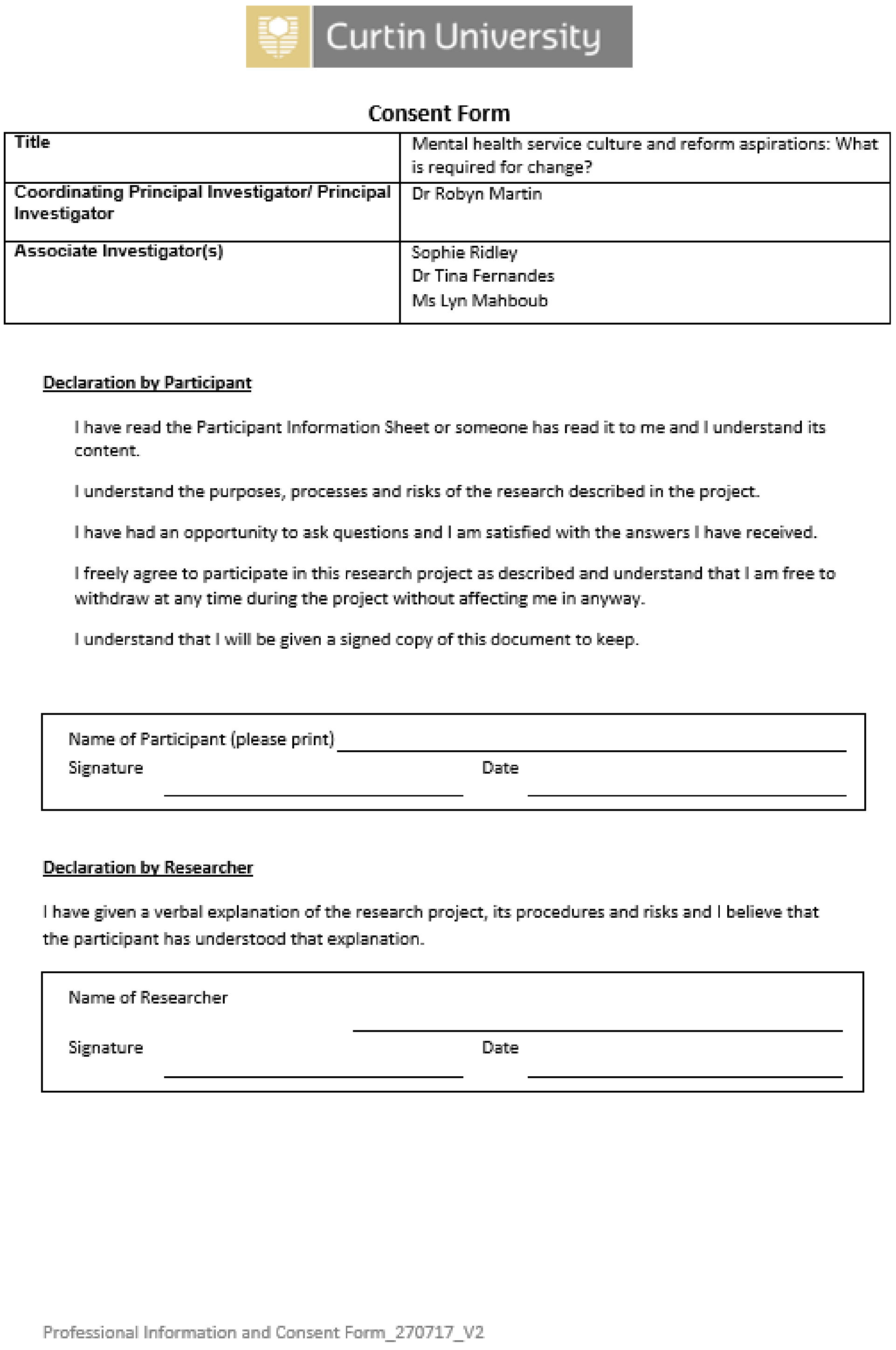
What if I have a complaint?

If you have any complaints or reservations about the ethical conduct of this research, you may contact a Curtin University Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Researcher contact details

Sophie Ridley PhD Candidate School of Occupational Therapy, Social Work and Speech Pathology Faculty of Health Sciences Curtin University Mobile |+61 0439 933 468 Email| Sophie.ridley@postgrad.curtin.edu.au	**Dr Robyn Martin** Director of Research; Senior Lecturer School of Occupational Therapy, Social Work and Speech Pathology Faculty of Health Sciences Curtin University Tel | +61 8 92662756 Email | r.martin@curtin.edu.au
Dr Tina Fernandes Course Coordinator and Lecturer Department of Social Work School of Occupational Therapy, Social Work and Speech Pathology Faculty of Health Sciences Curtin University Tel | +61 8 9266 7330 Email | c.fernandes@curtin.edu.au	**Ms Lyn Mahboub** Lived Experience Academic Clinical/Professional Fellow: Lecturer School of Occupational Therapy, Social Work and Speech Pathology Faculty of Health Sciences Curtin University Tel | +61 8 9266 7252 Email | L.Mahboub@curtin.edu.au

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2017-0654). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.



Curtin University

Consent Form

Title	Mental health service culture and reform aspirations: What is required for change?
Coordinating Principal Investigator/ Principal Investigator	Dr Robyn Martin
Associate Investigator(s)	Sophie Ridley Dr Tina Fernandes Ms Lyn Mahboub

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me and I understand its content.

I understand the purposes, processes and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting me in anyway.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) ____________________

