Unsettling the risk discourse: A dialogical narrative analysis of stories from CAMHS

Professional Doctorate in systemic practice and research

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ABSTRACT

The inadvertent harms stemming from risk management practices in mental health services have been widely highlighted, indicating that a change in approach to managing risk is required. However, suggested changes have tended to disregard the fact that risk is not merely a set of practices, but a discourse. This means that broader questions need to be posed to understand its power and influence; to see not simply what risk *is*, and how to tackle it, but what risk discourses *do,* and what they may be inhibiting. This study contributes to a body of literature that is concerned to locate discourses of risk within a wider cultural and political context.

The stories of 6 people who have either lived or worked with a young person perceived to be ‘at risk’ of self-harm or suicide within Child & Adolescent Mental Health Services (CAMHS) are analysed using the methods of dialogical narrative analysis. The analysis reveals the multiple discourses at play shaping and influencing how clinicians and families respond when situations are perceived to be risky. The risk discourse is seen to create contradictions that are incompatible with prioritising safety - serving the needs of organisations as opposed to service users or clinicians.

The findings indicate that connection, dialogue, and the sharing of expertise, not the eradication of risk, can be important in supporting people to live through difficult and unsafe times. The study concludes that changes need to be considered at a relational level if spaces of resistance to the dominant risk discourse are to be found, and a reframing of expertise is explored as one such potential site. A counter discourse of relational interconnection is thereby offered as a way to foreground safe contexts and safe relationships, as opposed to ‘risk-free’ individuals.

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Chapter 1: Introduction

1.0 What is this research about and why is it needed?

Working in mental health services sparked my interest in the different ways people perceive, manage, and respond when situations or people are experienced as being exposed to danger or as posing a danger. Practices have been developed and utilised in an attempt to turn unknown, potential threats into knowable, quantifiable, predictable risks. Risk, in this way is not a ‘thing’, it is a way of managing uncertainty, with the intention to protect (Van Asselt, 2000). However, my experiences have shown me that many of the risk approaches that are utilised in mental health services do not necessarily leave those deemed to be ‘at risk’, feeling safer. In fact, sometimes they leave them feeling less safe.

Risk assessment and management are the procedures through which mental health clinicians are tasked to identify and reduce risk through a mix of actuarial methods (statistical ways of combining information to calculate risk) and clinical judgement (Ahmed, et al., 2021). The actuarial model of risk focuses on future potential for harm and loss, but it can also serve to retrospectively allocate blame (Douglas, 1992) when risk results in harm occurring. Concerns have been expressed that clinical practice has become dominated by organisational models of risk management at the expense of meeting the patient’s health and social care needs (Godin, 2004). These models underestimate the complexity of mental health care in terms of the range of skills and expertise required to deliver care safely (Taylor-Gooby & Zinn, 2006). This leaves clinicians managing a precarious balance between promoting empowerment and safety, and managing fear and the potential for blame.

Furthermore, mental health policy has continued to stress that clinicians need to be competent to identify and minimise risk, whilst offering increasing levels of caution about the ways in which this is undertaken (Morgan, 2007). The approaches, tools and practices often employed in the assessment and reduction of risk have been subjected to concern and critique, highlighting the iatrogenic harms such practices can entail - diminishing the voices of service users (Felton et al., 2017) and engendering defensive practices that prioritise clinician safety (Wand, 2017).

Mental health services operate within a dominant and established discourse of risk and the influence this exerts, across multiple levels, has rarely been sufficiently considered. Therefore, the complexity that the issue of risk and its practices poses needs to be acknowledged and addressed, and this is one of the key aims of this study. There is an assumption that focusing on risk provides an effective route to safety. However, a strong case can be made that it is the risk discourse itself that is paradoxically making certain people less safe. This research study will thus aim to subject the risk discourse to further scrutiny, to understand both its effects, and its relationship to safety.

1.1 Personal motivations and influences

Early in my career two incidents occurred which left me questioning and doubting the practice of risk assessment and management. I qualified as a mental health nurse in 2001 and my first job involved working on an acute inpatient adult mental health unit in London. I finished my nurse training with the belief that if I employed the knowledge and skills acquired, that I would be able to keep people safe, that I would know when risk was lurking – it was a core competency for mental health nurses to be able to assess, manage, and reduce risk. Within that first year, two catastrophic events occurred; one involved a patient on the unit assaulting one of the nurses, the other was a young woman who ended her life by stepping out in front of a train.

Both incidents were shocking and devastating, there had been no obvious warning signs, no visible triggers, no history of such behaviours – making sense of it was hard. I was left feeling that my skills, knowledge, and training had let me down and it was impossible not to wonder whether a different approach, a different emphasis could have produced a more satisfactory ending. The doubt that lingered kept me alert to the huge amount that remains unknowable about people's lives, inner turmoil, and pain. I believe this served to influence a developing interest in the therapeutic potential found within relationships and this eventually saw me embark on the 4-year systemic and family psychotherapy training.

1.2 My professional identity

This inquiry has been undertaken as part of a professional doctorate in systemic practice and research, and my professional identity, and all this entails, is intimately woven throughout the project. My systemic training has had a huge impact on all aspects of my life – it has not been an identity that I am able to switch on and off – it has become an integral part of who I am, influencing how I think, the values I embody, and my ideas about how to be with people. As a systemic family therapist there exists an ethical requirement to apply a critical approach to even our best loved and favoured models and theories – in the words of Vicky Reynolds (2012) – critique is a gift that brings us back to ethics. I am also hugely influenced by Harlene Anderson (2012), significantly when she reminds us:

"The call is simply to propose that any knowledge – and discourse – should be subject to question or doubt regarding its claim to truth" (p10).

This research inquiry is, in part, a response to that call.

As a profession, systemic family therapists do not tend to fit neatly into the world of mental health services, perhaps significantly because our models and approaches are not predominantly underpinned by theories from health, science, or psychology, but more from philosophy, social science, anthropology, linguistics, and politics. Systemic family psychotherapists (SFPs) resist dominant truths and are critical of modernist doctrines; instead, they value multiplicity and difference and see every contribution as worthy – this can all present as a delicate balance to maintain. SFPs generally agree on the vital importance of context and relationships in how people make meaning in their lives, and how they come to know themselves. It is not possible to know oneself outside of context – it is seen both as what shapes and what reveals us.

1.3 Systemic family psychotherapy and risk

The systemic community seems to exist in an uncomfortable relationship with the risk discourse, and as a profession our position is often to question its certainty. Risk seems to require decisive, confident responses to take place within contexts of potential danger and uncertainty. Systemic thinkers know only too well the chaos and complexity inherent in our social worlds, and these requests for certainty are seen as unrealistic and unobtainable. Systemic research in the field of risk tends to focus on, and illustrate, how systemic approaches can be helpful in supporting families who find themselves in contexts of risk (Hartnett et al., 2016; Frey et al., 2020; Lear & Pepper, 2018; Boston, 2011).

There is a small amount of systemic literature that explicitly exposes the tensions and contradictions in responding to risk (Mason, 2019; Aggett & Messent, 2019; Hurst, 2011). This systemic body of literature broadly shares a commitment to relational-collaborative approaches, a resistance to certainty, acceptance of doubt, and the need to maintain a breadth of perspective to keep the organisational and cultural context in full view. Aggett & Messent (2019) stress the need for bridges to be built between the technical and relational approaches to risk, so that its ‘messy bits’ (p 644) can be laid bare and addressed, allowing for the incorporation of hunches and intuitions into the assessment and management of risk. The authors acknowledge the fallacy inherent in risk practices and advocate for a re-conceptualisation of risk management as a collaborative conversation with shared responsibility.

However, these changes of approach, accommodations, re-positionings, are all expected to take place *within* the dominant risk discourse, with no consideration of the barriers this discourse may exert. Ungar’s work (2001; 2014) does offer a more explicit challenge to the dominance of discourses that yield power and manufacture, pathologise, and limit stories of identity:

“Individuals and communities described as being at-risk or high-risk invariably understand how these descriptions stigmatize them” (2001, p62).

Ungar sees the ‘high-risk’ story as one that requires deconstructing if the conditions for the emergence of an alternative ‘health-enhancing narrative’ (p67) are to be established. He seems to be suggesting that risk discourses may be keeping people risky, and he advocates for a narrative approach to generate alternative forms of self-identity for young people – less ‘risky’ identities engender safer lives. The potential challenge to achieving this for Ungar is whether this *“new shape of meaning is serviceable within the social arena outside these confines"* (p. 218). I believe the point he is making is that the cultural view on risk may not permit these alternative identity stories to flourish. For Ungar certainly, there are barriers in place. My intention, through this research, is to expose and overcome some of these barriers.

1.4 Thesis overview

In Chapter 2, I define and explain how risk functions as a discourse. It is not sufficient to focus on what risk in mental health *is* or what its practices consist of or entail, but to determine what it *produces and inhibits*, and primarily, *who benefits*. I will draw on some of the important contributions social science has made to highlight how risk management can be viewed as a complex social process operating at individual, group, organisational and societal levels.

I will also consider in Chapter 2, the mental health context and the development and nature of the ideas, theories, policies, and research that have come to shape the business and ideology of mental health services and the management of risk. I will show how services often rest on contested philosophical foundations, lacking consensus or clarity over what mental ill health is. Mental health frameworks are important to consider as they will inevitably influence how ‘risky individuals’ are constituted, and how they are responded to. This is the context where the risk discourse is enacted, and it is therefore beneficial to think about how the interdependence of context and discourse is mutually reinforced.

To make the risk discourse visible also requires a more in-depth consideration of its impact, and this is achieved by focussing in on the stories from people who have been intimately affected by its practices, who are bound-up within its ideologies. The participants in this research study have either been subjected to the risk discourse (service users) or have had to practice under its dominance (clinicians).

In Chapter 3, I describe how I went about 'capturing' and making sense of these stories through the framework of dialogical narrative analysis, a methodology that enables stories to 'breathe' by questioning the work that stories do. I also explain my epistemological position - that of active participant in the research, inevitably shaping, and influencing the process. An ethnographic encounter undertaken within a crisis mental health team is shared in Chapter 4 which attempts to make myself visible as a researcher and gives a personal insight into how the context shapes risk practices on the front line of mental health services.

Chapter 5 proceeds to tell the stories of the participants - Becky, Karen, Cathy, Patrick, Sarah, and Laura. Notions of fear, expertise, responsibility, and blame emerge, as do discourses of measurement, personal agency, identity construction and individualism. Their stories highlight some of the limitations and contradictions imposed through the dominant risk discourse. Yet amidst the challenges, emerges a counter discourse, and Chapter 6 describes the threads of possibilities that both unsettle the dominance of the risk discourse, and ultimately offers alternative ways of 'being' when living and working under threat and uncertainty. I go on to suggest that through a reframing of expertise, a counter discourse of interconnection emerges – a discourse which foregrounds the development of safe relationships, as opposed to focussing on reducing risks. I conclude that operating within a discourse of relational interconnection is what will make life more liveable, and ultimately safer, for those who practise within mental health services, and for those on the receiving end of those practices. Ideas from the field of family therapy and systemic practice are shared as a way of maintaining this much needed relational and ethical orientation.

Chapter 2: Context and literature

2.0 Introduction

Beck (1992) argued that modernity and wealth has allowed for the formation of a 'risk society' which is negative and defensive in its ethos; we are no longer concerned with attaining something good, but with preventing the worst from happening (p34). It is perhaps then no surprise that the field of mental health is deeply implicated in managing risk with the identification and assessment of risk behaviours a central task of practitioners.

As described above, SFP has an uneasy relationship with the hegemonic discourse of risk assessment – that is, risk seen as a predictable and measurable entity whereby the role of mental health experts is to expose and control it. Concerns are also growing outside of the systemic field. The National Confidential Inquiry into Suicide and Homicide (NCISH) (Appleby et al., 2018) stated that despite a great deal of research on the subject of risk assessment in the field of mental health, not enough is known about what it feels like to be on the receiving end of risk management plans, what positive risk management really looks like and how it can be achieved, what a risk formulation is, and how organisations can improve the way they think collectively about risk; many questions and concerns remain unanswered.

The recent commentary regarding risk assessment practices has been rife with scepticism and criticism regarding their efficacy (Morgan & Large, 2013), with explicit calls made to broaden and develop how risk practices are being carried out that supposedly identify and anticipate future harms (Large et al., 2017). It has been argued (Turnell & Edwards, 1999; Aggett & Messent, 2019) that approaches to risk management fail to address the complexity of risk in the context of mental health, or to explore the implications for affecting change when organisations are situated within, and influenced by, a dominant risk discourse (Hardy & Maguire, 2016).

What is therefore required for meaningful change to occur, is the recognition that debates about risk inevitably involve and require there to be debates about politics, culture, and discourse (Douglas, 1994). Engaging in such debates could bring some understanding as to why it may be difficult for mental health services to make the required changes, even when current risk management practice has been shown to be at best, ineffective, at worst, harmful. Risk is not a neutral practice or concept, but it should be about ensuring protection from harm. I will show in this chapter how this intention to protect has been impeded, resulting in an increased focus on managing secondary risks to provide layers of ‘pseudo-comfort’ (Power, 2004, p50) to clinicians, organisations, and society.

This literature review will consider the concept of risk and significantly, how it functions as an organising principle of discourse. I will explore how risks are constructed through the language used to describe them, how these constructions are maintained (Haggett, 2004, p1), and whose interests they serve. I will argue that it is only through this broad consideration that answers will be found as to why it may be difficult to change risk practices when positioned within risk discourses (Petersen, 1996; Green, 2009).

2.1 Understanding discourse

Discourse as a concept has been defined as a set of *“practices which systematically form the object of which we speak”* (Foucault, 1972, p49) and in this way discourse goes beyond representation in that it *produces* something, a particular version of events (Burr & Dick, 2017). Foucault argued that it is only through discourse that anything can be meaningfully spoken about, and discourses do not just reflect or represent social entities and relations, they constitute them (Fairclough, 1993; 2007). In this way, institutionalised bodies of knowledge are able to gain the status and currency of ‘truth’, and alternative discourses that might challenge or resist the status quo are squeezed out (Fairclough, 1993; 2007).

A dominant discourse is therefore extremely powerful as it shapes our understandings of ourselves and others. Different discourses will position people in different ways as social subjects - ideas are influenced, put into practice, and used to regulate the conduct of others. Discourses in this way are about ‘being kinds of people’ (Hacking, 1986) as they enable us to understand each other through our shared conventions about how to use and interpret language. Discourses both preserve certain ways of conceiving the world and inhibit others.

Describing risk as a discourse emphasises how its meaning has been created through the communities and practices which have put it to use, for specific reasons and with particular consequences. To think ‘through’ discourse therefore helps us to overcome the distinction between language and practice (Hall, 2001; Bacchi & Bonham, 2014). To understand risk requires an understanding of society, institutions, governments, community groups, professions etc, and how they intersect with each other, contest with, or align with each other, in complex ways (Gee, 2014). Discourse is a product of communication, but also shapes communication; it reflects, constrains, and forms thought and behaviour, serving as a primary instrument of ideology.

2.2 Governmentality

In ‘Discipline & Punish: The birth of the prison’ (1977), Foucault outlines the power inherent in practices of normalisation and discourse, operating as they do as instruments of modernity through which the body of the ‘mentally ill patient’ becomes categorised, measured, segmented, and examined. Foucault addressed the way in which the power of government could be seen as a decentred process whereby control, power and discipline were fragmented amongst multiple agencies and exercised through a variety of institutions, strategies, and technologies, such as the discipline of psychiatry and discourses of risk. Governmentality thereby directs attention to the different ways the conduct of ourselves, and others, is governed (O’Malley et al., 2009).

Castel (1991), drawing on the ideas of Foucault, questioned the shift within psychiatry from dangerousness to risk and sought to understand what this signified. He argued that for psychiatry, risk essentially meant *“the danger embodied in the mentally ill person capable of violent and unpredictable action”* (p283). The repercussions of falling into the ‘trap’ of viewing danger as embodied within a concrete individual, meant exposing oneself to blame when mistakes were made. Danger began instead to be seen as resulting from a combination of abstract factors which rendered the occurrence of undesirable behaviours more or less probable.

Preventative policies were developed to allow these deviant behaviours to be anticipated and avoided. This new mode of surveillance was no longer focused on individuals but on statistical correlations, and factors liable to produce risk. Castel (1991) argued that the primary aim of prevention was to anticipate all possible forms of danger; it was no longer necessary for a person to manifest symptoms of dangerousness or abnormality, it was enough to display whatever characteristics had been constituted as risk factors (p 288). This quest to eradicate risk signalled the need for absolute control and through these preventative methods a mass of new risks were produced. Castel (1991) highlighted the inadequate consideration that has been given to the human and social costs of these iatrogenic aspects of prevention.

Risk discourses allow for certain threats to be identified as ‘risks’ for particular people. ‘High-risk patients’ and ‘high risk populations’ become a legitimate source of moral concern, and therefore subjects of scrutiny and control (Undrill, 2007). These disordered, deviant, unsafe bodies reinforce the power hierarchies tasked to maintain social order (Richardson, 2000). The politics of mental health tells us a great deal about the ways in which we understand and govern those who are seeming to fail at living a normal life; normality being that which does not require expert intervention (Rose, 2019).

The construction of service users as ‘objects of risk’ is influenced by professional, organisational, and social contexts (Felton, 2015). Practices thereby comprise an essential element in the construction of the system. The structures of discourse function ideologically which allows for practices to be seen as ‘natural’, universal truths, maintaining unequal power relations (Fairlcough, 1993). Yet discourses are opaque, and their effects can remain unnoticed and accepted uncritically.

2.3 Social theory

Social science research on risk is a growing field that has much to offer health care services but appears to be insufficiently utilised, perhaps due to the need for quick and easy solutions to policy problems and the dominance of biomedical science. Much of the risk policy in mental health has failed to sufficiently consider the epistemological foundations underpinning the concept of risk. Policy tends to locate risk in a positivist paradigm – a domain which emphasises the significance of the external world rather than the person's interpretation of it. Risk becomes a 'thing' in the world that we can identify, evaluate, and control.

Conversely, from a constructivist epistemology risk is described as a construct and science as entirely social (Van Asselt, 2000). Risk is therefore slippery and fluid, and people are seen to function as active players in its creation and analysis. How risk is perceived and mitigated is thus unpredictable and subject to individual bias (Seno-Alday, 2018). From this epistemological position the act of perceiving risk changes it, and research highlights how different factors alter risk perception and thereby our variable responses to it (Hsee & Weber, 1999; Wildavsky & Dake, 1990). Constructivism rejects that there is an unbiased reference point and instead sees all knowledge about the world as being influenced by how people experience and describe the world; we have learnt how to create and define risk.

The anthropological research on cultural bias suggests that individuals do not make independent choices, for example organisations will place perceptual blinkers on individuals, suggesting that risk perception should be studied as an institutional effect (Beck & Wynne, 1992). In this way physical risks are seen as created and performed within social systems, implying that the extent of the risk is therefore a direct function of the quality of the social relations and processes - not something residing within an individual, preparing itself for enactment. Where there is risk taking and risk aversion, there will be a manifestation of shared confidence and shared fears, shaping the dialogue on how best to organise social relations (Douglas & Wildavsky, 1983, p8). Risk assessments target ‘risky individuals’, but this becomes problematic when risk is seen to exist in a relational realm of possibility, not reality (Renn, 1998; 2017):

“Risks are conceptually uncontrollable; one can never know whether one is doing enough to prevent a hazard from occurring. Even after a hazard has occurred, one is still left with the question of how much more action would have been necessary to have prevented it, and whether such action would have been within the bounds of ‘reasonable behaviour’” (Jerome Ravetz, 1980, p47).

This social perspective on risk indicates that any calculation of risk becomes a cultural construction (Zinn, 2009). It is therefore futile to study risk perception without taking culture into account; the question about risk must be: how safe is safe enough, for this particular culture (Douglas, 1994), or organisation, or family, or clinician, or person? For example, a patient may end up being detained under the Mental Health Act because managing them in the community creates unendurable levels of anxiety for the clinicians, even though it may not be in the best interests of the patient. Once risk is understood as a culturally dependent phenomenon, the tension between risk and its perception cannot be resolved (Zinn, 2009).

Luhmann (1998) questions whether reaching a social consensus is even possible when each prediction about the future serves as a reminder that something is not known. Decisions can only be made in the present, and every decision – even the decision not to decide anything - is inherently risky. For Luhmann (1993) risk presupposes a decision and it is this that distinguishes it from the concept of danger; agency and decision making become highly relevant for understanding risk. Yet the uncertainty and fallibility of risk prediction becomes a problem that *“cannot be overcome by more and better knowledge, more and better science”* (Beck 2009, p115). This is evident in the phenomena, the failure of invariance (Kahnerman & Tversky, 1984) whereby estimations of risk can be manipulated by changing the reference point. Undrill (2007) gives an example of this in which a clinician’s risk assessments become more cautious and risk averse for some time following a patient taking his own life. This suggests that assessing risk to reduce harm, becomes little more than highly complicated, deeply contingent, and biased guess work.

The risk field more broadly has worked to reconcile positivist and constructivist views on risk and to incorporate socially informed approaches and discursive methods to support theoretical and methodological developments that expand understandings (Taylor-Gooby & Zinn, 2006). As risk practices become more accurately understood through a constructivist lens and risk is recognised as being a complex matter, the mental health field would do well to pursue more cross-disciplinary approaches. Understanding more about the history and context of mental health, and what shapes and constructs its ideology may help us to see why reaching out to other disciplines presents as a challenge.

2.4 Risk’s beginnings

It was in the 18th and 19th century that the ‘insane’ began to be seen as posing a threat, resulting in public protection becoming a core function of psychiatry. ‘Madness’ was seen to require a firm hand, resulting in insulin comas, shock therapies, forced incarceration, restraint, and psychosurgery – practices that became symbols of psychiatric oppression by the 1960s (Scull, 2015). Psychiatry was described as an institution of coercion and discipline (Foucault, 1965) and well into the middle of the 20th century the British government was still calling for greater inpatient provision.

The contradictions experienced between control, punishment, protection, and compassion continue to operate at the heart of mental health service provision (Felton, 2015). The order of the discourse of risk became structured around protection and control that maintained a power relationship whereby those with the power could exercise and keep it through coercion or consent, sustaining and legitimising the power relations between clinician and patient.

Suicide became the domain of medicine only at the beginning of the 19th century - there was the noble suicide, the suicide of honour, but all the rest were regarded as part of the new medicine of insanity (Hacking, 1986). The majority of people who come into contact with mental health services will be subjected to a risk assessment to determine if, and how much risk they may pose to themselves or to other people. Sometimes they will be aware of this taking place, but not always. This assessment is often what shapes decisions over the services and priority afforded and thereby works as a discourse of exclusion/inclusion. The assessment will also determine whether a person should be treated in the community or as an inpatient, whether they should be detained against their will under the Mental Health Act, be medicated, and generally how concerned everyone should be.

Anxiety is what Michael Power (2004) claims drives the need to risk manage, as internal control systems are put to use in a misguided attempt to manage the unmanageable, due to demands for:

“a procedural and auditable set of practices because control must be made increasingly publicly visible and because organisational responsibility must be transparent” (Power, 2004, p41).

Anxiety and fear thereby exert a powerful force that is both produced by, and reinforces risk discourses; overlapping, intersecting discourses of blame and responsibility become visible. Managing risk in mental health services requires that sense can be made of the relationship between risk and ‘mental illness’. If there is no ‘mental illness’ present, then the threats are generally seen as being ‘someone else’s problem’ (e.g. social services or the police), and therefore risk and ‘mental illness’ implicate one another. Establishing the nature of this relationship is extremely challenging when they are both complex and contested territories, but it is important to attempt to do so when subject positions are established and maintained through the discourses of mental health and risk. By taking up the position of ‘mental health patient’ one will be subjected to a range of discourse conventions, such as being ‘risk assessed’, or defined as mentally ill, that are legitimised through orders of discourse embodying ideological assumptions.

2.5 Conflicting definitions and emphases

Mental suffering within mental health services is predominantly viewed in the UK as being a ‘health’ issue rather than a ‘social’ issue, although this has been frequently contested (Szasz, 1972; Hacking, 2002; O’Sullivan, 2022; Foulkes, 2022). As a health issue, mental illness is seen through a biomedical or psychological lens whereby the problem arises from faulty processes or abnormalities occurring within the individual. Mental illness becomes a disease or a physical defect, commonly engendered by faulty brains or genetics (Bracken et al., 2012), or as a result of our inability to cope with what life is throwing at us – our lack of resilience, or tolerance. In this way it is likely to be the individual that is seen to need 'fixing', improving, or making safe. Thus, the individual is constructed as a stable, coherent, knowable self, and medical science as the paradigm from which all useful forms of knowledge can be provided.

Over several decades there have consistently been requests to widen the lens through which mental health distress is viewed, understood, and responded to, with varying levels of success (Fanon, 1963; Foucault, 1965; Bateson, 1972; Deleuze & Guattari, 1987; Hacking, 2002; Rose, 2019). One aspect that has been critiqued is the individualistic, biomedical view of mental illness (Davies, 2021). This is the dominant discourse within mental health services, which has been accused of *"medicalizing the ordinary travails of human existence"* (Conrad & Schneider, 1992, p20; White, 2017), through the arbitrary construction of disorders which define the boundaries of normality and abnormality.

Nothing short of a revolution in mental health is what has been called for (Kinderman, 2019; Boyle & Johnstone, 2020), requiring a paradigm shift that entails a fundamental change in the concepts, assumptions, and practices of a scientific discipline. The discourse of individualism has powerful implications for how people come to view risk, bringing the focus onto the 'object' at risk – constituted as vulnerable, ill, and in need of protection. Attention is instead drawn away from the structural factors that generate risk, vulnerability, and emotional suffering.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) provides a categorisation of psychological and emotional experiences explained through a medical framework (Rose, 2019). This classification system has been subjected to deep criticisms, with one of the most striking delivered by Thomas Insel, the director of the National Institute of Mental Health (NIMH)—a powerful public sponsor of mental health research, who referring to the DSM-5, stated that:

“The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not on any objective laboratory measure” (2013).

This critique holds particular importance as it comes from within the mental health field and the scientific community. It was felt to have huge implications for the place, role, and impact of mental health diagnoses (Pickersgill, 2013), but despite this, diagnoses remain powerfully embedded in service delivery. Diagnoses are sometimes viewed as enabling people to develop a better understanding of themselves, their symptoms, and to direct treatment options. In this way diagnoses are considered to guide research, they underpin the entire opus of evidence-based practice and are intricately intertwined within the structures and policies of mental health services (Craddock & Mynors-Wallis, 2014).

However, emotional turmoil is more socially intelligible than the biomedical model allows for (Laing, 1967). Approaching mental illness as a social phenomenon, as opposed to a health issue, draws attention to the social context being faced, viewing mental illness as a breakdown in response to overwhelming environmental stress (Thoits, 2012). The key distinction between a health or social perspective is that in the former, the determinants of mental illness are internal to the person, in the latter, the cause is external. Wilkinson and Kleinman (2016) introduced the phrase ‘social suffering’ which invited us to see the importance of understanding human suffering as taking place beyond the boundary of our individual form. They state that:

"Human suffering takes place both in the experience of disruptive events that crash into our lives and as a contingent product of cultural worldviews and social conventions that are rooted in historical and material circumstance" (p17)

Through this understanding, when human suffering occurs our "*social world is torn" (p9)* and the embodied experience which ensues, *"signals that something very bad is taking place and that there is something terribly wrong with our world" (p15).*

This resembles Szasz's (1961) argument when he claimed that the concept of mental illness is a myth and asserted that those who suffer from a mental disease are actually suffering from severe problems of living. Social theories of mental illness are often critical of the effects of labelling or categorising someone as 'mentally ill', labels which are seen as debilitating to one's growth and development (Smith, 2012).

It would be rare to find a clinician who would refute the influence of the social dimensions of mental health, and it seems clear given the polarised views from academics and clinicians, that there is no single lens – biological, psychological, or social - that can completely explain the causes of mental suffering or guide the required responses. Yet the systems of modern medicine leave little room to incorporate this complexity and uncertainty into practice (O'Sullivan, 2022).

Research is needed to ascertain why mental health services are not responding to the evidence suggesting the need for frameworks that are more socially informed, and I will endeavour to explore, through this research, the consequences that this holds for practice. How mental distress is defined, understood, and responded to will inevitably influence how the 'risky individual' in mental health services is conceptualised and 'made safe'. These notions will limit and shape the extent to which risk practices are able to shift and change - they are fundamentally intertwined, and yet their mutually influencing relationships have been insufficiently considered.

2.6 The research context

Boholm's (2016) linguistically focused research on risk, language, and discourse proposed that although there is only one unified concept of risk employed by society, this concept continues to produce a diverse articulation of risk issues, giving rise to different instantiations. This serves to yield a range of assumptions and interests resulting in risk discourses holding irreconcilable positions regarding what is danger and safety, who is responsible, what values are at stake, who the decision maker is and how to act, and what counts as scientific evidence. The research studies below have therefore been considered in order to describe and name the different discourses that are discernible within the dominant risk discourse and to highlight the contradictions engendered. There is a need to expose these different discourses and how they shape collective understandings and to explore the implications raised for practice.

Janse and Wath (2020) undertook an integrative review of the literature on the use of risk assessment tools within mental health services. The authors claim that risk assessments are integral to identifying treatment needs and for the delivery of safe care. Determining risk is described as challenging and subjectivity as misleading - a problem to be overcome. Despite this it is still seen as desirable and possible to calculate and control risk through the employment of the correct range of approaches and tools. The epistemological orientation is one of positivism whereby risk can be accessed as if it is an objectively knowable phenomenon. A discourse of measurement, tools, and quantification emerges whereby variability and discrepancy are solvable by employing standardised, formal, and informal screening tools.

A systematic review on suicide and self-harm risk assessments published by Saab et al (2022) offers a critique to this discourse of measurement by highlighting the lack of empirical evidence to support the efficacy of risk assessment tools. The authors argue that contemporary discourse in the patient safety literature on risk assessment tools needs to undergo a paradigmatic shift, as focusing on risk assessment tools may deter the development of alternative, more helpful frameworks. Their conclusion is that the discourse in relation to risk assessment requires a broader discussion to take place around the safety of patients. Kapur and Goldney's (2019) work on suicide prevention further reinforces this when they request that the risk assessment 'fallacy' be acknowledged, whereby assessment tools are recognised as serving the interests of organisations as opposed to patient need.

Another study which offers a critique of the measurement discourse is Wand's (2011) review which sets out to determine whether there is any evidence demonstrating the effectiveness of risk assessments in mental health care. The review exposed the serious limitations in clinicians' ability to predict aggression, violence, self-harm, and suicide, a factor which Wand argued questioned the integrity of mental health legislation, when it is largely based on the ability to determine a level of dangerousness indicating risk to self or others. The capacity of the risk discourse to deliver the quantification and measurement of danger is left looking questionable.

Felton's (2015) case study research also raised important questions regarding the objectification engendered through the risk rhetoric and how this results in risk assessments and management becoming a process of statutory control. Mental health service users, in being subjected to these processes are defined and constructed as objects of risk, creating a moral distance between patients and clinicians. The repercussions of this were captured in Lindgren et al.'s (2021) literature review which synthesised young people's experiences of self-harm. Healthcare professionals were described as often drawing rapid conclusions that served to leave young people feeling diminished, stigmatised, and questioned. They urged professionals to learn the language of young people who self-harm, if they were to break the cycle of suffering.

The notion of responsibility is discernible within the structure and practices of risk discourses in Clee & Aranda's (2020) study. They explore the experiences of CAMHS nursing staff working with young people engaging in self-harm or suicidal behaviours, and their research reveals the emotional burden that the responsibility for managing risk exerts, leading to anxiety and burn-out. The nurses are seen as being responsible for creating safety, and the solution to 'burning-out' also rests largely with them – they need to be equipped with better ways to cope with the risk burden.

In Derblom et al (2021) the responsibility felt by the nurses is placed alongside that of the patients' – they are seen as needing to be allowed to step into positions of responsibility. This study looks at nurses' experiences of assessing suicide risk in CAMHS – a task that is described as frightening and demanding – leaving them feeling responsible for another's life and worrying whether their judgement has been correct. The study embraces the complexity of assessing risk – it is not seen as being an objective, measurable process. The measurement tools cannot provide the answers nor reassurance around decision making. Instead, what the nurses are left with is their intuition, which is described as decisive, yet undefinable, alongside the need to create a positive nurse-patient alliance through collaborative dialogue.

It is interesting that the study's conclusions then stress that it is the lack of knowledge, and absence of structure, training, and clear guidelines that inhibit the nurse's ability to safely assess the risk of suicide (p782). A discourse of responsibility is emphasised and grows more powerful and challenging to inhabit when the nurses are no longer able to rely on objective, quantifiable assessments of risk to support their decision making. Beck (2009) asserts that: *"risk always involves the question of responsibility"* (p8) and so responsibility, like risk, functions as a powerful regulatory tool, defining the limits and borders of individual action (Gianni, 2018).

These studies show how risk practices that promote discourses of responsibility and measurement exert an often-intolerable effect on practitioners who are unable to predict risk with any level of authority or certainty. Clee & Aranda (2020) emphasise how blame cultures come to flourish with blame being levelled at clinicians, organisations, or patients. Discourses of responsibility become a powerful way of managing and apportioning blame. What is also clear is that practices operating within these discourses do not consistently promote patient safety, and their use can leave service users feeling unheard. The NCISH (Appleby et al., 2018) found that only 53% of participants felt listened to during the process of risk assessment:

"They are ticking off criteria in their heads robotically in their anxiety not to get it wrong, not to make the wrong decision. The only words they hear are risky ones, they do not hear my despair or existential panic, or my shame, my need for human connection and safety. What would happen if the aim here was not to avoid a 'risk event' but to address and reduce pain and suffering?" (Emma Standbrook, 2020).

Emma is advocating that clinicians step outside of the order of the risk discourse. As discussed above, there is strong evidence to suggest that this is not a choice that is generally experienced as being available. Yet the point that Emma is making is that safety sometimes requires a different response, a different focus. That discourses of risk provide structures and practices through which to bring safety is an assumption that appears to rest on contested ground.

2.7 Policy context

Policy cannot be neutral but, explicitly and implicitly, categorises and constructs people (Stone, 2002). Mental health policy is both influenced by, and influences cultures within services, promoting particular discourses, values, and philosophies in regard to the notions of human suffering, mental distress, danger and safety, and how these can and should be understood and responded to, and by whom. Distinctions and blind spots are thereby inevitably created and alternative ways of seeing and knowing become less available, highlighting the necessity of discovering:

"How it is that subjects are gradually, progressively, really, and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts etc" (Foucault, 1980, p.97).

An example of this is in the language of ‘burden’ and ‘resilience’ used in No Health Without Mental Health (DOH, 2011), which produced the discourse of ‘skivers’ - the weighty burden, who must be carried by others, and ‘the resilient’, who are capable of ‘bouncing back’ (Valentine and Harris, 2014). Mental health as a ‘problem’ to be solved is individualised through such language, with qualities such as resilience reified as static traits of the individual (Ungar et al., 2013).

The importance of preventing self-harm and suicide at a national policy level has been consistently emphasised (England NHS, 2014; Alderwick & Dixon, 2019). The message that is communicated through policy, practice guidance, and from inquiries undertaken in response to perceived service failings following ‘preventable’ deaths, is that with better knowledge, improved tools, and the delivery of competent, consistent risk practices, clinicians can predict, or at the very least offer a firm estimation of risk, and therefore potentially prevent harm from occurring (Lupton, 1999).

In 2007 the Department of Health published Best Practice in Managing Risk (2007) which provided substantial best-practice guidance and tools that would enable practitioners to undertake a structured, evidence-based approach to assessing and managing risk, that could be consistently applied across all mental health settings. Preventing personal bias from contributing to poor professional judgement was key, as was a good therapeutic relationship, sympathetic support, and an objective assessment. The assumption was that safety is most helpfully nurtured by managing risk, that there is an unbiased and objective place within which to stand, and the discourses are therefore ones of measurement, control, and professional responsibility.