Signature ____________________ Date ____________________

Declaration by Researcher

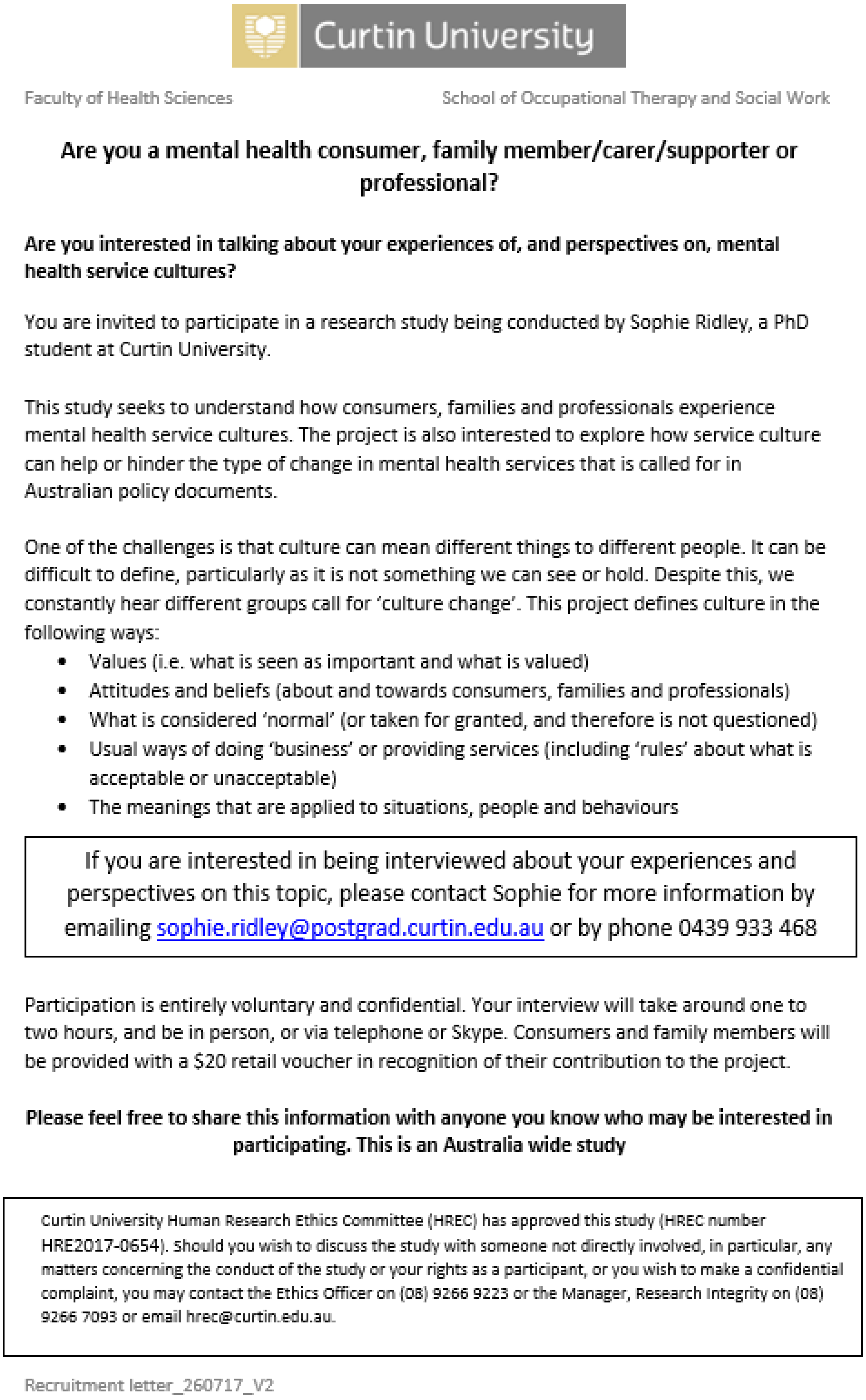
I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher ____________________

Signature ____________________ Date ____________________

Professional Information and Consent Form_270717_V2

Appendix B: Recruitment Materials



Curtin University

Faculty of Health Sciences School of Occupational Therapy and Social Work

Are you a mental health consumer, family member/carer/supporter or professional?

Are you interested in talking about your experiences of, and perspectives on, mental health service cultures?

You are invited to participate in a research study being conducted by Sophie Ridley, a PhD student at Curtin University.

This study seeks to understand how consumers, families and professionals experience mental health service cultures. The project is also interested to explore how service culture can help or hinder the type of change in mental health services that is called for in Australian policy documents.

One of the challenges is that culture can mean different things to different people. It can be difficult to define, particularly as it is not something we can see or hold. Despite this, we constantly hear different groups call for 'culture change'. This project defines culture in the following ways:

- Values (i.e. what is seen as important and what is valued)
- Attitudes and beliefs (about and towards consumers, families and professionals)
- What is considered 'normal' (or taken for granted, and therefore is not questioned)
- Usual ways of doing 'business' or providing services (including 'rules' about what is acceptable or unacceptable)
- The meanings that are applied to situations, people and behaviours

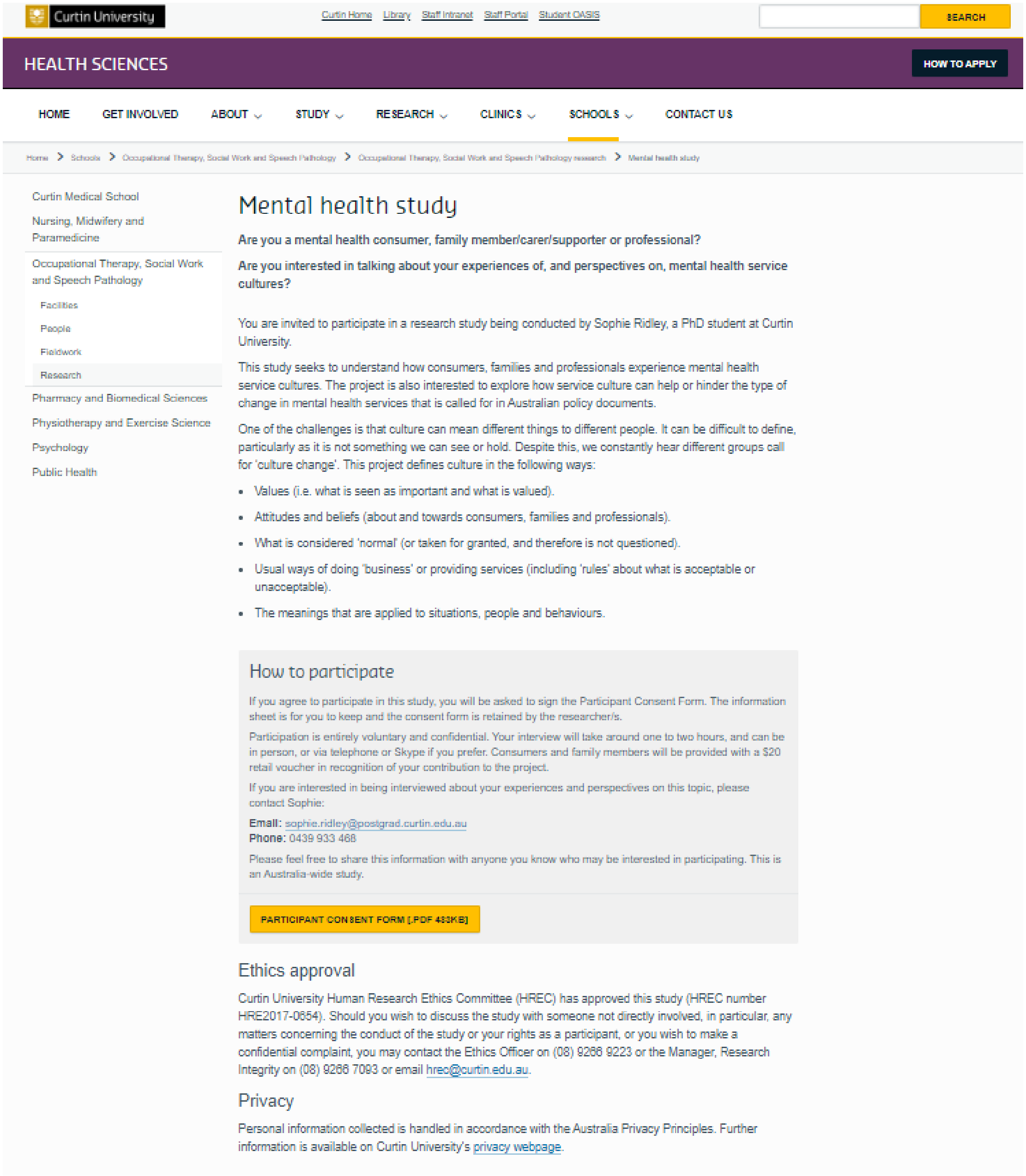
If you are interested in being interviewed about your experiences and perspectives on this topic, please contact Sophie for more information by emailing sophie.ridley@postgrad.curtin.edu.au or by phone 0439 933 468