By 2018, these guidelines had been undermined when the NCISH (Appleby, et al., 2018) report stated that attempts to categorise risk were an unhelpful way of guiding the treatment and management of clients and offered poor predictive value. They described evidence of there being a ‘low risk paradox’, referring to the immediate risk of suicide at the final service contact being judged by clinicians to be low or not present, for the majority of patients who later died by suicide. The report suggested an alternative way to improve clinical risk assessment processes as being to focus on building relationships and gathering good quality information to inform a collaborative approach to risk management. This was a robust undermining of the discourse of measurement, but there still remained the explicit request to assess and manage risk, by other methods, through a different emphasis - one that stressed relationships and collaboration.

This shift was also reflected in the critical briefing document entitled ‘Giving up the culture of blame: Risk assessment and risk management in psychiatric practice’ (Morgan, 2007). This document described the evaluation of risk as an inexact practice operating in a political arena, stating that interventions aimed at decreasing risks in one area, may serve only to increase them in another. The conclusion they drew was that risk cannot be eliminated, and they suggested that risk assessment practices can perpetuate a culture of blame - a culture which leads to defensive practice, and which serves political interests as opposed to client interests. The need for professionals to ‘protect themselves’ against any failure in their decision making was seen as unsurprising (Whittaker & Harvard, 2016) when *“following rules and being compliant can appear less risky than carrying the personal responsibility for exercising judgement”* (Munro, 2010, p. 6).

Power (2004) describes this as creating a conflict between the demands of primary and secondary risk management – a deeply paradoxical situation occurs which serves to divert professionals from their core task; professionals are distracted from the primary client risk as they are preoccupied with managing their own (secondary) risks arising from these blame cultures. The responsibility to oneself trumping the responsibility to patients.

The risk policy has destabilised the discourse of measurement and the possibility of engaging in objective assessments of risk, which was also largely reflected in the research reviewed above. What is seen in practice, however, is the corrosive influence of the discourse of responsibility, arguably fuelled by anxiety and blame-cultures where protection of the self, or of the organisation, produces irreconcilable tensions that limit the capacity to place patient safety at the foreground. Clinicians are no longer able to fall back on the certainties of objective science in their risk practices and instead they are left in the realm of intuition and judgement (Derblom, et al., 2021), arguably creating a more anxiety-fuelled position when the demands to manage and reduce risk remain unchanged. Instead, risk management practices are currently believed to require the ability of organisations to think collectively about risk, the development of positive relationships, dialogue, collaboration, and shared responsibility.

2.8 Conclusions

The 'making-up' of the mentally disordered, at-risk individual de-contextualises and individualises mental suffering and defines the 'self' as something that resides within the human body. This is a notion that Bateson (1979) would describe as a 'pathology of epistemology' causing the connections to the broader environment to be overlooked, threatening our very existence, and deceiving us into thinking that we can act alone or as masters of the environment (Shaw, 2015). This philosophical, political, and epistemological background is the context within which the dominant risk discourse has been shaped, and which engenders how risk is perceived and responded to within mental health. It is a discourse which assigns, requires, and maintains unequal power relations whereby someone is positioned as the expert, and someone as the lay person.

We are facing what are predominantly perceived to be individual health issues that require treatment if mentally ill people are to become safe, well and productive citizens. This is not *the* truth, it is one possible truth, one discourse, and the question remains whether it is the most helpful discourse to support us to respond to emotional suffering and/or the absence of safety. Hacking (2004) points out that we are witnessing a proliferation of medico-forensic-political language consisting of labels and categories that construct and control, and which will inevitably affect our ideas of what it is to be an individual:

"Who we are is not only what we did, do, and will do, but also what we might have done and may do. Making up people changes the space of possibilities for personhood" (Hacking, 2004, p107).

Even when risk practices are being critiqued and found lacking, solutions tend to be offered from *within* the dominant risk discourse. The criticisms of objectivity, measurement, prediction, and control are rigorous, but fear of blame and feelings of responsibility generated by risk discourses, present as barriers to change. The key question is whether practices can meaningfully transform without changes taking place at the level of discourse or epistemology. A focus on risk does not always appear to be the most helpful means of promoting safety, and this suggests that new directions and possibilities need to be considered.

Chapter 3: Conceptual foundations and methodological procedures

3.0 A methodological route-map

This chapter will describe the theories, procedures, and processes that I have drawn on to both guide and anchor me in the undertaking of this research inquiry. My overarching view is that methods do not just provide us with a means to access and describe the social world but are active in the shaping and defining of that very world, making our methodological choices a political and ethical concern that needs to be justified. Therefore, my methodological choices have been based on three key considerations.

The first was that I wanted to provide space for the stories of people living with threat, fear, and uncertainty to be heard and understood. The second consideration was to employ methods that would probe and agitate these stories. This involves viewing stories as constituted contextually and relationally and thereby exposing some of these constitutive forces was required. The third consideration was finding methods that were congruent with who I am, my beliefs about the world (ontology) and what it is possible to know about the world (epistemology). This chapter will go into more depth regarding these influences, choices, and the pull for me to select methods that captured and uncovered, rather than diminished, the complexity of the mental health field and the effects enacted by the risk discourse. My purpose was to *understand* rather than *prove*.

3.1 In support of 'self'

The paradigm of positivism remains powerful within the field of mental health care, with quantitative research and the esteemed randomised controlled trial (RCT) being seen as offering the best route to knowledge, the provider of 'evidenced' treatments that work, and a value-free science to underpin and justify policy and funding decisions. NICE guidelines which stipulate what should be seen as 'best practice' are based on findings from RCTs. This type of research entails representation, classification, and reductionism; it offers the credibility of science and the impression of truth. RCTs may be invaluable in pharmaceutical research, but what is completely lost is the ability to ask more subtle, multi-positional, systemically complex questions (Jones, 2003).

A positivist research paradigm requires the researcher to be 'written out' to address the contagion brought through subjectivity, bias, and influence, thus reducing the need for self-scrutiny by retaining our separateness. Is the 'self' really such a problem? There is, arguably, no detached place within which to stand (Rabinow & Sullivan, 1979) no matter what type of research is being undertaken; every act of observation produces something invisible (Luhmann, 2013). Knowledge practices and 'being' are reciprocal: *"we don't obtain knowledge by standing outside of the world; we know because we are of the world"* (Barad, 2007, p185).

Donna Haraway (2016) reminds us that we are *obligated* to speak from these situated worlds and Barad (2007) calls for an ethico-onto-epistem-ology, that marks the epistemological inseparability of observer and observed, in an intertwining of ethics, knowing and being. When our actions *make* the world, our practices of transforming it become a deeply ethical matter. Removing myself from this inquiry has not been my aim as it is neither possible, nor desired: authors are unavoidably implicated in the representational practice (Macbeth, 2001) and no research is innocent of bias, evasion, and selective interpretation (Gunaratnam, 2003).

Researchers who occupy a positivist epistemological position have less call to confront the constraints of the social world, and many researchers argue that it is an approach which silences too many voices (Denzin & Lincoln, 2005) and excludes practices that are not easily ‘proven’. Laing (1982) warns that what is scientifically right may be morally wrong and urges us to be aware of how a positivist 'force field' may serve to screen out competing and alternative discourses.

Calls have been made for NICE to adopt a research paradigm that takes the complexity of mental phenomena into account, arguing for ‘practice-based evidence’ as opposed to ‘evidence-based practice’, and respecting the multitude of qualitative methodologies that privilege and celebrate clients’ voices. This is the space this research seeks to occupy. Its aim is to challenge the hegemony of positivism in biomedical science. This could be seen as a huge challenge when *“a prevailing system of representation is naturalized and seen as the only truthful and correct way”* *(*Minh-ha*, 1992, p. 125).*

3.2 Entering a messy world

“We are contaminated by our encounters; they change who we are as we make way for others. As contamination changes world-making projects, mutual worlds – and new directions – may emerge”. (Tsing, 2015, p27).

My identity as a researcher incorporates a merging of my therapist, academic, and human selves. My world as a therapist can feel like a messy, inexplicable, and privileged one as I endeavour to support people to make sense of their lives and pain, to bear witness, to search for meaning, to create hope, to build trust, to tolerate suffering, to cope with uncertainty and incomprehension, and ultimately, to find ways to move forward. Law (2004) highlights how methodologies can seek to convert our messy world into something smooth, coherent, and precise, only to miss out on the textures of life by failing to account for its complexity. I was looking for theories and methods that would provide some structure to support the 'doing' of the research whilst retaining the flexibility to allow for what may be emergent and unpredictable (Jackson & Mazzei, 2012) as opposed to tidying up or simplifying the 'mess'.

Deleuze and Guattari (1987) have inspired me to hold on to this commitment with their reminder to embrace the creativity in our methods of inquiry; for them, the whole of life is difference, and they prompt us to seize the complexity and break away from the grid of social definitions that regulate everyday life (Coleman, 2013). This takes me into the paradigm of critical theory, a realm which requires that the status quo gets challenged, the balance of power is considered, and institutional structures that promote oppressive ideologies are exposed to increased critical consciousness (Aliyu et al, 2015).

As argued in Chapter two, the field of mental health is rife with contested categories and powerful discourses which shape and order understanding and influence how we create meaning; the axiological assumption being made within this research is that the risk discourses within mental health therefore require challenging. In this way:

> *"Research is not an innocent or distant academic exercise but an activity that has something at stake and that occurs in a set of political and social conditions" (Tuhiwai Smith, 2008, p5).*

Often what is at stake is the question of what notion of 'truth' or knowledge we are claiming to acquire through research. Methods have performative effects that do not simply *show* us how things are, but actually *shape* the reality they go on to describe – this is what makes them political (Law, 2004). The task of social science research therefore cannot simply be to describe and illuminate, but must attempt to unsettle and transform (Pillow, 2015). When methods are seen as having these constitutive effects, the research endeavour requires a critical stance to be taken towards dominant discourses, taken-for-granted knowledge, and practices. Methods will inevitably place a frame around what can be seen, and what remains obscured; methodologies apply blinkers and force researchers to make distinctions.

Simon (2014) encourages us to move away from ‘choosing a research method ‘, and instead to engage in the ‘shaping of a process’. This offers flexibility in the doing of research, an opening up of possibilities, thereby creating a co-constructed, unfinished product of history and culture (Etherington, 2004). Holding this view of research methods allows for authenticity, and ensures that there exists a congruence between practice, theory, and life. This need for congruence and authenticity was influential in the pull toward foregrounding both narrative and dialogue in my methodological choices.

3.3 Narrative and dialogical possibilities

The field of narrative inquiry stretches across different disciplines and professions and embraces the view of storytelling as a relational activity that binds us, constitutes us, creates our worlds, and provides meaning; self and identity thereby become dialogue dependent (Bruner, 1990; Riessman, 2008; Phoenix, 2013). This understanding has generated a flourishing interest in narrative inquiry as a research methodology through what has been described as the linguistic turn (Rorty, 1967). Tsing (2015) tells us that to listen to and tell a rush of troubled stories *is* a method, and she urges us to make this ‘rush’ part of our knowledge practices. My aim through this study was to harness the power and richness of the stories told by my participants, the stories lived, the stories shaping lives and ways of being, and through this harnessing, for me to be able to tell some different stories.

“To live means to participate in dialogue: to ask questions, to heed, to respond, to agree and so forth. In this dialogue a person participates wholly and throughout his whole life” (Bakhtin, in Irving & Young, 2002 p. 22).

Making a choice for a research method that incorporated a dialogical orientation was both ethically and philosophically driven. Buber (1937) has a lot to say about how to live a human life, and how we should treat each other. He says that what is essential is not what goes on within the minds of the people in a relationship, but what happens *between* them. The importance of dialogue and relationships in my clinical work was an important factor which influenced my choice of dialogical narrative analysis for this research inquiry. Systemic psychotherapy rests heavily on the possibilities for change offered through dialogical encounters: meaning is given the opportunity to develop in the spaces between us, as responses are anticipated and received (Shotter, 2015); everyone comes away changed. The emphasis is on the ‘doing together’ because, in a dialogical framing, we cannot remove ourselves from our relationship with the other (Frank, 2010).

If meaning originates between speakers and through dialogue, it is constantly in flux and thereby becomes an on-going process of re-telling. Finding the ‘whole story’ remains elusive, the story and the person are un-finalisable, futures are left open, and generalising is limited. Entering a dialogical understanding allows for multiplicity and potentiality, a person cannot be captured in a single, unitary story.

Dialogical principles are what shaped and guided my meetings with the participants in this study - allowing the interviews to unfold, as meanings were created through the generation of a responsive dialogue, reminding me to pay attention to how I was opening myself up to their stories. So, what emerges when narrative and dialogue are brought together?

3.4 Dialogical narrative analysis: a practice of criticism

"The story of a life is less than the actual life because the story told is selective, partial, contextually constructed and because the life is not yet over. But the story of a life is also more than the life, the contours and meanings allegorically extending to others, others seeing themselves, knowing themselves through another's life story, re-visioning their own, arriving where they started, and knowing the place for the first time" (Richardson, 2000, p158).

The narrative method that has steered me through this research journey is called dialogical narrative analysis (DNA): an 'anti-method' developed by sociologist and critical theorist, Arthur Frank. It could be said that DNA offers a less traditional narrative methodology, but after reading Frank's book, "Letting Stories Breathe" (2010), describing DNA, I recognised an approach which felt right for my research purpose. DNA encompasses aspects of critical theory, offering the flexibility for creativity; it was also congruent with my methodological orientation as outlined above. Frank writes that the stakes are highest when the storyteller is working hard, against forces to which they are vulnerable, to make their life coherent, to sustain their dignity. In this he captured for me some of the essence and struggle within my participants' stories about living with risk, and I felt that undertaking a DNA would allow *their* stories, and therefore mine, to 'breathe'.

Frank (2010) describes DNA as a way of putting into practice the theory of socio-narratology – a theory which recognises that being human, and social, requires the competence to tell and understand stories; to be in dialogue. What results with DNA is more a *“practice of criticism”* (p73) than a prescribed set of methodological steps - a heuristic guide, a method to encourage the movement of thought. As an approach, it allows us to orientate towards the:

> *“Mirroring of what is told in the story – the story’s content – and what happens as a result of telling that story – it’s effects” (p71)*

and to cherish the importance of that effect. DNA involves thinking *with* stories and situating them within a broad historical, political, and cultural context to be able to make sense of their effects. This is where the literature discussed in the previous chapter was critical in providing that context, supporting the analysis.

Stories depend on a collection of shared narrative resources that are available at any given time: there is a limited stock of possible story lines, and cultural understandings limit the stories available to be told (Phoenix, 2008). It is not uncommon for people to produce culturally sanctioned scripts that reflect dominant ideologies and discourse (McAdams, 2006). My relationship with the literature reviewed in Chapter two allowed me to tease apart and recognise some of the many available threads, and the boundaries they imposed, within the participants’ stories.

If I had read different literature, I would have noticed *different* things, and thus stories must always ask the question: what kind of truth is being told? This question may remain unresolved, but sometimes we must learn to live with, and navigate through, complicated, multiple, and partial truths. Truth must then be seen as something negotiated and debated, rather than something pronounced from on high (Bakhtin, In Todorov, 1984).

3.5 Preparing to do the research: zooming in and out

Applying for ethics approval to undertake this study involved outlining clear plans regarding the questions that I was seeking to ask and detailing how I was going to go about finding the answers. This required me to ‘zoom in’, to examine the subject area, the steps that I would be taking, and how to proceed ethically. Once granted I was in a position where my methodological choices required me to ‘zoom out’ in order to engage in a generative dialogue to open out understanding, rather than closing down the conversation with too many pre-determined ideas or questions.

My initial questions emerged from my experiences working in CAMHS and seeing some young people reach a point where they could no longer be supported in the community due to fears about risk, often leading to them being admitted on to an inpatient unit. I was interested in how this was experienced, negotiated, and understood by the parents and the clinicians involved, the system supporting the young person, and how this impacted their relationships with one another. I had a sense that there was not always a shared consensus on how unsafe a particular situation or behaviour was, how worried to be, and the level of response required.

The questions I formulated to initially shape the research focus were:

How does the perception of risk affect relationships between CAMHS clinicians and parents?

Sub-questions:

1. **How is risk conceptualised by clinicians and parents?**
2. **How does communication between clinicians and parents change when risk is perceived to increase?**
3. **What positions are opened up or closed down for clinicians and parents when attending to risk?**

The interviews did not utilise these structured questions, however, as it was methodologically important to keep the direction of the dialogue open and fluid.

3.6 Introducing my ‘conversational partners’

Having received ethical approval, I extended an invitation, via email, to the clinicians working within the service where this research was being undertaken and which included the purpose of the study and the requirements for participation. It was an offer to the clinicians, and their clients, to meet with me to talk about their experiences. My intention had been to meet with three clinicians and three parents of a young person receiving support from CAMHS, with six participants ensuring that the analysis would bring depth as opposed to breadth. I met with the participants on a ‘first-come-first-served’ basis, and my initial meeting took place in December 2021, and the last in March 2022. Each interview lasted between 1 and 2.5 hours and all took place in person, with consent given to record and to later transcribe (undertaken by me) our conversations.

All three of the parents: Becky, Cathy, and Karen were mothers and were all working parents. Although it would have been interesting to have a gender mix, it is unfortunately not untypical within CAMHS to meet with more mothers than fathers. The three clinicians had each worked in the field of mental health for over 10 years: Patrick, a systemic family psychotherapist, Sarah, a clinical psychologist and Laura, a dual trained mental health nurse and social worker. All the participants were white/British, reflecting the homogeneity of the local area, and therefore a cultural and ethnic richness is not offered through this study. In sharing their stories, they will have chosen to present a particular perspective to me, and this will have been influenced by me: the listener, the power relations within the relationship, and perhaps experiences such as pride or shame. In this way interviews are always actively constructed. I have already described the dialogical orientation that shaped my participation in the meetings with the participants, and I saw my role of interviewer as that of active listener and collaborating participant (Talmage, 2012).

Each interview started with me explaining that through my time working in CAMHS I had experienced the difficulties and fears that often come when situations feel unsafe, and I would go on to ask if they were able to connect with this, inviting them to share some of their own experiences, in whatever way felt comfortable. I sought to begin with an openness that allowed them to determine how and where they wanted to start with telling me their story. Following this there were no set questions and the interviews varied in terms of my level and style of contribution, depending on what I felt the participant needed from me to be able to tell their story. What felt consistent across the interviews was that the participants shared their stories with a generosity that was moving and at times emotional, and my responses, reflections, utterances, silences, and questions, needed to be authentic and reactive rather than pre-planned, and these all became part of what I went on to process during the analysis stage.

3.7 Me: An insider

Patrick, Sarah and Laura all work in a CAMHS team that sits geographically next to my own service, and these teams are part of the same NHS trust. The clinicians and the teams were therefore familiar to me, although from a slight distance. I have thus engaged in what could be termed ‘insider research’, and I would argue that this has brought many benefits, as well as factors that have required me to remain vigilant. For example, recruiting participants was more straightforward, even with the professionals in CAMHS that did not know me, they knew ‘of me’, and I think they would have therefore felt more reassured to reach out to the families they were working with and to share details of the research study. I also wonder if Becky, Karen, and Cathy shared their experiences with me with what felt like such openness and honesty, due to them feeling reassured that I would understand and empathise - that I had some insight and knowledge.

This insider knowledge also meant that I was able to hear the unsaid, to make connections and to probe when needed during the meetings. An insider position can however bring a familiarity which blurs boundaries, and I was aware of the danger of imposing my own values and beliefs, of understanding too quickly or making assumptions. The question for me became how to use my own experiences, with their intimate familiarity and hence potentially deeper understanding, while at the same time, not impose my experiences on the participants (Pillow, 2003) or through the analysis.

3.8 Processing the interviews through ‘plugging in’

“As researchers, what can we be certain about; if we’re researching things that defy categorization, how do we constitute data; how do we avoid getting frozen by uncertainty; if we’re not doing realist, modernist research, what systems do we employ?” (McWilliam, Lather, & Morgan, 1997, p. 2).

Once the interviews were completed and transcribed, in August 2022, I began to undertake what may best be described as multiple diffractive readings (Barad, 2007), which involved questions (see below) being posed, as I attempted to create a kind of rupture, a Deleuzian ‘line of flight’ that would allow my thinking to ‘travel’. I was therefore seeking the conditions under which something new might be produced, opening myself up to the possibility of different ways of thinking - attempting to remain fluid and in flux rather than fixed and discrete. This process of data analysis is referred to by Jackson and Mazzei (2012) as ‘thinking with theory’ and they explain that:

“Qualitative data interpretation and analysis does not happen via mechanistic coding, reducing data to themes, and writing up transparent narratives that do little to critique the complexities of social life; such simplistic approaches preclude dense and multi-layered treatment of data” (2012, vii).

As an alternative approach, plugging into theory stands in contrast to interpretivism – my aim was not to work out what the participants’ stories ‘meant’ or find the most ‘truthful’ version, but *“to seek the voice that escapes easy classification and that does not make easy sense”* (Mazzei & Jackson, 2009, p4). The practice of diffractive analysis helped me to discover new connections and to explore the entanglements of ideas through a process of co-constitution (Taguchi, 2012) which allowed different elements to constitute one another, and in so doing, to try and create something new. Here is an excerpt from my writing that may bring this process to life:

I read the emotionless words of Becky’s transcript and I find myself questioning and doubting some of the judgements and choices she had made as Milly’s mother. What strikes me is how this differs to when I was sat in the room with Becky, hearing her story that pulled at my heart strings as I connected to her words, fears, and emotions – one mother to another. In the room I witnessed her love, her good intentions, her wish only for Milly to be safe and happy - understanding how deeply you feel your child’s pain when they are suffering.

I feel uncomfortable with the arrival of these new critical thoughts, and it prompts me to consider what is being made narratable in Becky’s story. Her story is, in part, a quest that tells of the need to be understood, that makes visible the dangers inherent in simple understandings, shaped through critical judgements. I begin to think about discourses of motherhood and what factors come to influence how we evaluate ourselves and others, and how this may have been experienced by Becky. Being the mother of a child who does not want to live - I cannot imagine how unbearable that would be. I read about the ‘good mother discourse’ – accounts of how mothers are in *a constant state of surveillance, objectification, and regulation to ensure they abide by socially constructed norms of ‘good’ mothering behaviour (Goodwin & Huppatz, 2010).*

I think about the way ideas about good and bad mothers continue to regulate women and my horizons start to shift - I connect to a deeper understanding for why Becky may feel a tremendous pull to find out what is wrong with Milly. It is perhaps the only tolerable place for her to go that preserves her sense of being a ‘good mother’. I consider mental health expertise and notions of normalcy within this, and how this may influence evaluations of ‘good mothering’ – it takes me back to Ian Hacking’s work on making up people. These evaluations are made possible through discourses of measurement and risk, as parent behaviour comes to be classified as a ‘factor’.

Choices and selections have been made in terms of what literature I ‘plugged into’, and there have been multiple entry and exit points taking me into different literature via various routes, informing and influencing this research. At times this would take me off on tangents, and at other times, disparate ideas would connect. I would read not just to absorb the content, but to notice the ‘off-shoots’ from the literature, launching me into new and exciting territories - creating new shapes of life (Deleuze & Guattari, 1980).

This process of plugging into ideas, theory, sensations, meant that every time I returned to the interview transcripts, I was altered, and new thoughts, understandings and stories would emerge by introducing the participants’ stories to an array of literature, theory, and philosophy. The intention through this was to contribute other voices, to situate the participants’ stories amongst other stories, to offer possibilities, complexity, and the potential offered by seeing what else the participants’ stories were connected to (Frank, 2010). For Frank, (1995, 2010) the dialogical interest is in what a story requires of those who receive it and the consideration of what the telling *does.* To be able to feel equipped to respond to these questions and to produce a dialogical narrative analysis, I required the assistance of theory and concepts.

The initial questions that shaped my reading of the transcripts were taken from Frank (2010):

- **How does the story call on me to shift my horizons?**
- **What does the story make narratable, and what becomes visible that was invisible?**
- **Who is caught up in which story? What is the effect of being caught up in this story, while living with people caught up in other stories?**
- **Are some stories silencing other stories? What stories are being overlooked?**
- **What other stories are required, for this story to be told?**
- **What is the force of fear in the story and what animates desire?**
- **How does this story help people to remember who they are? What is being reassembled or reconfigured?**
- **Who is holding their own in the story? Is the story making it more difficult for other people to hold their own?**

These questions provided a framework through which to connect the transcripts to the theory, and back to myself, in a recursive interweaving, and this process inspired me to write - freely and creatively, experimenting with different positions, different writing styles, using images and metaphors to open up my thinking.

I intermittently wrestled with the fear that my conceptual leaps were too great, that I was going off on tangents, that I was distorting the participants' stories so as to tell my own story - 'messing' with the 'gifts' that did not belong to me, but which had been given with trust. My regular conversations with my supervisor, my reflective writing, and continual return to the participants' words, reassured me to keep going as I persisted in plugging into the dialogues in ways that, at times, felt indiscriminate.

Finding a point to end this process also felt somewhat arbitrary, and in the end, it was the practical consideration of time that forced me to pause the analysis stage, and to start to think about how I might pull three years of work into a cohesive, coherent, useful, and interesting account. I had been holding out for the oft cited ‘saturation’ point where nothing new was emerging, but this did not seem to present itself, perhaps due to the nature of the methodology. Instead, I had reached a point where I had found the inspiration to tell my own story, about the stories that the participants had shared with me (Zinn, 2008).

3.9 Writing to make my-self visible

“How do we, rather, escape the inside/outside binary of where we stand when we write to negotiate in praxis and represent in text the never-ending contradictions that stymie, the looping folds that shift us into some different pause from which we try to make a more tentative sense, or the last interpretation that is always presumptuous and often violent?” (St Pierre, 2000, p262).

How was I to ‘write myself’ into this thesis if it was not possible or desirable to write myself out? This connects to what Geertz (1973) referred to as the ‘burden of authorship’ and it is a burden that has weighed heavily upon me. My task, as I have seen it, in inhabiting the position of researcher, has been to really *listen* to the stories of the people with whom I have met. To listen not just with my ears, but with my eyes, and my body, and my heart. To listen not just as a researcher, but as a mother, as a middle-aged woman, as a child of the past, and as a white, western, privileged professional. This has been needed because it has only been through the opening-up of my multiple selves, that the stories have been given the space to let me feel their full force – I have cried, I have doubted, I have felt shame, I have felt lost, and I have been left questioning. Throughout this research process I have learnt to notice all these effects because they have shaped my encounter with the stories, and I have therefore attempted to write these into this thesis at relevant points.

There is an expectation from the more traditional research paradigms for researchers to clearly describe each stage of the research process, in part to demonstrate the validity and quality of the study. Even if it were possible to capture all the nuances, the cross-roads, the detours, the paths not taken, I am not sure that it would be either helpful or interesting to read. It would neither make the research replicable nor more valid or truthful. Just as aspects of the process have been left out, I have had to make decisions about which parts of *me* to include and exclude. It feels important to acknowledge that:

"There is no clear and easy route by which to confront the self who observes" (Behar, p6, 2022)

and representing the self is both personally negotiated and politically situated (Fine, 1994; Bright et al., 2023). This research journey has not been a cold, distant, academic process, but both a joyous, exciting, and painful journey of personal discovery and growth. Authenticity in storytelling, for me, comes from the dialogue between the storyteller and the listener – I am accountable to the story that I am telling through this thesis, and that accountability requires as much transparency as can be captured and described, within the limits of this thesis – I hope I have achieved this balance.

Chapter 4: An ethnographic encounter

4.0 Warming the context

“I must be ready to confront feelings and ideas within myself…if I am to have any time to live with my mask off. And should I wear my mask for too long, when I take it off and try to discard it, I may find that I have thrown my face away with it” (Kopp, 1976, p18).

I am turning to the time before the interviews were conducted because I want to offer this part of the research as an entry-point into the next section – in the hope that it provides some warmer ground for the reader to step into. As soon as I had gained ethics approval, I began this research by spending three days observing a CAMHS crisis mental health team. My hope was that it would provide a helpful backdrop to the interviews, potentially triggering ideas for questions I might want to ask or areas of interest to pursue, and I also hoped it would offer me a useful steppingstone into a researcher identity. I needed to create some distance - to try and see through different eyes to those of my familiar ‘CAMHS clinician eyes’.

During those three days, I listened, I watched, I asked questions to try and increase my understanding, and I went away at the end of each day to write extensive, detailed field notes. I did not know where it would take me, and I was unsure what contribution it would make to the overall project. It was an experience that pushed me out of my comfort zone. I think there was something valuable for me encountering this discomfort as, in part, it helped me to observe through a different lens, and with different intentions to that of my clinician self.

Ruth Behar talks of how, as researchers, we ask others to expose themselves to us, *“we make others vulnerable, but we ourselves remain invulnerable”* (Behar, 2022, p. 273) and ethically it felt important to experience this vulnerability. I noticed that it helped me to reveal, and shed, some of my own masks, prompting me to see things through different eyes, to expose a little of my own biases, and to glean some of the assumptions and preconceptions I was inevitably holding, but was not sufficiently aware of.

Geertz (1973) tells us that if you want to know culture, you have to put yourself in the middle of it, and ethnography is what can transport the reader into an *actual* world, revealing the cultural knowledge working in a particular place and time. Through this ethnographic encounter I have tried to tell a story that allows the reader to imagine a little slice of the world that this thesis is stepping into.

4.1 Observing in a crisis team

I arrive on my first day, it’s still dark, and I navigate around the large modern building, trying to find the correct entrance. My heart pounds with the nervous anticipation of how I will be received by the clinicians: a nosey, busy body, an interested fellow clinician, a serious researcher? I feel like an imposter. Once inside, the stark, whitewashed corridors present themselves in a confusing sprawl, lined by the empty offices all waiting for the buzz of the day to begin. One side of the building houses the adolescent in-patient unit, and I realise I have gone the wrong way when I come up against a securely locked door – I wonder when, and why they stopped calling them ‘psychiatric hospitals’, and why it was replaced with ’unit’, or ‘facility’. There is certainly a clinical, sterile feel about the building, but it’s not ‘saying hospital’ to me; there’s more of a corporate, impersonal feel. I spot the occasional picture dotted about the walls - it feels like a small, token effort that has been made to create a more enticing

vibe. I am not sure that it has been successful, and I shudder at the thought of any of my children having to be locked up in this place.

I am greeted by a warm and friendly nurse who was expecting me - she tells me that lots of people come to spend time with them – new employees from different service areas, or students; the team seem non-plussed by my presence as they show me around. There are two large, open-plan offices which offer a base to the crisis team, and the home-based treatment team (HBT). The former of which has a 72-hour remit within which to respond, assess, and reduce the risk associated with mental health issues, while the HBT Team is given the luxury of 12 weeks to support young people and their families to get to a better, safer place. I inquire where the idea of these being the best or most helpful time frames came from, but no-one seems to know – it is just how it is. Although these time restrictions seem to pose challenges at times, they appear to be unquestioningly accepted.

Lauren is one of the nurses from HBT and she tells me that she is finding it hard to get used to this imposed 12-week time frame; she has moved across from working in community CAMHS where she would sometimes work with people for up to 2 years. She tells me: "I just have to get stuck-in here, be more upfront and insistent – and I need to get better at 'endings', which is hard when the ending often involves putting them on a waiting list before they can get picked up by CAMHS". Amanda, a more senior nurse chips in – she seems less bothered by the restraints of time – they just have to go in, and be forthright, especially with parents. She describes risk as being the 'elephant in the room' that needs tackling head on – it is too easy to avoid it, to skirt around it. She tells me the story of a young person that had rung the team feeling suicidal. She had just had a therapy session with her art therapist but had not been able to mention these suicidal thoughts to her, because she was "too nice". I am struck by the strength of Amanda's commitment to her view – that risk must be exposed, confronted, addressed, - and I wonder how much this is shaped by being on a 12-week countdown to safety. I am aware of my irritation; I do not agree with her. I think it is her certainty and I muse over whether she would find my lack of certainty equally irritating.

I saunter across to the Crisis Team office – there are more staff in here and I get chatting to the nurse in charge of the shift, Janet. She quickly seems comfortable enough to tell me that she has recently stepped down from doing a management job and is now working in the crisis team – it was either a drop in grade or 'burn-out' and she decided she had to look after herself.

(The phone rings: it is social services. A 12-year-old boy is on the roof of his home – can the crisis team support? The conversation comes to a swift end with the concerned caller being told that this is 'not a mental health issue'. The request for support is rejected.)

Janet seems happy to tell me about the ins and outs of the role of the crisis team – she moans about the reams of forms and paperwork that need to be completed as part of the 'managing risk' process. She doesn't think it necessarily makes things safer for the clients – "it's all about defensible documentation and keeping professionals and organisations safe from the wrath of the coroners court" she tells me. Their remit is to contain the crisis within 72 hours – it is all about assessing risk and calming it down, containment – often this is containment of other people's anxieties, rather than risk. Sometimes the psychiatrist will start the young person on medication, they always teach a 'traffic light system' to parents – giving the family a way to communicate levels of safety and/or risk – green, amber, red. Parents are told to remove anything that could cause harm from the home. Complexity is reduced, the environment made safe, the lid is put back on - they exit. If it is not safe within this time frame then the intervention can be increased in intensity from either HBT, who can go into families' homes several times a week, or the young person can be admitted onto the 'unit' for more comprehensive, 24-hour protection.

(The phone rings: it is the SMASH worker (school-based counsellor) of the 12-year-old boy on the roof – he is still on the roof. The boy has been running county lines, Mum found his stash of drugs and handed it into the police, and now the drug dealers are after him. Social services insist that the boy has 'mental health issues', and they are urging the crisis team to respond. Crisis tell them: of course the boy will be scared, but he has 'capacity', he is 'street-wise' - this is not 'mental health'. The request is declined for a second time. This time

there is a come-back - the caller adds: the boy has ADHD (attention deficit hyperactivity disorder). There is a pause before a response is given – “the boy needs to be safe before we can assess his mental health”. The ADHD diagnosis is not enough to make it ‘their’ problem; it is passed back again).

Over the three days I weave between these two offices where I am warmly welcomed into their teams, their discussions, their successes, their failures, their personal struggles. Laurence has come across from the unit where he works as a nurse. He spends one day a week with the crisis team in an effort to improve relationships between the crisis service and the inpatient service – I get the sense that the interface between the two can be thorny. Laurence is young and loud and passionate – full of his own views, and happy to express them. He tells dramatic stories of young people spending 6 months in ‘ligature suits’ on the unit, kids who have fractured lives, inadequate family support. They are sad stories, but the drama makes it almost feel like these are not real people, not real suffering. The staff all chip in and there seems to be a shared belief that most of the young people they work with appear to require social service involvement – they tell me that they rarely encounter supportive, effective parents and they describe their work as “shoring up poor parenting” and being confronted by conflicted family relationships. I think about how this illustrates a discourse of the ‘moral underclass’ and wonder what helps them to make sense of this, to empathically understand their challenges, experiences, and relationships, with such limited time, and with such a prescriptive remit.

(I am in the HBT office on my second day when Amanda returns, furious, from her meeting with the crisis team. She proceeds to tell us the story of the 12-year-old boy who had been found on the roof the previous day. She explains that he has progressed from his roof to a bridge, thereby escalating concerns with the addition of a few more metres. She questions the crisis team’s previous lack of response, dismissing the idea that his being on the roof and his drug running negates the possibility of this being seen as a ‘mental health issue’. Amanda is enraged as she highlights his age, his desperation, his fear, his vulnerability, the ADHD that might incur impulsive behaviour. The rant ends abruptly as she leaves to undertake a mental health assessment on the 12-year-old boy who is now on a bridge).

I find myself transfixed by the enormous whiteboard which covers the whole length of the office – it is filled with list upon list of services and their respective contact numbers; it is like a sprawling spiders web – how did it get so big? Since when did it become so acceptable that so many young people were requiring such extensive expert intervention? There is a constant hum of dialogue that takes place between the clinicians throughout the day, as they respond to the varying requests and calls for support that keep coming in – do we step in, or step away? Is it for us, is it for someone else? Is it mental health, is it bad behaviour, is it poor parenting? Witnessing their dilemmas in action – of having to make sense of something before deciding whether they should respond, with limited information, and in the knowledge that sometimes stepping in can make things worse, not better. I felt exhausted just witnessing it all.