Participation is entirely voluntary and confidential. Your interview will take around one to two hours, and be in person, or via telephone or Skype. Consumers and family members will be provided with a $20 retail voucher in recognition of their contribution to the project.

Please feel free to share this information with anyone you know who may be interested in participating. This is an Australia wide study

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2017-0654). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Recruitment letter_260717_V2



Mental health study

Are you a mental health consumer, family member/carer/supporter or professional?

Are you interested in talking about your experiences of, and perspectives on, mental health service cultures?

You are invited to participate in a research study being conducted by Sophie Ridley, a PhD student at Curtin University.

This study seeks to understand how consumers, families and professionals experience mental health service cultures. The project is also interested to explore how service culture can help or hinder the type of change in mental health services that is called for in Australian policy documents.

One of the challenges is that culture can mean different things to different people. It can be difficult to define, particularly as it is not something we can see or hold. Despite this, we constantly hear different groups call for 'culture change'. This project defines culture in the following ways:

- Values (i.e. what is seen as important and what is valued).
- Attitudes and beliefs (about and towards consumers, families and professionals).
- What is considered 'normal' (or taken for granted, and therefore is not questioned).
- Usual ways of doing 'business' or providing services (including 'rules' about what is acceptable or unacceptable).
- The meanings that are applied to situations, people and behaviours.

How to participate

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. The information sheet is for you to keep and the consent form is retained by the researcher/s.

Participation is entirely voluntary and confidential. Your interview will take around one to two hours, and can be in person, or via telephone or Skype if you prefer. Consumers and family members will be provided with a $20 retail voucher in recognition of your contribution to the project.

If you are interested in being interviewed about your experiences and perspectives on this topic, please contact Sophie:

Email: sophie.ridley@postgrad.curtin.edu.au
Phone: 0439 933 468

Please feel free to share this information with anyone you know who may be interested in participating. This is an Australia-wide study.

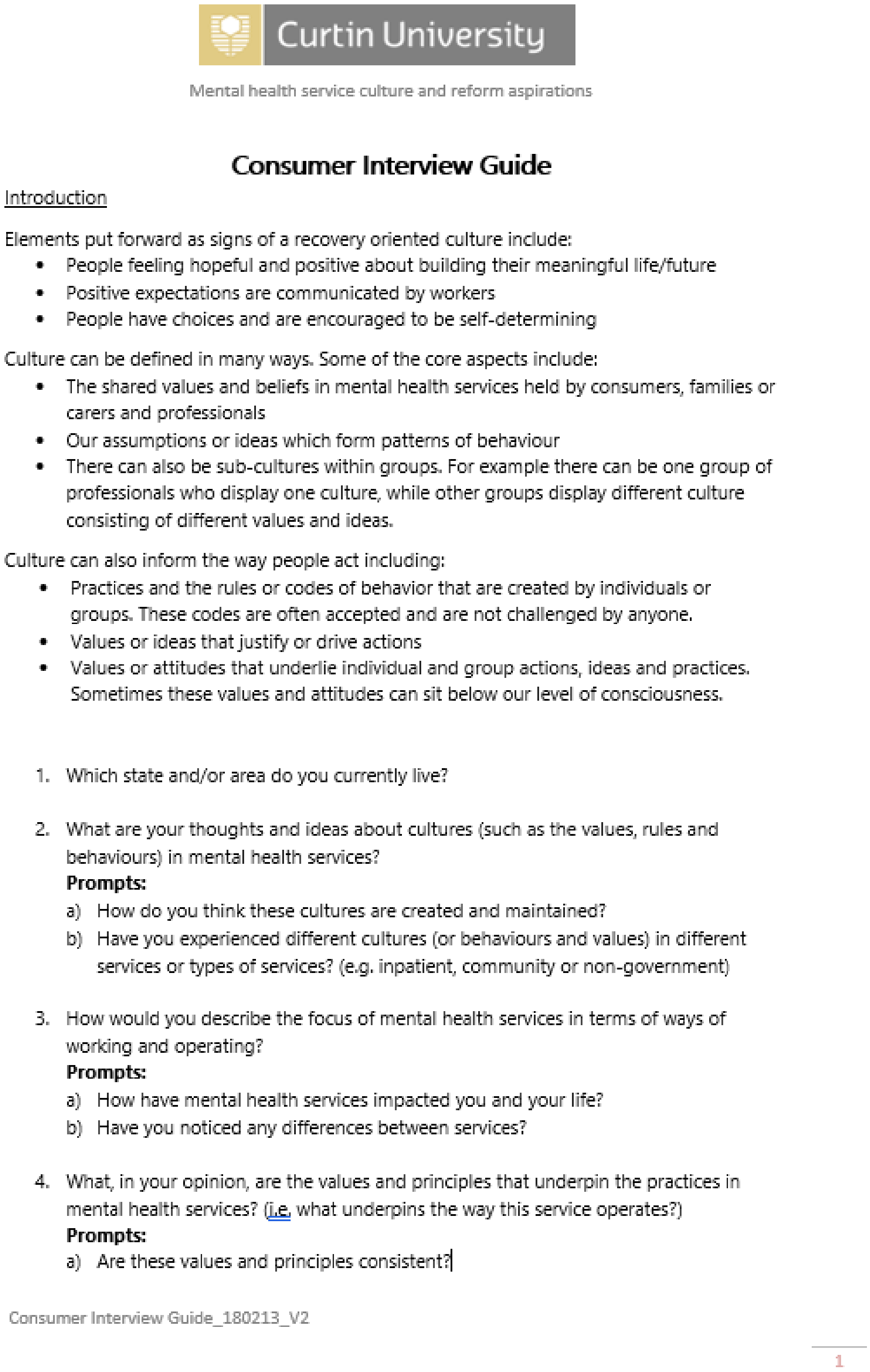
Ethics approval

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2017-0654). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Privacy

Personal information collected is handled in accordance with the Australia Privacy Principles. Further information is available on Curtin University's privacy webpage.

Appendix C: Interview Guides



Curtin University

Mental health service culture and reform aspirations

Consumer Interview Guide

Introduction

Elements put forward as signs of a recovery oriented culture include:

- People feeling hopeful and positive about building their meaningful life/future
- Positive expectations are communicated by workers
- People have choices and are encouraged to be self-determining

Culture can be defined in many ways. Some of the core aspects include:

- The shared values and beliefs in mental health services held by consumers, families or carers and professionals
- Our assumptions or ideas which form patterns of behaviour
- There can also be sub-cultures within groups. For example there can be one group of professionals who display one culture, while other groups display different culture consisting of different values and ideas.

Culture can also inform the way people act including:

- Practices and the rules or codes of behavior that are created by individuals or groups. These codes are often accepted and are not challenged by anyone.
- Values or ideas that justify or drive actions
- Values or attitudes that underlie individual and group actions, ideas and practices. Sometimes these values and attitudes can sit below our level of consciousness.

1. Which state and/or area do you currently live?

2. What are your thoughts and ideas about cultures (such as the values, rules and behaviours) in mental health services?
   Prompts:
   a) How do you think these cultures are created and maintained?
   b) Have you experienced different cultures (or behaviours and values) in different services or types of services? (e.g. inpatient, community or non-government)

3. How would you describe the focus of mental health services in terms of ways of working and operating?
   Prompts:
   a) How have mental health services impacted you and your life?
   b) Have you noticed any differences between services?

4. What, in your opinion, are the values and principles that underpin the practices in mental health services? (i.e. what underpins the way this service operates?)
   Prompts:
   a) Are these values and principles consistent?

Consumer Interview Guide_180213_V2

1

   b) What do you think is the most important thing for the people working in these services?
   c) What do you think drives the behaviours, values and beliefs of managers who direct staff within these services?
   d) We hear a lot about changes in mental health services. Have you noticed changes in mental health services? What seems to never change?
   e) What do you think is done well in services? Why?

5. In mental health services whose opinion, ideas and knowledge or experience is valued most?
   Prompts:
   a) Are there times when this can shift?
   b) What do think encourages or reinforces the valuing of this position or role?

6. What do you think it's like for the people who work in mental health services?
   Prompts:
   a) Do you think they get support and have enough time? Why?
   b) Do you think that people working in mental health services have any way of influencing how the service operates?
   c) Do you feel the policies and procedure in services support the workers to be effective in their role? Do you think that the people working with you feel restricted by the services rules policies and practices? Why?

7. Do you have family, carers or supporters who have shared experiences, or supported you when you have used mental health services? How do you think they would describe their experiences?
   Prompts:
   a) If your family member has also used mental health services, and this is known to the staff, do you think this impacts the way services respond or interact with them?
   b) Do you think your treating team acknowledge and respond to your family/carer/supporter needs, concerns and feedback?
   c) Do your treating team involve your family/carer/supporter enough? Why/why not?

8. **National policies and frameworks (such as the National Framework for Recovery Oriented Practice) state that mental health services should give you a feeling of positivity and hope. They also include statements about consumers having choices in decisions, opportunities to be self-determining, and feeling valued, welcome and safe.**
   a) In your experience, are positive expectations (belief in you and your future prospects and opportunities in terms of recovery and building a good life) communicated to you by the workers, staff and services?

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this? Are there limits to this positivity about future opportunities and prospects?

b) Do services mental health services (including staff, policies and practices) promote hope and optimism?

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

Do the building/s and facilities you receive/d services from and in give you a feeling of hope and optimism? Why/ why not?

c) When staff/professionals talk to you, do you feel that they are giving you choices for self-determination?

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share a little more about your experiences of this? What opportunities do you have in regards to choice? Are there differences between staff or disciplines (i.e. nurse, OT, psychiatrist)?

d) When you first walk into mental health services, do you feel welcome, safe and important?

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

9. Overall do you feel your experience of services reflects theses key principles (hope, optimism, feeling welcome and safe, valued and important, enabling self-determination)?
   Prompt:
   Do your experiences differ in different services?

10. If you had ultimate power to change three things in mental health services, what three things would you change?
    Prompt:
    a) What would get in the way of this change occurring?
    b) What could make this change happen?
    c) At times mental services can only offer a narrow band of help, if you could get any support to aid in your recovery what would it be?

11. Vignette question

Vignettes are description or stories based on true experiences. They can be useful in providing a deeper insight into the underpinning values and ideas of particular circumstances. This vignette is very broad, however the focus is on your interpretation of consumer experiences within this services:

Peter has been accessing services at different times for approximately ten years. Peter's first experience involved an inpatient stay of six weeks when he was 21 years old. He received a Community Treatment Order for three months following his discharge. Peter was hospitalised again seven weeks ago, and has recently been discharged and is living at home with his family. Peter is described as being quite 'difficult' by some of the staff at mental health services in his area. Currently Peter is feeling very intense anger, at times out of control and like no one is listening to him.

a) If you were Peter, what would be most important to you at this time?
b) What would you want staff to consider?

12. Sometimes the cultures within mental health services create feelings that may be difficult to define. Can you think of a time when you experienced strong feelings which may have been connected to the way you were treated, the language used, the rules you had to follow or the layout of the space you were in? Would you like to share any of those experiences with me?

13. Do you have any other comments about service culture or anything else you would like to say?

Family/Carer/Supporter Interview Guide

Introduction

Elements put forward as signs of a recovery-oriented culture include:

- People feeling hopeful and positive about building their meaningful life/future
- Positive expectations are communicated by workers
- People have choices and are encouraged to be self-determining

Culture can be defined in many ways. Some of the core aspects include:

- The shared values and beliefs in mental health services held by consumers, families or carers and professionals
- Our assumptions or ideas which form patterns of behaviour
- There can also be sub-cultures within groups. For example there can be one group of professionals who display one culture, while other groups display different culture consisting of different values and ideas.