(Amanda returns – the boy is off the bridge, and it is 'not mental health' after all. I am curious about the different reasons people might have for wanting to jump off a bridge, and what would place it inside, or outside, the category of 'mental health'. I consider asking her this, but I see that she has moved on, and I wonder whether the staff must protect themselves against their lives, services, and systems becoming too complex and messy. Finding ways to be certain, simplification, reduction, clear and uniform processes – these may be the only things keeping this sprawling and confused service from disintegration, and the professionals working in it from paralysis.)

4.2 Postscript

In this encounter I was both a participant and an observer, affected whilst also having an effect, and therefore I was never able to see something that would have taken place in my absence (Behar, 1996). What I gleaned was therefore but a fleeting glimmer into a complex environment, and my reflections and thoughts indicate this partiality. I had come away from my time in the crisis team feeling emotionally exhausted from listening to the stories of pain, suffering, abuse, trauma – some of which were blessed with happy endings, but many of which were not.

I felt huge gratitude at the generosity of the clinicians in giving me their time and I was touched by their commitment to their clients and their work, amidst such confusing, pressured, and challenging environments. There seemed to be at play some inherent internal contradictions between the material conditions of the service, and the philosophical wranglings and disagreements over what the clinicians were trying to respond to, make sense of, and to what end. Notions of risk, mental distress, and complicated relationships comprising a recipe that was rarely easy to fathom, and one which often provoked uncertainty and doubt. Yet the pressure to bring safety quickly, inevitably served to exert a powerful pull towards certainty and simplification. The stories that became more visible were those that had the capacity to cage the uncertainty, thereby enabling the clinicians to endure the force of fear and confusion.

The team's success was based largely on their ability to make things safe within 72 hours, to keep people out of hospital, and to ensure that their practices do not put themselves at risk. In this way, the specifications and parameters of the service influenced and determined what stories were possible to tell, and ostensibly closed down or dismissed what could be more effective ways of being or understanding; process and structure provided the contextual force shaping practice, and not always to good effect.

The story of risk in the crisis team ensured that others were positioned as being responsible – it tells a story of what is possible – that achieving safety by reducing risk is the responsible focus for the team. This can be helpful when safety needs to be seen as being established quickly, whether that be visible to other professionals or parents, or society more broadly. Yet when risks are high, stories of fear and worry abound, and it is likely that feeling fearful has the potential to create a ‘responsibility stale-mate’ that possibly fuels notions of ‘poor parenting’ or spurs clinicians to find ways of ensuring that this is ‘not mental health’ or not ‘risky’ enough, or ‘a normal response’. In terms of Frank’s questions above (p 45) as providing my guiding framework, it seems that stories of parental failure or stories that dismiss the relevance of risk are doing important work as they call on us to ‘shift our horizons’ and thus our ideas as to who should be held accountable.

I wondered, as I came away from this encounter, whether safety was *often* established by tackling risk ‘head on’? I also wondered whether sometimes young people ‘being risky’ might be serving an important purpose that needed to be witnessed rather than quashed. What work might these stories of risk be performing for these young people – what are they making possible or visible, that was invisible? I am reminded of an African proverb: The child who is not embraced by the village will burn it down to feel its warmth. I was left feeling curious as to how parents and clinicians found ways to tolerate the heat of risk, and to sometimes resist running around looking for water to put out the flames.

The discourses in force are seen to be constraining and shaping parental and clinician agency, at times creating adversarial and critical relationships. Foucault’s (1982) notion of subjectification highlights how our capacity for individual agency is inhibited by the subject positions we inhabit, and we can identify the clinicians as being the observing, judging subjects, and the clients as being the observed, subordinated subjects - categorised as healthy/ill or normal/abnormal/effective or ineffective. As subjects struggle to act within the competing discourses, collective agency emerges through group formations to assist with the ensuing indecisiveness, further reducing the possibilities for individual agency. Whether discourses of risk are irreconcilable with a discourse of individual agency is a question that lingered.

Chapter 5: Creating new stories

“You tell these stories because you believe they do something in the world to create a little knowledge, a little humanity, a little room to live and move in and around the constraints and heartbreaks of culture and categories, identities and ideologies. You wonder whether this is what your stories do or should do. You wonder whether the people in your stories recognize and admire themselves, whether they are angry or embarrassed that your words about them are in the world. Sometimes you are sure about your answers to these questions and sometimes you don’t know” (Adams & Jones, 2011, p109).

5.0 Stepping into stories

Not all stories are equal. Risk conveys many stories in different guises, and we have heard from some of the bigger stories that speak out powerfully through the world of policy or academia. The next part of this thesis aims to allow the smaller stories to breathe, to hear the quieter voices, in the hope that these will provide us with multiple meanings and layers, and thereby invite us into new territories. These stories are broadly about living and working with risk, yet interestingly, risk is not always the central character.

I have tried hard to notice the stories told by my participants that may have been easy to overlook, as can be the case when thinking and understanding is hemmed in by familiar theories, normative concepts, and dominant discourses; this has required looking beyond the general to capture what is unique. This chapter is therefore my attempt to ‘scratch the surface’ and to find the moving force within the stories – the making of moments, giving wings, singing songs about potatoes, being alongside, hatching chickens, working out how to live, learning from each other, conquering fear, and ticking along; these kinds of stories do not appear in the mental health literature so very often.

The names within this research have been changed to try and protect the confidentiality of those who appear ‘by accident’ in this study, by virtue of their stories being told, and those who agreed to share their personal experiences with me. I am not telling *their* stories – I am sharing *pieces* of their stories, whilst offering other stories alongside these. Some aspects of the participants’ stories have not been described in this thesis – there would have been too much to incorporate their stories in entirety. For example, Becky’s story spans 15 years, it is a long and intimate story while, in contrast, Karen’s story spans 1 year, and feels more like a short, sharp, shock. The selections and omissions have generally been based on what will bring the most depth and richness to this study, on which stories have highlighted the differing conceptions, issues, and implications within discourses of risk, and were therefore most in need of being given room to breathe.

5.1 Becky: reclaiming motherhood through the ‘making of moments’

Becky had been the first parent to express an interest in meeting with me, to share her story of supporting her daughter, Milly, who had been at risk of ending her life. I asked Becky if talking with me might be upsetting and she replied that she would try not to cry – but during the two hours that we spent together, we both shed tears. At the end of the meeting Becky said that she had felt pleased that her tears had not got in the way of being able to tell her story, and she thanked me for my tears. Showing emotion as a professional can feel shameful; the risk of seeming fragile – as if we are the ones that need looking after, when we should be the ones doing ‘the looking after’. Yet in the presence of pain and distress, it can be hard to remain unmoved or to temper the emotion generated. I hoped that my tears communicated to Becky: I recognise your pain, I want to listen to your pain, your pain matters, your pain is my pain.

5.10 Sense-making

Becky’s story is that of a mother’s journey to understand her daughter, whilst navigating through the confusing landscape of mental ill-health, in the hope that this landscape would bring clarity and resolution:

I didn’t know what I was dealing with, I didn’t know how you deal with mental health, but I do now, much more, but not then.

It’s almost like looking for a portal, you know, in a game. I try and have a look in her life, wherever she is because she’s not very good at telling me what’s going on. She’s got better, but part of her problem is that I haven’t understood.

Becky’s journey showed her the impact an absence of understanding had on Milly; Becky was eventually able to shift her horizons and to see that she was integral to

Milly’s safety and wellbeing, but this was a story that sadly remained invisible to Becky for some time, overshadowed by stories of ‘mental disorder requiring treatment’. This was therefore a story about a Mum who had to remain open to learning, to finding out what mattered, and her quest to find a position within which to stand. It is also a story that starts with Becky looking predominantly to the experts for answers and for reassurance:

You’re very much on your own as a parent – it’s a lot of guesswork. There’s a lot of parents out there who are just totally, they haven’t got a clue, and it’s really hard to live with. It’s hard to live with.

Becky took me back to the very beginning – to the little girl with blonde curls who just wanted to stand in the garden with her easel and paint. I learnt how Milly struggled all through her early years, to fit in, to feel comfortable in the world, to manage the school environment, to socialise – she would cry all the time, she would feel overwhelmed, she would pull out her hair, her eyebrows, and by the age of 12 years old it had all got too much, it had broken her. Milly had tried to persevere, to keep going with school, to be ‘normal’, to live ‘normally’, to try and adapt to life:

There was always something you know, she was that type of kid. And I could never put my finger on it, but there was always something. There was always a problem.

She’s had lots of struggles in life because she hasn’t adapted to life easily…so by the time she got to senior school it was too much and she seemed to be having a little bit of a break down.

Becky tried to make sense of these differences over the years, and this attempt at sense-making occurred, unsurprisingly, through the available frameworks and stories that inform how and whether a child is developing ‘normally’, what a ‘normal’ child needs and what they should be able to accomplish – nursery, socialisation, riding a bike, doing homework, not being too quiet, or too loud, compliance. Becky could see that Milly did not fit neatly into these boxes and this was problematic for Milly, because she could see it too, as could other children who would bully her. The dominance of these stories of disorder and deficit resisted infiltration and instead saw Milly configured as ‘abnormal’. Becky went to the teachers, to the doctors, to the psychologists, to try and seek some clarity, to request support, and she would ask:

Do you think something’s going on, you know is there a little bit of something, do you think there’s something not quite right?

Becky was denied any satisfactory answers, the validation she was seeking or an acknowledgement of her worries, and she repeatedly walked away feeling like a “fussing mother”.

5.11 Expert needed for a ‘broken’ child

Milly is constituted in this story as a ‘broken’ child who needs to be fixed so that she can adjust to the world, rather than as a child whose world needs to adjust to her. The plot shifts in emphasis from Becky’s desire and demands for the world to embrace and know her daughter and to provide her with what she needs to thrive, to accepting that there is something wrong with Milly that needs fixing. Becky is positioned as being outside of the expert understandings that are required if she is to really *know* Milly, and therefore reliant on professionals to show her how to understand her daughter, how to care for her and respond to her:

So, the doctor (psychiatrist) started seeing her which was helpful because she accepted what Milly was doing, she never reacted to it. She had heard it all before, so it was somebody who was putting some normality on it for me. I felt safer because somebody else was talking to Milly who knew what was going on.

When Milly’s struggles are eventually confirmed as being ‘real’ and in need of intervention from mental health professionals, it becomes both a story of triumph and one of tragedy. The triumph is that Milly’s struggles are afforded the promise of finally being understood:

Her inability to cope with life due to autism….this is what the professional’s think…and things have happened along the way which have compounded how she’s felt…so she’s ended up with schizo-affective disorder.

A story has been offered that explains why Milly has not thrived and Becky achieves validation that she had been right - there had been something wrong with Milly all along. The tragedy is that the validation story is dependent on the expertise of the professionals – it is *their* story, and it leaves them holding the power and the knowledge to be able to bring understanding and the solutions required for Milly. As experiences and distress are medicalised, Becky is pushed further away from feeling that she can understand or be the one to support Milly; the story of expert definitions thereby holds its own over a marginalised story of intuitive understanding:

It is really the stuff of horror stories, and very hard to adjust to that, because I wanted to help her, but I didn’t know what I was doing, I didn’t know how to help her…. I couldn’t see how her brain was working.

Becky described intimately and graphically the “horror” and fear that accompanied Milly’s hallucinations – “weird”, “unnatural”, “like someone possessed” – the force of fear in the story is strong and it seeks certainty and understanding to cage the fear. A specialist psychosis team offers support to Milly, support that continued for three years, resulting in Becky feeling that she was getting “well educated” learning all about psychosis and schizophrenia from the professionals, but despite their efforts to speak with Milly, she would not engage with them:

He was a great guy, but he did just talk and talk and talk, and he tried to talk to Milly, but she wouldn't engage with him at all. He brought these sheets of paper to do CBT **(cognitive behaviour therapy)*….and one day she just wrote 'bollocks' across it, coz she just thought it was a load of bollocks.***

This act of protest was not lost on me, and I laughed along with Becky at her description of Milly's response, whilst inwardly admiring her spirit and wondering how she had managed to maintain this, to keep hold of it. I wondered what stories were lurking in the shadows of this dissent, hoping, or waiting to be told. A change of service brought a change of worker as CAMHS stepped in. Becky became hopeful once again because the practitioner was trendy and wore doc martins:

But it didn't work because she was young and she was training, so she had a set path she was going down and, erm, I don't think she had enough life experience to be able to talk to Milly.

5.12 A turning point

There is a moving and striking turning point in the story when Becky starts to speak from a different position:

I think she needed to talk to somebody, but she didn't know how to, and I mean, along the way, we talked, and I started to learn a lot from Milly.

Becky shared how she began to try and put her 'Mum feelings' on the backburner - she had discovered that too much emotion closed Milly down – instead she learnt to talk about the 'horror', the 'self-harm', the thoughts of wanting to die, *"like it was normal"* and to *"walk beside"* her child, all which involved being less of a *"real Mum"*. This 'beside-ness' evoked some powerful images for me - of connection, partnership, visibility, availability – to walk beside requires synchronicity, you need to be going at the same pace. I was struck that Becky did not feel that she was being a 'real' Mum in these moments, and I wondered what other stories of ‘real-motherhood’ were in danger of being overlooked. Becky’s story from this turning point develops into a journey to becoming the Mum that Milly needs, in being open to learning this *from* Milly, in trusting her own intuitive knowledge, something that flowed from the differences newly created through their shifting relationship:

I changed our routine, I didn’t just carry on as normal, I changed what I was doing, and so, I would make time. We would go for a walk pretty much every night, so when we were walking, she could tell me anything because I wouldn’t react too much like a mum, coz if she told me stuff, I’d get upset and that didn’t help her. I had to put my mum feelings on the backburner.

I wondered whether expert involvement had positively contributed to this learning, this change in some less noticed way, or whether it had served more to obstruct its development over the years.

The telling of Becky and Milly’s story bore witness to the enormity of what Becky had navigated through and sacrificed, to be a ‘good Mum’, and the importance of having other people notice these challenges. I could see how these sacrifices had, at times, had to incorporate an almost anticipatory grief around the potential loss of her daughter to suicide, alongside an acknowledgment of the limits of her capacity to protect Milly:

The only thing that helps me, is I know I can do no more than I am doing. And I’m knackered. I feel like half the person I was. So, I feel as safe as I can feel, and I know that I’m doing everything for her that I possibly can do, and, if, if one day it doesn’t work, then I’ll have to deal with that then, but, for now, we just tick along.

Throughout the telling of the story, I am constantly reminded that Becky is not the ‘patient’; she has not been the person ‘suffering’, the person worthy of support, in need of care. Instead, she has been the person to doubt, to question, to ignore, to blame, to hold to account. What becomes narratable is a story of Becky as a ‘half-person’, a ‘half-mother’, preparing herself for the possibility that her daughter might end her life but still just finding ways to ‘tick along’. She tells me:

Anybody that you see is for Milly, and they don’t have any time for you

This comment smacks an emotional punch and I wonder what it would take for Becky to feel like a whole person again, what story would be required for her to matter, and to enable her to be reassembled as a ‘full person’.

5.13 Thinner stories

The story of Becky ‘making moments’ with Milly would I feel, have been easy to overlook - they are not richly described but seemed important to me:

She **(Milly)** ***was thinking – I’m just going to step out now, and it’ll all be over. And then she thought, she remembered the dog, on the other end of the lead, and she thought, if I do that, he’s gonna be stood here on his own, and that’s what stopped her. And it’s moments in your life, people who want to die, it’s moments in their lives, something will just either tick-over, stop you, or it won’t.***

We **(Becky and Milly)** ***sing, and I can’t sing to save my life, so she laughs her head off at me, it’s a way of getting her to laugh…and we break into song about anything…to be a bit crazy…and so she’s breaking into a song about peeling potatoes. So, I’ve created a sort of semi-mad world for her, where she feels comfortable.***

If singing songs about peeling potatoes entails the ‘making of a moment’ that keeps Milly safe from suicide, what might we call that? Is it even possible to harness or theorise such moments? If practices could be shaped by moments such as these, what would this look like?

Despite the therapy and the medicine and the inpatient stay, despite the different professionals that came and went over the years, with varying degrees of helpfulness experienced, Becky ends her story by telling me that she has simply had to find a way to accept the presence of risk in their lives, to control her own fear, and to allow Milly's independence to grow:

Living with a daughter who was wanting to die for the last five years, you know, you get used to a way of thinking. If she really wants to do it, she'll do it. I've done everything I can possibly do for Milly, and I will continue to. But, if at some point in her day she wants to go, she can do it. There's plenty of opportunity because I have to let her live a life.

What is not explicitly stated, but palpable in Becky's story, is that it is fear that has animated throughout the story – at times pulling Milly and Becky closer together or pulling them apart; creating the felt need for professionals and their explanations, theories, medications, and certitude. Life was able to be lived again for both Becky and Milly, once fear became manageable, it was the stories of fear that seemed to create paralysis and uncertainty. Becky's story showed how the presence of experts helped her to feel less afraid, because she was no longer alone. Fear can keep us locked in and therefore less 'at risk' than when reaching for a future. It was not the *risk reducing* that enabled them to get on with living their lives, and Becky shared how they continue to live with risk. In this way the problems being faced seem not to be primarily about how to reduce risk, or cure an illness, but about how to live a life even when things feel unsafe.

Interpretation

5.14 Expert frameworks

There was an unexpected sense of freedom that came from being with Becky as a researcher, as opposed to being with her as a therapist. Goffman (1959) shows how it is through our roles that we come to know each other and how we are also able to know ourselves. My researcher role did not require me to make things better, to cure Becky's pain, to 'work it out', and it therefore allowed me to feel somehow more connected to Becky – perhaps because I felt more able to embrace what made us the same, rather than feel the distance created by what made us different. Patient/professional, healer/helped, ill person/well person, giver of knowledge/recipient of knowledge – roles position and assign expectations and responsibilities that emphasise difference – they are dualities that say: I am different to you, I am not like you. They are also dualities that ascribe who holds the expert knowledge and therefore the power.