Culture can also inform the way people act including:

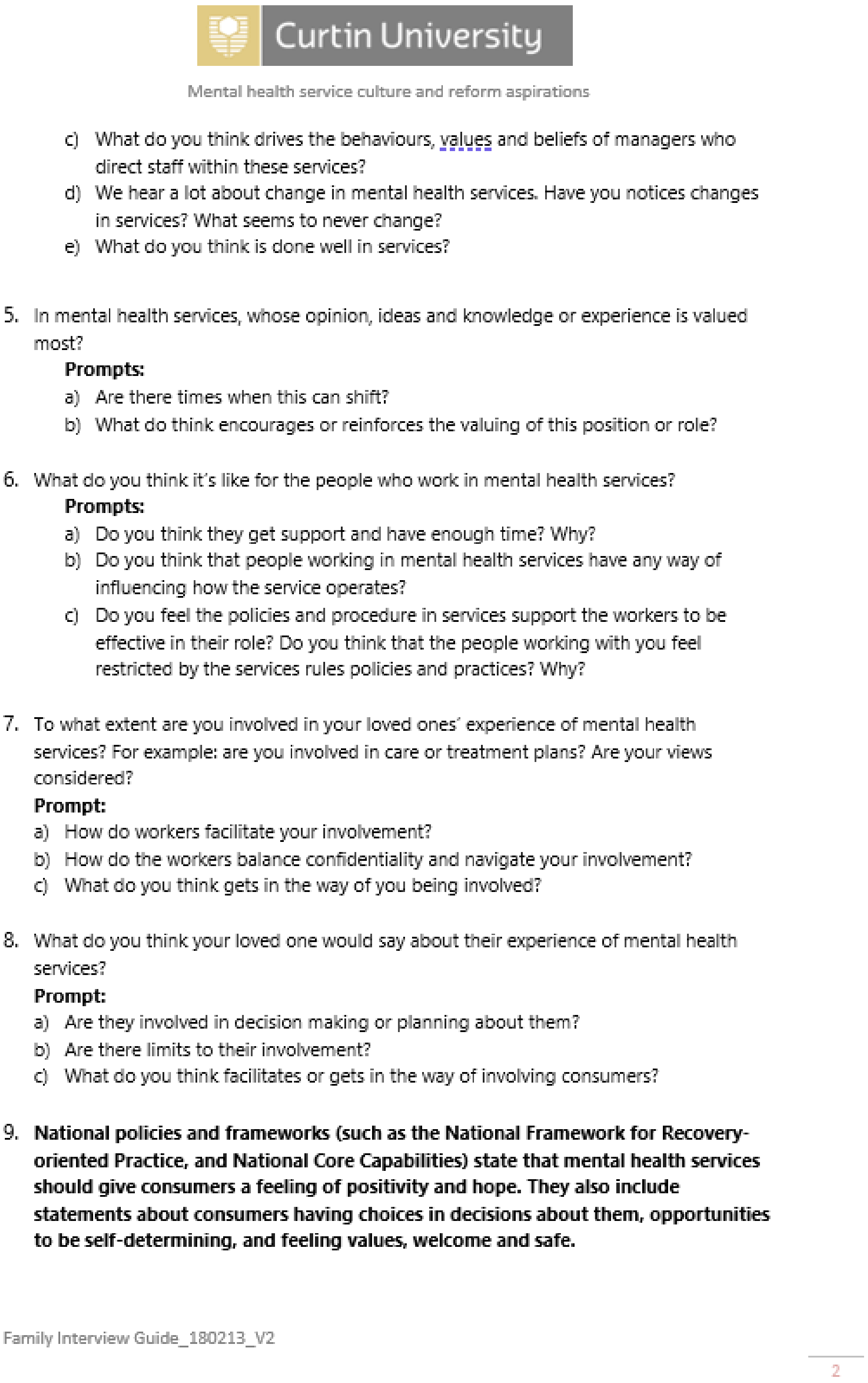
- Practices and the rules or codes of behavior that are created by individuals or groups. These codes are often accepted and are not challenged by anyone.
- Values or ideas that justify or drive actions
- Values or attitudes that underlie individual and group actions, ideas and practices. Sometimes these values and attitudes can sit below our level of consciousness.

1. Which state and/or area do you currently live?

2. I'm wondering what your thoughts and ideas are about the culture (such as the values, rules and behaviours) in mental health services?
   Prompts:
   a) How do you think these cultures are created or maintained?
   b) Have you experienced different cultures (or values and behaviours) in different services or types of services? (e.g. inpatient, community or non-government)

3. How would you describe the focus of mental health services in terms of ways of working and operating?
   Prompts:
   a) How have mental health services impacted your loved one and your life?
   b) Have you noticed any differences between services?

4. What, in your opinion, are the values and principles that underpin the practices in mental health services? (i.e. what underpins the way this service operates?)
   Prompts:
   a) Are these values and principles consistent?
   b) What do you think is most important thing for people working in these services?



c) What do you think drives the behaviours, values and beliefs of managers who direct staff within these services?
d) We hear a lot about change in mental health services. Have you notices changes in services? What seems to never change?
e) What do you think is done well in services?

5. In mental health services, whose opinion, ideas and knowledge or experience is valued most?

   Prompts:
   a) Are there times when this can shift?
   b) What do think encourages or reinforces the valuing of this position or role?

6. What do you think it's like for the people who work in mental health services?

   Prompts:
   a) Do you think they get support and have enough time? Why?
   b) Do you think that people working in mental health services have any way of influencing how the service operates?
   c) Do you feel the policies and procedure in services support the workers to be effective in their role? Do you think that the people working with you feel restricted by the services rules policies and practices? Why?