Becky's story evoked a powerful narrative of the pull to look to expert knowledge to bring understanding, and it raised questions as to how normalising processes come to determine what lies inside and outside of parental capabilities, how these stories are diminished or evoked, and how they shape what the 'lay-person' can 'know' or feel equipped to deal with. This goes beyond definitions of 'normal', but points to the construction of the establishment of normative orders (Krzyżanowski, 2020) and how, as Frank (2010), suggests these serve to emplot what becomes narratable. In this way discourses of motherhood and parental competency are inevitably shaped, determined, and judged by the huge networks of expert knowledges and the institutions and practices that accompany it. Theories of child development and mental illness are communicated as if they are concrete truths that exist outside of history or culture, rather than as responses formed within, and influenced by, a specific time and place. These dominant stories with their normalising effects, were, to some extent, undermining of Becky's identity, and sense of herself as a competent mother.

Within British culture, it is accepted unquestioningly that if you are suffering and unable to rectify this, that you should approach an expert who can explain and remedy these difficulties (Smail, 2018). Every sufferer will instinctively seek a cause for their suffering, to be able to assign responsibility for such experiences to something, or on someone – we need stories that will explain the mysteries of our suffering. Religion used to provide these stories, now we look to science and medicine. When Becky is initially turned away by professionals, when her concerns are left unheard, her sense of powerlessness, worry and fear increases, and so does her belief that Milly needs expert intervention. If discourses of risk are understood as 'technologies of government' that function to reinforce and preserve a way of thinking that draws attention to the contingency and misfortune of life (Boholm, 2016), then responding to it becomes an activity requiring expertise.

There is a redemptive quality to the story once Milly's problems are defined through the lens of mental health disorder, providing Becky with some validation thereby potentially absolving her of any blame. However, the story makes visible the possible dangers inherent in simple, technological understandings when they create the illusion that once it is known what is 'wrong', then the knowledge of how to fix it will become accessible and available. The labels of autism and schizo-affective were offered as explanations of Milly's suffering, but the vulnerability inherent in such explanations is that it can stop the search for alternative meanings, or broader understandings, whilst defining and limiting responses.

5.15 Quieter stories

There are aspects of Becky’s story that remained largely untold, but which hinted at the non-technical dimensions of mental health such as relationships, meanings, and values. These are stories that can become less relevant when technical expertise is prioritised. One example is the thin thread of the story of Milly’s father, a largely invisible character, someone Milly loves, but “can’t stand”, and we hear only that he does not understand Milly, does not believe her, and does not know how to support or respond to her. Milly’s little brother also enters the story on a few brief occasions when we hear how he took up some space that Milly resented – she was jealous of him, and she could not be trusted to be left alone with him. I am in no way suggesting that Milly’s conflicted relationship with her father was either the cause of, or to blame for her pain, but he could have been part of the solution, and I wonder what may have been possible had more ‘non-expert’ voices been invited in.

Becky’s story began with the sense that she had been stripped of her capacity to recognise the narratives that told of her success and support, less able to feel the benefit of their full force. Yet it was the changes that Becky finally made and storied, which enabled her to recognise the value within her own knowledges and the potential her relationship with Milly offered. Becky turned towards Milly, began to learn from her, rather than solely concentrating her hopes on the experts being able to teach her what to do, or make her child well and safe. A discourse of personal agency triumphed and allowed a shift to take place that seemed to engender the key changes in Milly’s life. The professionals certainly seemed to play a role in enabling this, but there is a sense that this was not always the primary intention, but more of an unforeseen consequence. An example was in witnessing the psychiatrist's approach in talking about self-harm and hallucinations with Milly - Becky became less afraid, therefore more able to respond to her daughter, and more open to learning from her.

Two kinds of emplotment are taking place through Becky's story: one that configures risk as resulting from mental health disorder and requiring professional expertise – treat the disorder and the person should become safe. A counter emplotment is, however, also at play which locates risk in a more relational territory, pointing to what can ensue when we are not heard or understood by those around us. The effect of being caught up in the 'risk/mental disorder' story, is that alternative stories become squeezed out and less visible.

I am reminded of a quote from William Hodding Carter (1953) when he wrote that there are only two lasting bequests we can hope to give our children - one of these is roots, the other, wings. The wings for me are about being able to trust and love children absolutely, so that they can choose their own path to follow. Bequeathing wings amidst a context of self-harm, or when there are dark thoughts lurking, can be needed, but it is often a terrifying step for both parents and clinicians to take. They want risk 'to be managed' before giving out any wings, but *sometimes* the wings are needed for safety to grow, and we see this vividly in Becky and Milly's story.

5.2 Cathy: CAMHS – villain and hero?

5.20 On being both

When I embarked on this research study, I had wanted to hear the voices of both parents and professionals, and the three mothers who met with me all happened to be both, as many parents of course are. Cathy worked as a learning disability nurse and her story served as a helpful reminder that we are never one unitary story. Listening to these mothers wrestling with the tensions inherent within their multiple roles and identities, engendered strong emotional resonances for me. The lock-down response to covid-19 was brutal for many and my then 14-year-old daughter, was hit particularly hard by it. I witnessed her retreat into an old, oversized, green hoodie, her body shrinking before my eyes as her sense-of-self slowly eroded away.

Seeing your child wither is extremely painful, but there was a secondary pain that came with the realisation that there was no way I would be able to tolerate my daughter being on the receiving end of mental health services. It is not an easy situation to be confronted with when you recognise that you would not trust your own service with your child. This is not an indictment on the many caring and skilled people working in the field of mental health, but points instead to the broader influences at play: I was too aware of what can result when you turn children into ‘mental patients’ and what can happen when your child sees that you cannot cope with their pain.

And so ‘my mothers’ in this story are not ‘just mothers’, and I am not ‘just a practitioner/researcher’, and yet in the interfaces between our multiple selves emerge some interesting insights. For Cathy there were potential resources in her dual roles, but also some restraints. She saw her professional identity as offering her objectivity, knowledge, and skills and there was a sense that she should be able to access these, to make use of them and that they ought to show her what to do, as a mum. When she found herself in situations that were full of fear and uncertainty Cathy could no longer access this objective, sensible, professional part of her brain; she needed the rationality of the experts to guide her out of the depths and into shallower water. When her daughter, Mary, started to express thoughts of wanting to die Cathy told me:

This is beyond me. Like, this is beyond what a mum can do…I'm just a mum, and when I'm mum, I'm in mum brain, and it's sometimes really hard to access the more objective parts of your life.

And it's very scary as a mum, to think that you can't protect, or knowing how best to protect without making the situation worse….it's hard to get that perspective about what is a real, genuine risk, and what's mummy-panic-brain.

Cathy recognised that being a mum, right from the very start, involves keeping your child safe and managing the risks that the world poses to them – it is second nature as risks are endemic. But Cathy felt that she was in unknown territory when her child started to pose a risk to herself - started to have thoughts of wanting to die, actively placing herself in danger, becoming both the producer and arbiter of risk. Cathy could not make sense of what was a 'real' or 'genuine' threat, her doubt somehow residing in her mum-ness, undermining the very essence of a mum's purpose – to keep your child safe. It is the fear that is narrated as getting in the way of being able to 'know' what she is facing. When faced with a situation that is 'beyond her', Cathy recognises that she must reach out. This involved placing trust in the experts:

That risk was horrific, the feeling that I felt as a parent. I felt completely powerless, completely and utterly powerless….Initially getting practitioners to listen to my concerns was difficult and getting practitioners to understand the risk that I felt I was seeing escalate was not easy and not successful in the beginning.

5.21 Harm or heal?

When Mary was referred to CAMHS and offered an assessment, Cathy's 'panic brain' started to calm down due to the hope created that someone would be able to help her child, to make things safe. This assessment took place over the phone due to covid, and it quickly quashed their glimmer of hope when support from CAMHS was denied. Cathy was left feeling that she had not managed to find a way to tell her story adequately, and Mary, a shy, awkward, distressed 14-year-old, had not managed to tell a complete stranger, over the phone, that every single day she was feeling like she wanted to die.

She was devastated. She was like: no-one's listening to me, no-one's taking notice of me, why don't they care? Why don't they do something?

This experience left Mary believing that no-one could help, but when risks escalated further a subsequent referral was made to CAMHS. Mary was initially adamant that she would not engage with CAMHS, the people who had added to her pain, but she was persuaded to try again:

The waiting, the waiting was horrid. You're kind of holding on, as a parent you're thinking she's gonna get the support, and this is gonna help her, so I'll just hold on, like you literally start to hold all your life together, like you start taking a big, deep breath, and holding onto it. You put so much emphasis onto the fact that when therapy starts it's gonna be like a magic wand, and it's gonna make it all better, and go away, and of course, it doesn't, it's just the start of it all.

Cathy immediately felt as though the risks had reduced, just from the fact that someone was seeing Mary, someone else was talking to her. What appears to have *actually* reduced was Cathy's fear - the responsibility for keeping her child alive was no longer her burden to bear alone.

Therapy began and ended all too quickly – Mary ‘engaged well’, she said all the ‘right’ things, did all her CBT homework, the therapist said how pleased she was with her progress, and Mary was discharged. Cathy recalled:

I was told that she had done so much better than expected, had engaged so readily, and that was just what I wanted to hear, you know, god, my daughter’s done really well, things aren’t as bad as I thought they’d been, it’s just mummy worrying, she’s gonna be alright. But I had this massive inside feeling, you know the gut feeling, the one that’s hard to express, justify even, but that real gut feeling that says: there’s been no change.

Cathy had not been a part of the therapy and was left questioning how open Mary had been. Cathy *knew* her daughter, how she liked to please, how she may have been motivated to be a ‘good patient’, to not cause any bother, but this potentially invaluable knowledge was left untold or unheard. Mary’s belief and hope that anything could really change, that her thoughts of wanting to die could leave her, spiralled away and it did not take long for the dangers to increase again, leading this time to the crisis team responding. This is the part of the story where CAMHS is experienced by Cathy as transforming into more of a hero than a villain.

The crisis team brought about a key turning point in the story; Cathy described their involvement as the best thing that could have happened, because:

This is where things started to feel, I’m talking about my perspective, better for me. So, for the first time, I was there when she was spoken to, that was the first time I was actually present while she spoke……it was really important for me, as a parent, to be able to see how she was engaging, to see what level of honesty she was giving them about her situation, and to hear their response, because hearing their response gave me strategies on how to manage Mary. That was the start of talking about risk – it turned out to be the biggest turning point because we started to have these dialogues about risk.

It seemed like a highpoint for Cathy, she was now a part of it, but I was struck by how long it had taken for these inclusive conversations to take place.

Cathy's experience of being included, of hearing and listening and contributing, enabled her to start having open dialogues about risk with Mary – something that was made available to her when she was actively invited in, when she saw and learnt that it was ok to ask difficult questions, when she no longer felt alone, and ultimately when she felt her fear reducing again. Cathy shared how she had to confront the tension between balancing privacy against protection and how there were:

times when I checked on her, for my own peace of mind, and that's not necessarily been the right thing for her, but it's been the right thing for me.

It was a time that was described as being a 'living hell' when every morning she would wake up feeling sick from the sense of dread until she heard Mary's voice, which gave her the signal that she was alive and well. There is a sense of Cathy managing a 'double edged sword' – the more Mary experienced that her Mum was able to witness and hear her pain, the more she could be open about her suicidal urges, and the more the fear grew in Cathy, a fear that needed to be kept under control in order to find a helpful balance between privacy and protection, and which allowed her to attend to Mary's needs whilst neither prioritising nor completely neglecting her own. The story shows how their relationship becomes crucial to safety; what people often lack is someone in their life who cares enough to listen and who they trust enough to talk to – ideally, I would argue, that this person should not be someone who is merely passing through their life.

5.22 Shifting sands

At this point risk enters the story like a ‘hot potato’ that no-one wants to be left holding as the responsibility for creating safety resounds around the system. CAMHS appears more villainous than heroic as Cathy hears the intolerable message:

’Well you’re the parent, you’ve got to manage the risk’ – if I had a pound for every time that was said to me I would be rich….basically what they are saying is: ‘if your child takes their life, tough, you haven’t been good enough’, and they put in letters things like ‘mum is aware of the risks’ – but that’s meaningless, what does that even mean? And?

What *does* it mean? It perhaps means that everyone is afraid, and no-one wants to be left carrying the burden of responsibility; that it will not be ‘my fault’ and that *we* can be less afraid, but *you* must live with the fear. In protecting myself, *you* are left more exposed. Cathy is left believing and feeling, in that moment, that she is the one left holding the responsibility, an attribution that serves to increase her fear and erode relationships.

By the time of our meeting Cathy had reached a point of accepting that risk was here to stay, alongside the realisation that life could still be lived:

The funny thing about risk is, risk is still here. The risk moves, it doesn’t stay the same. But things are safer. Does that sound bizarre?

For Cathy this realisation was a ‘funny thing’ – that the threat of harm, or the risky behaviours could persist, but a feeling of safety still be present. They had found a way to keep going despite the risks remaining ever present in their different guises and this brought a sense of empowerment:

The two practitioners that have worked really well with us, neither of them have ever said – ‘you must do this, you must do that’. And they’ve also said – ‘you are the mum, you know your child, it’s ok for you to decide’. But they haven’t

said – ‘well the risk lies with you, if something happens’….that’s where you start to feel empowered as a parent, it’s the fact that I can, that I have learnt, and she has learnt her way of letting me know what she needs.

Getting to this point seems to have required some key ingredients: the development of honest, trusting relationships – between mum and Mary, and the family and the clinicians; the acknowledgement and sharing of expertise – everyone’s expertise; hearing, understanding, and responding to fear; resisting the pull to avoid stepping into responsibility; and acceptance of the ever-present threats.

Interpretation

5.23 Managing potential harms

Cathy's story was difficult to hear in parts as often it is a story of CAMHS not reducing distress or pain but adding to it. One example of this is when Mary was refused support from CAMHS - the discourse of risk becoming a discourse of inclusion/exclusion as Mary struggled to hold her own in this story, in the face of institutional processes and boundaries. Making decisions on whether to offer, or declining to offer, specialist mental health support to young people is not always straightforward. It can be seen as harmful pulling young people into CAMHS when what they are experiencing could be perceived as being within the parameters of what is a shared, common experience, (life hurts at times), or when they are coping with life's challenges reasonably well, thereby undermining what they are achieving independently, or with the support of their loved ones. There are risks in turning young people into 'mental health patients', such as when risk discourses overshadow a discourse of personal agency.

Children can also be harmed when they experience what feels like rejection from mental health services – their problems are seen as not mattering or not being severe enough or serious enough, eradicating hope, as with Mary. Either way, there is the potential for harm, and it is not uncommon for families to enter CAMHS feeling dejected, exhausted, despondent, or frustrated. It can be a starting point that can create adversarial responses between families and clinicians, resulting in unhelpful judgements being made on both sides.

As a service that functions within an established discourse of risk that often perceives risks as being real, identifiable, and manageable through measurement and professional judgement, it is uncomfortable to be confronted with situations whereby in attempting to do just that, dangers have actually been heightened. These types of stories often sit silently, and Frank (2010) reminds us to consider what is at stake, and for whom within these quieter stories. Stories of incompetence or causing inadvertent harm, or getting things wrong are incompatible with stories of professional competency. These stories are dangerous as they have the potential to undermine, to question expertise and thereby to unsettle power and authority. A professional hierarchy is at stake.

Cathy’s story shows how her safety is intimately tied up with Mary’s safety – she knows that she can make things worse if she is unable to walk the delicate balance that is required. Clinicians in CAMHS are constantly faced with the tensions at play between confidentiality, patient choice, competence, parental responsibility, and safeguarding. The relationships between these tensions are, in my experience, rarely considered sufficiently in all their complexity, alongside the implications they may hold for practice and safety. When the service is seen as being ‘for young people’, *their* choice is often what is prioritised, reinforced through policy, and it is not uncommon for adolescents to opt to leave their parent out in the waiting room. The justification given is that parents are kept informed of any safeguarding or risk issues, and the discourse of privacy is seen to trump all others. The relationship between clinicians and parents becomes one based on ‘information exchange’ but what can be lost is the potential brought about by creating opportunities for generative dialogue, or the nurturing of understanding, or the foregrounding of relationships, or seeing how safety is relational.

5.24 Safe relationships

Mental health services, and modern British culture more broadly, pay only lip-service to relationships, we live and work in a highly individualistic culture where relationships become either invisible or pathologised; we learn to pay attention to individuals from an early age and to ignore relationships (Scheff, 2013). Cathy's story resonates with Becky's in that we see the potential that comes from inclusive practices that promote dialogue and which help to build safe relationships. When emotional pain and upset is part of everyday life, and is often very typically heightened during adolescence, how are lines of responsibility determined? Should experts be 'taking over' or coming in alongside parents so that 'it' is no longer experienced as being 'beyond them' to manage their child's mental distress – and whose decision should this be?

The risk rhetoric offers us a way to communicate uncontrollable fear and a route to remove ourselves from unbearable responsibility. Fear reduces when responsibility is shifted and the discourse of risk acts as a 'forensic resource' in providing explanations and apportioning accountability when things have gone wrong (Lupton, 1999). Cathy experienced the weight of responsibility acutely, and the subsequent empowerment that resulted from it being shared. Achieving this genuine sharing of responsibility comes with challenges within mental health services due to its struggle to escape from the culture of blame, where back-covering and responsibility-shifting has become common, and where clinicians are consequently wrestling with their own fears that demand containment.

Safety is often seen as the antonym of risk – in this way if a situation is safe, the risks must surely be reduced (Moller, et al., 2006; Aven, 2009); safety is thereby defined as the absence of risk. Yet Cathy and Becky's stories show us that this is not accurate –

risk and safety can and do co-exist. This poses the question as to whether safety is more about *acceptable* risk? About *feeling* safe, as opposed to *being* safe. If this is the case, then we are firmly in an explicitly subjective, culturally, and socially mediated realm, without the façade of science and objectivity to hide behind. How much danger are we able to tolerate and yet still feel ‘safe-enough’? This would surely vary hugely from person to person, from family to family, from organisation to organisation.

Throughout Cathy and Mary’s story, risk has appeared like shifting sands, and therefore the question becomes: is it always the most helpful area to focus on when it can be so impossible to grab hold of? One might also ask – what is the *point* of trying to grab hold of risk, if safety is not contingent upon it? If safety does require risk to be at an ‘acceptable level’, then value judgments about tolerability come into play, and the world of values and emotions are notoriously confusing and messy.