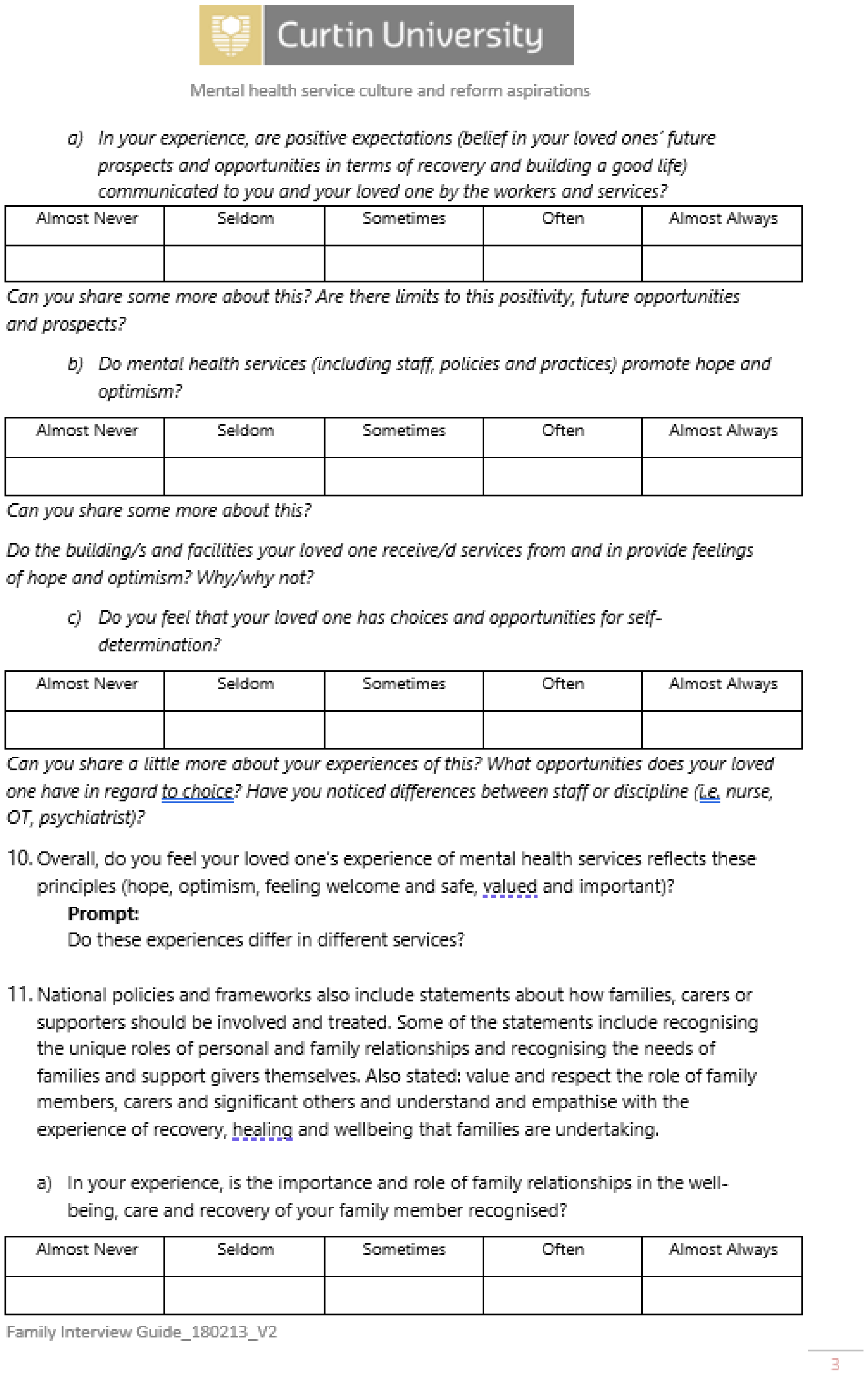
7. To what extent are you involved in your loved ones' experience of mental health services? For example: are you involved in care or treatment plans? Are your views considered?

   Prompt:
   a) How do workers facilitate your involvement?
   b) How do the workers balance confidentiality and navigate your involvement?
   c) What do you think gets in the way of you being involved?

8. What do you think your loved one would say about their experience of mental health services?

   Prompt:
   a) Are they involved in decision making or planning about them?
   b) Are there limits to their involvement?
   c) What do you think facilitates or gets in the way of involving consumers?

9. **National policies and frameworks (such as the National Framework for Recovery-oriented Practice, and National Core Capabilities) state that mental health services should give consumers a feeling of positivity and hope. They also include statements about consumers having choices in decisions about them, opportunities to be self-determining, and feeling values, welcome and safe.**



a) *In your experience, are positive expectations (belief in your loved ones' future prospects and opportunities in terms of recovery and building a good life) communicated to you and your loved one by the workers and services?*

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this? Are there limits to this positivity, future opportunities and prospects?

b) *Do mental health services (including staff, policies and practices) promote hope and optimism?*

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

Do the building/s and facilities your loved one receive/d services from and in provide feelings of hope and optimism? Why/why not?

c) *Do you feel that your loved one has choices and opportunities for self-determination?*

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share a little more about your experiences of this? What opportunities does your loved one have in regard to choice? Have you noticed differences between staff or discipline (i.e. nurse, OT, psychiatrist)?

10. Overall, do you feel your loved one's experience of mental health services reflects these principles (hope, optimism, feeling welcome and safe, valued and important)?

    Prompt:
    Do these experiences differ in different services?

11. National policies and frameworks also include statements about how families, carers or supporters should be involved and treated. Some of the statements include recognising the unique roles of personal and family relationships and recognising the needs of families and support givers themselves. Also stated: value and respect the role of family members, carers and significant others and understand and empathise with the experience of recovery, healing and wellbeing that families are undertaking.

    a) In your experience, is the importance and role of family relationships in the well-being, care and recovery of your family member recognised?

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

b) Are your needs recognised?

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

c) Do you feel valued and respected?

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

12. Overall, how does these statements fit with your experience of mental health services?

13. If you had ultimate power to change three things in mental health service, what three things would you change?

    Prompt:
    What would get in the way of this change occurring?
    What could make this change happen?

14. At times mental health services can only offer a narrow band of help, if you could get any support for you and/or your loved one, what would it be?

15. **Vignette question**

    Vignettes are description or stories based on true experiences. They can be useful in providing a deeper insight into the underpinning values and ideas of particular circumstances. This vignette is very broad, however the focus is on your interpretation of consumer experiences within these services:

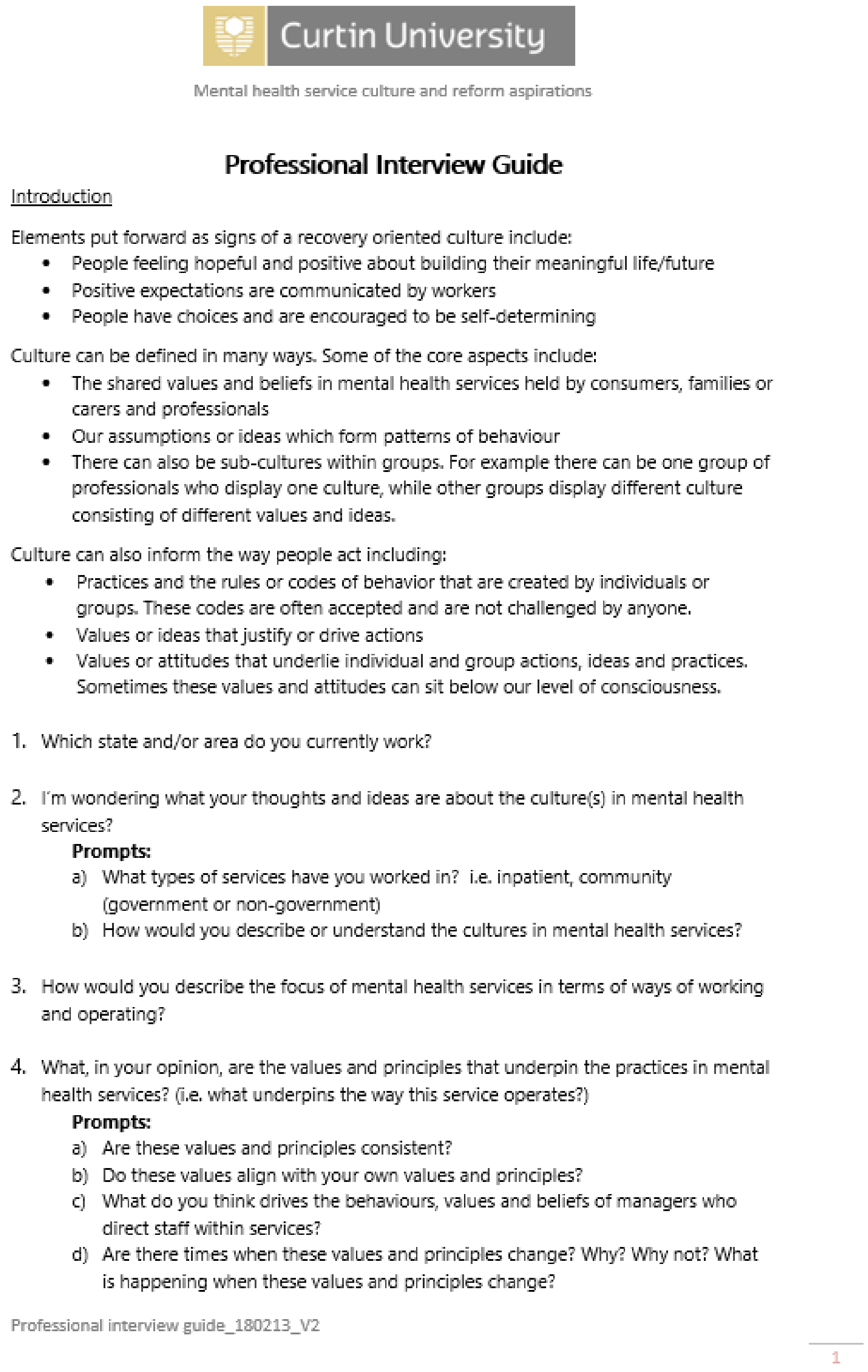
    Peter has been accessing services at different times for approximately ten years. Peter's first experience involved an inpatient stay of six weeks when he was 21 years old. He received a Community Treatment Order for three months following his discharge. Peter was hospitalised again seven weeks ago, and has recently been discharged and is living at home with his family. Peter is described as being quite 'difficult' by some of the staff at mental health services in his area. Currently Peter is feeling very intense anger, at times out of control and like no one is listening to him.

a) If Peter was your loved one, what would be most important to you at this time?
b) What would you want staff to consider?

16. Sometimes the cultures within mental health services create feelings that may be difficult to define. Can you think of a time when you experienced strong feelings which may have

been connected to the way you were treated, the language used, the rules you had to follow or the layout of the space you were in? Would you like to share any of those experiences with me?

17. Do you have any other comments about service culture or anything else you would like to say?



Professional Interview Guide

Introduction

Elements put forward as signs of a recovery oriented culture include:

- People feeling hopeful and positive about building their meaningful life/future
- Positive expectations are communicated by workers
- People have choices and are encouraged to be self-determining

Culture can be defined in many ways. Some of the core aspects include:

- The shared values and beliefs in mental health services held by consumers, families or carers and professionals
- Our assumptions or ideas which form patterns of behaviour
- There can also be sub-cultures within groups. For example there can be one group of professionals who display one culture, while other groups display different culture consisting of different values and ideas.

Culture can also inform the way people act including:

- Practices and the rules or codes of behavior that are created by individuals or groups. These codes are often accepted and are not challenged by anyone.
- Values or ideas that justify or drive actions
- Values or attitudes that underlie individual and group actions, ideas and practices. Sometimes these values and attitudes can sit below our level of consciousness.

1. Which state and/or area do you currently work?

2. I'm wondering what your thoughts and ideas are about the culture(s) in mental health services?
   Prompts:
   a) What types of services have you worked in? i.e. inpatient, community (government or non-government)
   b) How would you describe or understand the cultures in mental health services?

3. How would you describe the focus of mental health services in terms of ways of working and operating?

4. What, in your opinion, are the values and principles that underpin the practices in mental health services? (i.e. what underpins the way this service operates?)
   Prompts:
   a) Are these values and principles consistent?
   b) Do these values align with your own values and principles?
   c) What do you think drives the behaviours, values and beliefs of managers who direct staff within services?
   d) Are there times when these values and principles change? Why? Why not? What is happening when these values and principles change?

e) What do you think is done well in services? Why?

5. Whose opinion, ideas and knowledge or experience is valued most (by you, other staff and also consumers and families)?

   Prompts:
   a) Are there times when this can shift?
   b) What do think encourages or reinforces the valuing of this position or role?
   c) How do you feel about it?

6. Overall, what's your experience of working in mental health services?

   Prompts:
   a) Do you feel well supported, do they have sufficient time?
   b) Do you feel you can influence the way the service operates?
   c) Do you feel the policies and procedures support you to be effective in your role? I.e. do you feel you are enabled or restricted by policies and procedure in anyway?