5.3 Karen: Learning that knowing him is enough

Karen’s son, Mason, went to school one day and told his teacher that he was having thoughts of wanting to end his life. Mason was 15 years old at the time of this revelation and it came as a huge shock to everyone. These shock waves reverberate through Karen’s story – they are almost palpable – the shock and the incomprehension. The story begins with an inpatient admission and ends a year later with Karen accepting that risk may not go away but believing that she is able to understand how to live alongside it, and to trust that she knows Mason well enough to recognise it.

5.30 Making things worse?

Mason had told people about his thoughts because he was feeling increasingly afraid; the crisis team swept in, Mason was seen by a psychiatrist, and the decision was made for him to go into the CAMHS mental health inpatient unit. This decision seems to have been based, in part, on the fact that no-one, not even Mason, could understand why he felt the way he did:

He said he didn’t understand why, he didn’t know why. Nothing had happened, you know, nothing – and he still says the same now…it was horrible, and I just thought, well why? Why d’you feel like this? How can I help you and how do I keep you safe?

Karen was firmly tasked by the professionals to keep Mason safe at home – he had a plan to end his life which he would not share - and so Karen did as she was told and remained by his side. She told me:

It was all about keeping him safe really…and then I was spoken to as if I was making it worse because I was with him all the time. I went in on the big teams

meeting and it was suggested that I would've made it worse by being overly anxious, but I don't feel like I was. I was just being there for him, I felt.

The words 'overly anxious' feel somewhat violating as Karen is reconfigured in the story as a mother who is failing – how much anxiety would be seen as acceptable when faced with your son telling you that he plans to end his life? I felt pulled to ask more questions about the admission, perhaps because just as soon as it was mentioned Karen seemed to be steering me away. But the pull also came from feeling enraged. My time working in mental health services has highlighted that inpatient admissions can produce very mixed results, and my sense is that I hear more accounts of harm and trauma stemming from inpatient experiences, than stories of success and recovery. Perhaps these are simply the stories I am more drawn to because it does not feel acceptable for services to be causing harm, by intervening in ways that are known to have the potential to damage.

Karen's initial reluctance to talk about the admission was something I noticed when returning to the transcript, it was the first time I had really probed during the interviews. I wondered what it takes to criticise a service that you feel has brought many positives, and which you still feel reliant on to keep your child safe and well. This dependency can create a striking power differential which may render many stories untellable:

Me ***Can I ask about the decision to go into*** (name of unit)***?***

Karen ***So it was his decision, he felt so unsafe, he wasn't sectioned or anything.***

Me ***Did you want it to happen?***

Karen ***Not really no. But, but, I have always been happy to go along with whatever he, and the professionals think that he needs, and that's what they thought.***

Me ***So he wanted it, and the professionals thought it was a good idea?***

Karen ***Just coz everybody was so shocked, everybody, like why, why would he feel like that? You know and we still don't know why.***

> Me ***And so him going in, that wouldn't've been your choice?***
> Karen ***Not really, no.***

Despite claiming that she had felt 'happy', I did not sense that it had been a 'happy' option to go along with the professionals' decision. I think this 'sense' arose from the brevity of Karen's answers. I felt that Karen became more willing to talk about the admission when I expressed some surprise and interest that alternatives had not been considered, perhaps this reassured her that it was safe to criticise. She explained why she had not wanted Mason to go into the unit, and why she had not shared her views:

Just because I didn't think it was the right sort of setting for him…and I just knew he wouldn't get anything from it, and he didn't. And he asked to leave because he got attacked by somebody in there. So, it just made the whole thing a lot worse, and then he came home.

I thought well he must be better off in the unit then because I mustn't've been doing it right. … I felt like he'd been taken away because they could do a better job but then they weren't, they didn't. And he was anxious and frightened the whole time he was there.

Mason was on the unit for 6 days and Karen shared how in that time he had been placed on long-term medication by day three and assaulted on day six by a 17-year-old male patient who had simply taken a disliking to Mason. Mason was unsurprisingly still struggling with this assault at the time of our meeting almost a year later. As Karen shared what Mason had experienced, I wondered how anger was not making an appearance in the story, as I felt its presence acutely in my own embodied response.

As I listened to Karen, I imagined how I would feel if this had been my child. I felt the rage of a mother, and the indignation of a clinician in CAMHS, and I was conscious of the need to remind myself that I was bearing witness to only one part of the story, one version. This does not detract from the significance of Karen's story, but it was a reminder to contain my critical thoughts and my exasperation towards a service that may (or may not) have made poor or overly hasty decisions.

5.31 Fear's dance

Frank suggests that it is important to understand what is driven by fear and what animates desire in stories (2010, p81). I think it is reasonable to say that Karen's fear bears forcefully down upon this story, the fear that her son could end his life, the request and the desire to keep him safe, and the fear that she could get this wrong. These are fears that render her powerless, silencing her voice, leaving her unable to speak for her son, to say what he needs. It is a fear that, in that moment, invalidates her belief that she knows Mason better than anyone else.

They were basically saying, hide things that he could harm himself with, you know, to keep him safe – it's so broad for someone that's in shock…. I just felt like, well I was scared so I was just with him constantly.

Karen's fear does also serve a useful function, we see in the story how it pulls her towards her son, she sleeps in the room with him, she rests her hand on his leg so that she will wake if he moves. Through Karen's story I start to witness fear's rhythm as Karen learns to accept her fear, to manage it, to respond to it – it is like a beacon that tells her when she needs to stay close to him, and when it is safe to retreat again.

It was scary, but I didn't let him see that I was scared about it, that's the difference from the time before to the time now.

When you're a mum, and you've never experienced your child saying that they feel that way, it was difficult. I was a bit like, I wanted to shake him, you know – 'don't be like that, you've got so much to live for' – I found it really difficult.

Fear becomes activating, and as the story progresses, we see how Karen is no longer disempowered or incapacitated by its force. A key factor in bringing fear into this bearable rhythm is the approach taken by their CAMHS keyworker which Karen described as helping her to understand Mason, and helping Mason to feel understood by his mum, even when there were no words available. Mason's fear became a barometer for Karen's fear as they entered into a wordless dance that told them both how they were doing and what they needed from one other.

Through the support of CAMHS we both understand each other more, and we've both learnt from it. I've learnt how to act when he says certain things and what I should be doing.

He won't sit down with me and tell me how he feels. I'm just like, observations, he's had a shower, he's been going outside, he's laughed….and that's all I can do – I can only observe, he won't let me in. He doesn't need to say it anymore, I can just see it in him, he does let me know just by being him and just being more aware of his feelings instead of presuming that he's ok, I just can't presume that he's ok.

The fact that the admission ended up causing more trauma than healing could be seen in some way to offer back to Karen some of her parental authority. She begins to connect more to her capabilities, and we see fear reduce and self-assurance return:

I just feel that as a parent, that your child's safe with you as long as you are a safe kind of parent.

Karen and Mason's dad went together to the unit to bring Mason home, and it is at this point that we begin to see Karen reclaiming her motherhood. It is the only time dad makes an appearance in the story, but it seems significant because they go together to collect their son, despite being separated and not on speaking terms. I wondered what this was like for Mason seeing his parents turn up for him, estranged but unquestioningly coming together due to his struggles and his suffering. Once Karen felt like she understood the process, the systems, once she had developed relationships with the professionals involved, she was able to feel that people were listening to her. This meant that she could make her intuitive knowledge of her son count and be heard – a knowledge that comes from a parent's love and intimacy as opposed to knowledge that comes from professional training.

5.32 Symbolic practice

Mason went on to encounter another difficult stage, which took him from thinking about ending his life, to attempting to end his life. Karen described the mix of emotions this gave rise to, but also how she had managed to remain steadier, calmer. There was a sense that this time she knew what to do, she knew there were people she could turn to for support – she understood the rhythm, the roles – there was a more predictable routine, an offering of practices and responses that could be expected.

The fear was more palpable in Mason:

> ***Mason's mental health deteriorated again, and it was suggested that he go onto the unit, and he wanted to because he felt that poorly, that he didn't think he could be safe at home, and I was thinking: please no!***

The unit rejected this request, to the relief of Karen, but to the disappointment and confusion of Mason – the message for him was that he was not 'bad enough' this time, and it is easy to see from where this confusion arose, when he had been admitted for thinking about suicide, but rejected after attempting suicide. Embarking on a different journey this time around, a less predictable, familiar journey, saw Mason's fears increase.

The alternative plan was to bring the crisis team in to support Mason, and they came to visit each day and Karen thinks that they did help to keep Mason safe, even though he would not speak to them:

He finds it really hard to form bonds, especially when they are talking about how you're feeling. And he felt a bit like – 'you know they keep asking me on a scale of 1-10' – I just said, like, just humour them, like, 'yeah, I'm fine' – but he hated, hated being scaled, and they just kept doing it.

Knowing that somebody was going to be checking-up on him tomorrow….not even by doing anything, just, just turning up.

I was struck by how simply 'turning-up' was the bit that helped – even though they were irritating and going about it in the 'wrong' way – 'turning up' is what was perceived to have kept Mason safe. A less visible story is revealed, a story that hints at the symbolism underpinning the act of 'turning-up' - it may not deliver any practical benefit to Mason but it offered what could be seen as a symbolic gesture – a representation of care and concern, a reassurance that others were looking out for them - available, dependable.

Karen pleads with Mason – you have to humour them, to show you believe in them, because we need them to turn up. The irreverence in Karen telling Mason to just "give them any number" was startling – it says to me: don't let them think we are not believing in them, because they may stop coming – just play their game. Connection, acknowledgement, and mutual understanding could all be seen as essential when we are left to navigate through unsafe circumstances, and this is perhaps why Karen needed them to come.

5.33 Hatching chickens

For me, there is a big piece of the story that remains unknown, missing, and it is a piece that is missing for Karen too, and maybe even for Mason. That piece is the bit that tells the story of why a loved, cared for, 15-year-old boy, with a life full of possibilities ahead of him, ends up wanting to kill himself. It was this unanswered question that invited anger from Karen when she described wanting to shake him back to his senses. She explained how, following Mason's over-dose, she had felt guilt for feeling angry, believing that she should have been more understanding. I shared with Karen that I would have felt angry too, I knew this intuitively as a mother.

When things are incomprehensible and we are afraid, we are drawn to 'simple' stories or explanations – depression, autism, trauma, but I do not often find these very convincing. They are stories that require suffering to be narrated as illness, deficit or disorder. These explanations become so fundamental that other experiences are written out, silencing other possible understandings of how emotional pain, distress or disillusionment become present in people's lives. With Milly we had the 'easy' explanation of disorder, for Mary, trauma was more than sufficient in providing understanding, but for Mason, what did we have? On day three of Mason's inpatient admission, he had been started on anti-depressant tablets – so he was suffering from depression? This did not provide a very fitting conclusion – it was a 'thin' story (White, 1997) and I felt drawn towards stories that led us into different territories.

I asked Karen what she thought it would take for Mason to be living a safer life:

Karen ***it's (school) in the way of him feeling well because he feels well outside, with an animal of any kind, you know.***

Me ***Has he always been like that – out-doorsey?***

Karen ***No, no, he's never been like that, until he first said that he felt suicidal, and I said – you need some pets, so we got some chickens…we hatched some chicks and I said, they're yours, you have to look after them…he loves it, they've all got names, they all jump on his shoulders…and that sort of responsibility of having to be ok for them.***

We hear the story of a boy who is starting to thrive, who has found a purpose in his life, a way to feel needed, responsible, successful; we hear that he now knows what he wants 'to be' - a farmer, and so it has also given him a possible future, an aim, a hope, a passion, a reason to live his life. Mason, with the help from his mother who knows him, found a way to live his life in a different way, one that had not been available to him previously. Karen thinks that it might be a bit strange for a 15-year-old boy to love chickens, but their CAMHS keyworker took an active and keen interest in this part of his life, visiting the house, seeing the chickens, reflecting, and validating this new preferred identity story that was being authored - bearing witness to it, and thereby 'thickening' it.

This story offers up a very different narrative reminding us of what is arguably needed to live a good life (purpose, to contribute, a sense of achievement, validation, and recognition from others etc), and serves as a warning of what can happen when these things are not available. It is no longer an illness/risk narrative, but a health/vitality narrative – what do we need to live? Not, what do we need to cure us? Karen knows that hatching the chickens is what made the difference for Mason, but it is not the part of the story that she foregrounds. In fact it is a fragment of the story that we almost seem to stumble upon, and which she moved away from quite quickly, as if she thought it would not be the bit that mattered to me, the moment that would grab me, the moment that I would want to hear about – because after all, I am 'interested' in hearing about ‘risk in CAMHS’, not hatching chickens. And yet it was the part of the story that made my heart sing and brought tears to my eyes.

Interpretation

5.34 Colonising motherhood

Karen's is another story which reveals the potential that mental health services have for causing iatrogenic harm - harms 'brought forth by the healer'. What is surprising is that these harms appear to have left Karen's trust in mental health services unshaken – the professionals are generally believed by Karen to always know what is best for her son, despite at times, clear evidence to the contrary. Mason's willingness to return to the unit despite it failing to keep him safe highlights how trusting in expert knowledge can bring safety and containment amidst a sea of confusion, threat, and fear. This unswerving trust in the experts comes at a cost however, and one such cost is the erosion of motherhood that is storied and witnessed, but which is almost overlooked by Karen.

In using the word 'colonise' my intention is to try and communicate something of the power infused take-over of motherhood that is visible through Karen's story. At times it is subtle, and at other points more explicit, but it emerges through practices that, at best, fail to take account of her expertise as the person who knows Mason best in the world, and at worst, demoralises and disempowers her. I am regularly perplexed when clinicians, who may have only met a young person once, assume they are better equipped to assess the child's risk than their parent. Interestingly, parents don't often protest this, possibly because they do not appreciate that there is no complicated science behind these predictions. Instead, what it involves is the capacity to be able to have tricky, painful, and open conversation about confusing emotions, or traumatic events. I am not suggesting that this does not require skill, what I am suggesting is that perhaps the real ‘skill’ involved when safety is created is in fact being overlooked or presented as something that it is not.

5.35 Risk as ritual

This takes me back to the practice of ‘turning-up’ that was experienced as being integral to keeping Mason safe. I felt that there must be more to the story than simply ‘turning-up’ – if it is not about what they *do*, then is the significance to be found in what they *represent*, who they are – mental health experts? ‘Turning-up’ engenders a sense of ritual – helping to control a situation, by creating expectations and responsibilities, by modifying experiences through the expression of status, the assigning of social relations and duties.

In this way trust is and must be held in those cast in their roles, as they turn up with their professional badges, offering their unusual questions and their advice. Ritual is typically repetitive, purposeful, symbolic behaviour that we generally can’t comprehend, or necessarily explain. Yet often the connections between culture, cognition, and perception, are revealed in these symbolic forms (Turner, 1969). Malinowski (1948; 2014) theorized that rituals are innately tied to anxiety-provoking situations - they help decrease anxiety that may impede normal functioning and can reinforce a sense of community through the sharing of common beliefs. Rituals show us what matters and what moves people the most and reveals the values that lie at the deepest level (Turner, 1969).

The professionals that just ‘turned-up’ for Karen and Mason progressed through the stages of assessing and managing risk, a process which could be described as engaging people in a ritual that builds relationships, which opposes isolation, opens dialogue, and makes emotional pain understandable. It is a ritual that communicates that ‘people care’ and that ‘you matter’. Of course, risk practices could not be storied as ‘emotion management’ because emotion linked to risk is almost taboo – emotions are dangerous - unquantifiable, unscientific, subjective, and intangible - the opposite of the risk and measurement discourses. Yet a ‘ritualistic response to fear’ seems reflective of what is taking place in the encounters between the crisis team, Karen, and Mason. Karen tells us at the end of the story that risk is still around, but they have found ways to live safe enough lives, free from paralysing fear.

5.4 Patrick: Striving to undo the damage

5.40 Antihero and/or family therapist?

Patrick warned me as he shared his story, that his lack of anxiety when working with risk may be an indication of the presence of psychopathy, a personality trait that is often to be found in our favourite antiheros. His comment is tongue-in-cheek, and hints at the possibility that he is not the 'norm', he is not *like the others,* as he strips off his work clothes and firmly shuts the door on his day. Patrick has worked in mental health services for over 30 years and at the time of our meeting worked as a senior systemic family psychotherapist in CAMHS. Patrick's ideas separate him out from the established order, and he makes it clear when he emphasises:

I'm coming from a different place to most of CAMHS.

Straight away we are alerted to the fact that his ideas and views may not be representative and Patrick proceeds to share a powerfully scathing view of the service within which he works:

We have made parents suspicious of every behaviour and every feeling that their children have…that you need an expert to diagnose and fix for you…and I can't help feeling that as a service, we've kind of colluded with that.

I think we just make things worse. Our existence makes things worse.

5.41 Pathologising childhood

This last comment is elaborated on at various points in the story, as ideas are offered which may explain why the existence of CAMHS is inherently problematic. Patrick introduces us to a narrative which he describes as the 'medicalisation of distress', the consequences of which are that:

As a culture, we have undermined parents' confidence and competence in being able to manage their children.

We have professionalised, pathologised, childhood to the extent that now we have a whole series of acronyms that mean parents can't parent their child; there's something wrong with them, they need a professional.

Patrick's frustration is palpable as he describes CAMHS as contributing to what he sees as the "outsourcing of parenting", but you get a sense at times that his frustration is struggling to find the right focus. Should his anger be directed at parents, services, professional knowledges, or society more broadly? He *sees* the cultural narratives that are at play and shares his ideas about how society and culture over the years has created different opportunities and forms through which people communicate distress.

Patrick has seen symptoms and behaviours (such as self-harm) shift and change in prevalence during his work-life, and the culture of 30 years ago is storied as a time when people were held more by their communities with less reliance on experts. These 'things', these 'disorders' are not seen as being real, and Patrick points to their socially constructed nature. There is a story that is offered towards the end of our conversation that points to CAMHS being poised on the edge of change – that change is called becoming 'trauma informed'. This shifts interest to understanding what has *happened* to a child, rather than on working out what is *wrong* with them. I am curious about the difference such a change might bring, and Patrick acknowledges that it would have been unusual for any clinician to completely ignore what has gone on in a child's world, and to view symptoms exclusively as the result of pathology. This seems to suggest that this shift is not feeling significant for Patrick, but this is left equivocal.