7. In your opinion, how do you think consumers generally experience mental health service?

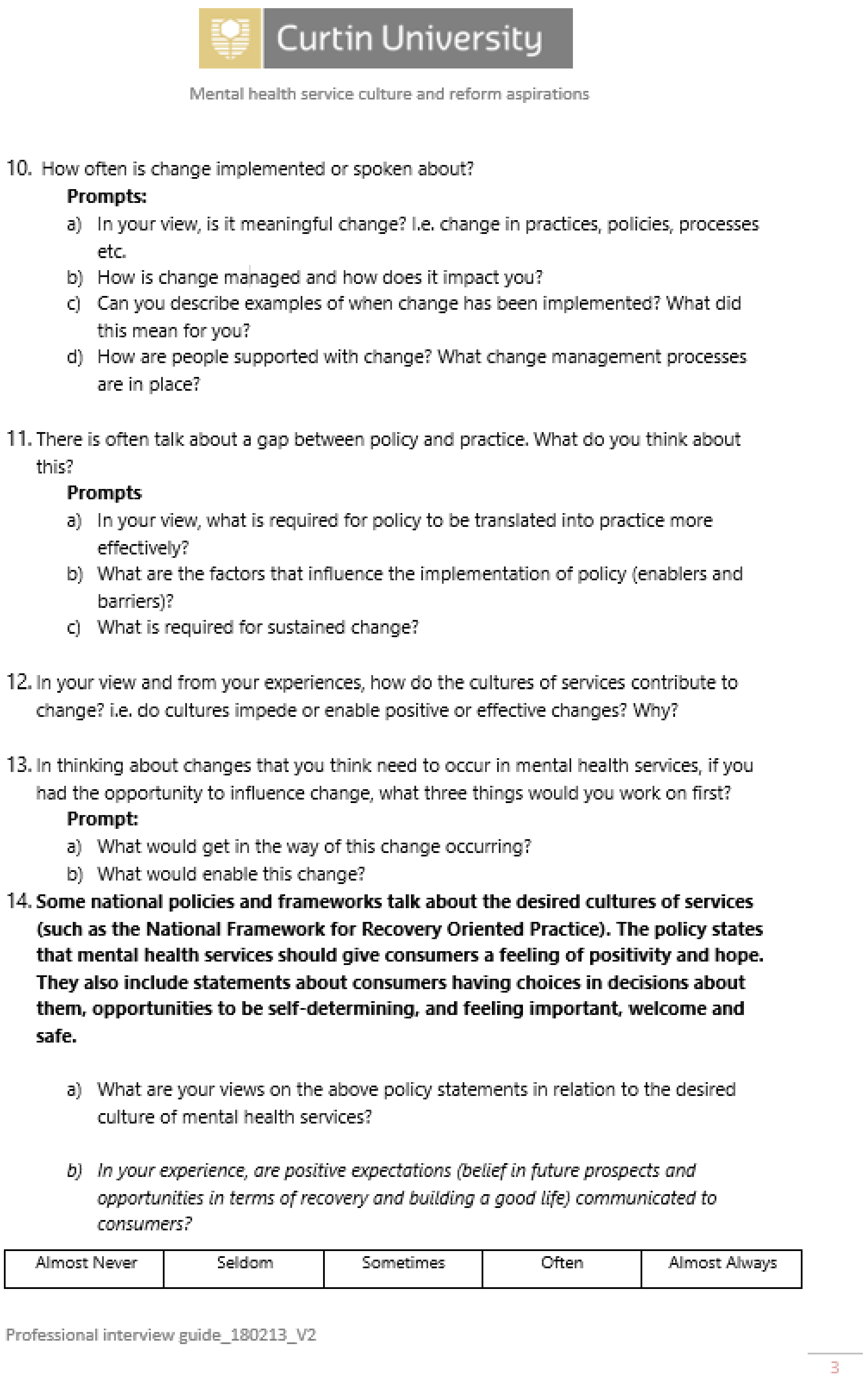
   Prompts:
   a) Do you think services are responsive to consumer experiences, self-defined needs, concerns or feedback?
   b) When thinking about the involvement of consumers in their recovery, care or treatment plans, what comes to mind? When might consumers be involved? What gets in the way of involving consumers?

8. How do you think families, carers or supporters experience mental health services?

   Prompts:
   a) How do you think services generally respond to families' experiences, self-defined needs, concerns or feedback?
   b) When thinking about the involvement of families/supporters, what comes to mind? When might family members be involved? What gets in the way of involving family members?

9. In regards to your practice, what guides, informs or reinforces your practice? For example: are their specific policies or frameworks, principles, supervisors or colleagues, research, professional training or development?

   Prompts:
   a) In what ways is your practice influenced?
   b) What are your views and ideas about current mental health policies (national, local and specific to your organisation)?
   c) Are policy directives visible in mental health services **Yes/No**
   d) How do they inform the operation of services?



10. How often is change implemented or spoken about?
    Prompts:
    a) In your view, is it meaningful change? I.e. change in practices, policies, processes etc.
    b) How is change managed and how does it impact you?
    c) Can you describe examples of when change has been implemented? What did this mean for you?
    d) How are people supported with change? What change management processes are in place?

11. There is often talk about a gap between policy and practice. What do you think about this?
    Prompts
    a) In your view, what is required for policy to be translated into practice more effectively?
    b) What are the factors that influence the implementation of policy (enablers and barriers)?
    c) What is required for sustained change?

12. In your view and from your experiences, how do the cultures of services contribute to change? i.e. do cultures impede or enable positive or effective changes? Why?

13. In thinking about changes that you think need to occur in mental health services, if you had the opportunity to influence change, what three things would you work on first?
    Prompt:
    a) What would get in the way of this change occurring?
    b) What would enable this change?
14. **Some national policies and frameworks talk about the desired cultures of services (such as the National Framework for Recovery Oriented Practice). The policy states that mental health services should give consumers a feeling of positivity and hope. They also include statements about consumers having choices in decisions about them, opportunities to be self-determining, and feeling important, welcome and safe.**

    a) What are your views on the above policy statements in relation to the desired culture of mental health services?

    b) *In your experience, are positive expectations (belief in future prospects and opportunities in terms of recovery and building a good life) communicated to consumers?*

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this? Are there limits to this positivity, future opportunities and prospects?

c) *Do you think services promote hope and optimism?*

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

d) *Do consumers have choices and opportunities to be self-determining?*

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share a little more this? What opportunities are provided in regards to choice?

e) *Do you think consumers feel welcome, safe and important?*

Almost Never	Seldom	Sometimes	Often	Almost Always

Can you share some more about this?

15. **Vignette question**

Vignettes are description or stories based on true experiences. They can be useful in providing a deeper insight into the underpinning values and ideas of particular circumstances. This vignette is very broad, however the focus is on your interpretation of consumer experiences within this services:

> *Peter has been accessing services at different times for approximately ten years. Peter's first experience involved an inpatient stay of six weeks when he was 21 years old. He received a Community Treatment Order for three months following his discharge. Peter was hospitalised again seven weeks ago, and has recently been discharged and is living at home with his family. During his discharge meeting the hospital social worker stated that he will refer Peter to a community mental health service. Peter is described as being quite 'difficult' by some of the staff at mental health services in his area. Currently Peter is feeling very intense anger, at times out of control and like no one is listening to him.*

a) If Peter was a consumer (or patient) in your service or under your care, what would you consider most important to consider?

16. Do you have any other comments about mental health services, service culture or anything else you would like to say?