5.42 Being responsible

Patrick portrays himself as an irreverent, maverick character that feels no anxiety in the face of danger, it is simply ‘not his job’ to manage risk. He is somewhat baffled when his colleagues are left more susceptible to worry and gives an example of a young person who has self-harmed:

She’s in hospital, they’re stitching her up if she needs stitches, mental health liaison will assess her if she needs assessing, there are processes, what is there to feel anxious about?

There are also moments in the story when Patrick appears incredulous at the parents who expect him to fix their child, or when they are looking to off-load some of the responsibility for responding to their child, onto him. Patrick has established a clear position which:

Is not to assume the risk is my responsibility. It’s their child, it’s their responsibility.

The more anxious I get, the more responsibility I assume, the more responsibility I assume, the less responsibility the family does and the more trouble the kid’s in.

For Patrick it is evident – no good will come from the presence of anxiety, and there is nothing served by being pulled into taking responsibility. There is a clear judgement apparent that if it wasn’t for the existence of CAMHS, parents would have to do ‘their job’ and look after their child, instead of ‘ringing him’. But there are softer moments when Patrick acknowledges and validates the fear, confusion and uncertainty that leaves parents without an anchor, and looking to him for support, which he seems to give willingly and effectively. I would argue that Patrick *is* creating safety despite him not seeing this as being his responsibility, and I wonder if this is overlooked because it is neither his focus nor primary intention, but something that happens as a *consequence* of his presence in their lives:

I think the relationships I have with all the parents of the kids that self-harm, I would say I have a really good relationship with them, because, as I say, my primary relationship is with the parents, not with the child.

There is a sense that safety is being created not through the discourses of risk or responsibility, but through some other unnamed counter-discourse. Patrick describes his position on managing risk which is:

Not to assume the risk is my responsibility, that's not to say that as a professional I don't have a responsibility, but that it's the parents' responsibility, it's their child, their responsibility.

It is as though he is arguing that to not take responsibility for safety is what is required if we are to inhabit a *genuinely responsible position*: it is the responsible choice to refuse responsibility. This does not appear to be a commonly held view in his team however, and Patrick suggests that the 'myth of mental illness as disorder' has been bought into by professionals who then believe that they are perhaps more expert and more needed than they really are. This view pulls clinicians into positions of responsibility when expertise is seen as being essential for safety, recovery or change to take place. I think that Patrick is less clear where he sees his responsibilities lying, but he makes reference to how:

The work is shared but the responsibility is the family's

and he sees his primary focus as being to build a positive relationship with the parents; what this nurtures is safe parents, safe relationships - not risk-free children. Patrick's position is perhaps both more understandable and simpler to maintain when risk is not seen to be situated within the framework of pathology or resulting from the presence of mental illness – if mental illnesses are not static or ‘real’ but shift and change amidst a cultural, relational tide, then you can’t acquire expertise in them or be responsible for curing them, or not curing them. Patrick stands opposed to discourses of individualism and inhabits instead a discourse of interconnection.

Often when responsibility is being evaded, the driving force is avoidance of blame, or concerns around failing, or of being held accountable – it is *fear* that is behind the wheel. This does not appear to be what is driving Patrick’s resistance – his beliefs around what position to take vis a vis responsibility are not psychological in origin, for example protection from anxiety, but are underpinned by an epistemic justification – that is, his views on what position to take are based on his beliefs about mental distress being socially and culturally constructed. If we approach what is being understood as relative in essence (as opposed to realist) from a position of certainty, authority, and expertise, this would not only be incongruent, but it could also risk causing more harm. Therefore, Patrick’s decision around how to position himself regarding responsibility seems to also be ethical in nature.

5.43 Locating empathy

Being immersed in Patrick’s narrative I am aware of feeling drawn to question the moral work that is being performed - Frank (2010) tells us that stories are performed for a purpose and urges us to remain alert to the effects that stories have. At points I feel confused as to what response is required of me due to how parents are being constructed in Patrick’s story. This confusion is compelling as it leaves me unsure where my empathy should lie. It would be surprising for parents and families to present with anything other than culturally sanctioned scripts. The power and authority held by children’s services means that parents can be admonished for *not* turning to experts, for *not* heeding the 'correct' advice. Despite this, Patrick's irritation appears at times to be directly aimed at parents for willingly giving up aspects of their parenting into the hands of the 'so-called experts'. Yet there is also alongside this, a sense of deep understanding conveyed towards their plight, and the need for them to be able to re-claim their confidence and parental capacity, otherwise:

The danger becomes the parent is just considered incompetent and blamed for the child's problem.

The story quietens down its irritation and fosters more of an empathic stance towards these parents who have been narrated at points as disempowered, or criticised for not feeling competent to manage, or blamed for being the source of the problem. There are therefore two distinct discourses of risk in this story – risk as a matter of individual agency, and risk as a socially constructed fallacy.

5.44 The double-edged sword of expertise

There is a visible tension running through the story between the families who position Patrick as an expert - someone they need, the contradictions and damaging repercussions he sees as being inherent in expertise – something to reject, and his role and status in CAMHS which infers expertise. This is a story that therefore problematises expertise: expertise is blamed for producing needy, overly reliant parents, and it is therefore vilified by Patrick:

To train a community that you need experts to look after your children – I think it's been a disaster.

Patrick, however, consistently demonstrates and shows himself drawing on his own expertise in his quest to empower parents. Is this perhaps indicative of a different story of expertise, one that is not viewed as damaging or disastrous? Patrick's expertise reveals itself in different guises, and we hear him presenting explicit, expert knowledge at times, for example when he offers distinctions and clarity to parents:

Slicing a hole in your arm..that is not the same as taking an overdose and trying to kill yourself…and we blur the two into a sort of loose thing of self-harm…and if there is anxiety in it, it should be for the kids trying to kill themselves, not the ones slicing holes in their arms. They're different things: one is about managing the here and now, the other is about giving up on the here and now.

Patrick acknowledges that the distinction between self-harm and suicidality is sometimes hard for parents to grasp, and we can see how his experiences and knowledge are what grants him this luxury. It is an example of how it is precisely his expertise that allows him enough understanding and awareness to be able to gauge how concerned to be, a privilege not always available to parents. Patrick ends our conversation by offering a concise summary of what he draws on in his work with families, what is important:

I position myself not to undermine parents' competence by avoiding language that professionalises their child's experience. ….so all the time it's about normalising distress and trying to make the parents competent, and indeed, responsible, rather than me being some expert in their lives that they need to fix their child, because that increases risk in my opinion.

For Patrick, his role is not to measure or manage risk, but to support parents to have agency over risk in their lives and family.

There is something of the paradoxical in the way Patrick narrates his expertise, whilst denying that this is what he is – an expert. Does he not notice his expertise, or is it his view that what he is offering does not fit within the accepted parameters of expertise? Is there a belief that if he is positioning himself as being 'against expertise' that this will be sufficient to absolve the damages and disempowerment that expertise is seen to incur? Patrick's story nudges us to question the different ways that expertise can be defined, how expectations are potentially shaped by the levels of trust held in experts, and what relationships are made possible and less possible when they are experienced as being expert/lay relationships.

5.45 Conforming to risk

What Patrick's story makes narratable is the relentless complexity and challenge faced when working in a service situated within an opposing paradigm to your own, and alongside discourses that are counter to your ethical position. Patrick valiantly holds his own in the story and seems driven by an ethically situated desire for change, but this is inevitably set against an invisible pull to conform – if you are to exist and function inside a system, there has to be some level of conformity and acceptance. Risk is subtly storied as an area where Patrick seems almost to conform. Almost every aspect within the story is exposed to critique, or at the very least, irreverence, but risk is warily accepted. At the beginning of the story Patrick shares that:

The only kids we see are ones that are high risk…they only make it into CAMHS if there is a considerable risk, considerable anxiety.

For Patrick, risk is always 'the thing' and the work of CAMHS is about reducing the risk 'just enough' because:

If CAMHS is gonna exist as a service it ought to be for reducing distress, and risk and threats of suicide probably creates the greatest level of distress.

A comparison is drawn between a young person that expresses suicidal intentions or actions, and a young person that has shut themselves away in their bedroom, and it is unequivocable from a service perspective who would be seen as the priority - anxiety around the potential for harm to the body trumps all. Patrick acknowledges the uncertainty of risk – it is unpredictable, you don't see it coming, and any assessment of risk will give you only the reassurance in that moment, a fleeting glimpse of the here and now:

It is that erratic - she's absolutely fine, we have a laugh, go out for a McDonalds, and then she takes an overdose. You know, it's the unpredictable-ness of it…it feels not knowable - it's the unpredictable nature of it that makes people so anxious.

In this way there can be a hard reality to risk, but it is slippery. I sense Patrick's caution as he holds back from engaging in challenging the risk rhetoric explicitly, he is no longer the antihero, but instead is conforming. There are contradictions in discourses of risk narrated through his story that highlight a struggle to understand his own position. Patrick locates a patch of steadier ground when he says that assessing risk needs to be more focussed on assessing the *system's* capacity to manage risk, to contain it. From this perspective you can have a risky young person in a very solid system, and therefore the risk of harm can be low – the risk cannot exist within a discourse of individualism, it is inherently systemic. From Patrick's experience, the young people that end up on an inpatient unit are from families that are so traumatised as a system that they cannot bring safety. This is as much as he offers to unsettle the trope of risk – safety requires that we see the young person in context, we have to think 'system', not 'individual' and in this way risk becomes at least partially controllable, as long as practices are being shaped by the right discourses.

Interpretation

5.46 Antihero

There is much of the antihero about how I have come to view Patrick's character as narrated in his story. To some authors an antihero is fundamentally a hero from a particular point of view, one that often provides a critique of social morals or culture. In Catch-22, for example, the protagonist, Yossarian, a bombardier in the Air Force, is demoted because he no longer cares whether his bombs miss or not, his goal is his own survival, and he is traumatised and disillusioned by the war, but remains a part of it. In a similar way Patrick's story speaks forcefully and critically of the repercussions and damages generated by CAMHS and the unhelpful discourses perpetuated and sustained within the mental health field. And yet Patrick remains a part of these services and I receive his story as a quest to find spaces within which he can expose and protest, alongside an implicit message which reads: 'I represent this service, but this service does not represent me'.

Patrick's professional identity exerts a powerful force in the narrative; as a discipline family and systemic psychotherapy arguably lies on the margins, an almost liminal profession that does not fit comfortably within the landscape of mental health - it questions the status quo and unsettles its steady ground, often operating as a counter-discourse. It is not hard to be experienced as an antihero when you are offering a damning critique of services. Those on the border expect a different future and see the established centre as incorrigibly evil, opposing institutions (Douglas & Wildavsky, 1983). The centre's influence is exerted in the mental health field through its concepts and practices, within its structures and processes, all made visible through the emotional experiences of clinicians and in the expectations of families.

5.47 Against expertise

Foucault (1977) demonstrated how normalisation and the discourses within mental health became powerful instruments of modernity which monopolise consciousness. His concept of governmentality shows how expertise is institutionalised through the professions, whereby professionals are part of the process of governing. This legitimises the role of experts who are seen to be maximising autonomy, whilst also operating as an apparatus of control. Contemporary British societies are arguably ‘knowledge societies’ that run on expert processes and systems, and which are structured into all areas of social life (Cetina, 1999; 2007). The ‘mentally ill’ unsafe subject becomes the product of expertise.

Patrick is hugely critical of expertise, despite displaying it in various ways. His criticisms resonate powerfully with the stories of the ‘mothers’ – how fear creates a need for professional expertise, whilst often serving to disconnect people from their own alternative forms of expertise. It is the very uncertainty of risk that draws people in, that demands expertise, and which has thus seen the development of a huge network of expert knowledges, practices, and institutions (Lupton, 1999).

Given this, it is surprising that the role that expert knowledge plays in identifying, assessing, and managing risk is left largely unquestioned in Patrick’s story. One possible answer may be that it is harder to challenge the reality of a sliced arm, or a young person on a motorway bridge, and Patrick does not attempt to do this. Patrick’s story instead suggests an expertise that is *relational* in essence - establishing helpful relationships that can support but not disempower, that can be healing, without offering ‘a cure’. His story of expertise therefore points to the less visible and different textures of knowledge that contribute to expertise. We begin to see a picture forming of a mutually dependent, influencing, and complex relationship at play between risk and expertise – a relationship that has both powerful and negative consequences.

5.5 Sarah: tense contexts

5.50 Pinning down risk

Sarah began by telling me something of her professional life and the experiences she had encountered working as a clinical psychologist in different settings over the previous 14 years – experiences that had allowed her to witness significant changes in the way risk had variously been conceptualised and approached, and what she had drawn on to manage being in this territory of shifting consensus. Sarah highlighted how conceptions of risk have felt broader at times during her career, only to then become narrowed down, and she questioned:

> ***Is it to do with risk to self in terms of self-harm, or in terms of threat to end life? Is it to do with risk around harming others, including therapists, and keeping ourselves safe? Or is it to do with risk of deteriorating mental health?***

Sarah was attempting to place a boundary around risk by emphasising the struggle involved when trying to ascertain: risk of what, and to whom? I felt my own doubts creeping in: ‘What is this research about? What ‘bit’ of risk are you interested in when there are so many to choose from? Maybe you should have been clearer!’ I reminded myself that my interest lay in people’s stories of risk, in whatever guise these may have been experienced, but it requires courage to remain open and exposed, alert to the need to go in different directions, primed to hear the unexpected.

Throughout our conversation, Sarah was able to show me how hard she has had to work, to make sense of some of the confusions and tensions that the risk trope has generated. How risk is defined and what ‘bit’ of risk CAMHS responds to has not been a consistent experience for Sarah. One such tension was the competing priorities at play between organisations, clinicians, and families and how this has required Sarah to move around inside the risk discourse, finding ways to make it work for her, to support her decision making, to leave her feeling less exposed. Institutions are thereby seen to emplot risk in such a way as to make it hard for Sarah to incorporate her lived clinical experiences of risk in a meaningful, congruent way.

5.51 What paradigm are we operating in?

What feels like an impossible task for Sarah is when she finds herself hemmed into what she terms a narrowly defined concept of risk. She explains how these definitions have implications for clinical decisions that can end up resulting in people being excluded from receiving a service or result in them sitting on a routine waiting list due to the dangers not being relevant or severe enough. For Sarah, these definitions matter when they are seen to have real consequences for people's lives. The challenge here is not aimed at risk assessment, perception, acceptance, or calculation, but is to do with what risks are selected and which are ignored. Sarah describes having both:

This kind of narrow view of risk, which is self-harm, suicidality, and the broader type of risk, which is risk in society, communities, how we keep people safe in terms of their general well-being.

What is being defined here is what constitutes a threat, or hazard – and where it is located. This seems to vary depending on how narrow or broadly you *choose* to define risk; the threat defies being objectively knowable or concrete. Sarah's dilemma stems from what dangers end up being defined as CAMHS business, and which ones don't. This powerfully aligned with my crisis team observation described in chapter 4 and how services construct their borders through discourses of risk and exclusion. Sarah gives an example of when she worked with asylum seeking families:

When families came to the UK we saw risk in very different ways….not knowing where your family members are, having to leave the country, and then you've got the risk in terms of uncertainty: will I get sent back to all this chaos and all this war and threat?

For Sarah these were broader types of risk that are deemed social or environmental in nature and which can lead to people being denied support from mental health services, even though they can have huge consequences for mental wellbeing. In this way risk perception may pose a threat to mental health and safety, but that does not necessarily mean it fits within the CAMHS remit, and questions are sparked as to what determines this selection process. These distinctions bring a 'multi-layered-ness' to any decision Sarah makes, the complexity of which is often left unacknowledged when risk, or rather the nature of what is seen as being a 'relevant threat', is written out due to the narrow definitions employed. In the case of asylum-seeking families:

They'd probably say life is still risky, but from a service perspective, they're not in danger. They're safe, so we don't need to act urgently around those cases.

Sarah emphasises how risk prediction therefore feels highly contingent and unstable, despite this not always being explicit:

It's that presumption that risk is static, and that you can capture someone's level of risk in one moment, and actually it's much more fluid than that. So somebody might be really ok today, but tomorrow someone might trigger them and they suddenly become more urgent….Depending on how you understand problems might determine how you understand what's safety and what's risk.

Notions of 'risk level' and 'urgency' are located in discourses of prediction and measurement and yet Sarah is suggesting that this is not realistic - future events can never be predicted with any certainty and can change in a moment, rendering any calculation fairly meaningless. Furthermore, she has indicated that 'what risk is' is contingent on how you select what is problematic; this contingent and fluid nature of risk creates tensions and pressures that need to be managed. At this point it seems as though Sarah is taking us into the very essence of Frank's idea whereby stories are able to 'hold their own', as she begins to undermine the ability of the risk story to 'hold its own'.

Sarah shares what, for her, is at the centre of this risk tension – often risky behaviours make sense to her, they are almost to be expected in the circumstances of what is going on in young people's lives. Risky behaviours can serve an important purpose and should not simply be quashed or managed or reduced:

I think there's something about supporting parents to have the skills to not panic, and not push those behaviours away….there's something about the function of the behaviour, and this is how they're communicating.

Yet, this does not take away the potential for danger, and the powerful force of obligation and duty on clinicians to make things safe. I wonder whether it is the risk discourse that is the source of Sarah's felt tension, or whether it is the discourse of responsibility that risk engenders – the requirement on her to make decisions in the absence of any objective criteria and in contexts of uncertainty, which feels more problematic?

5.52 Sharing responsibility

There are parts of the story where Sarah begins to consider what options are available to her when navigating the 'likelihood' of a threat occurring, and what can be drawn on to support with this. She tells a story of when she felt reassured by being able to share out the responsibility for responding to risk in relation to a girl who had taken overdoses on several occasions:

Making sure Mum was aware of what I expect of her…..and I have actually set up risk planning meetings where it clearly specifies what our role is, what's the expectation under different scenarios, what's mum's expectation…so it's very clearly communicated.

Sarah's language felt infused with certainty at this point in her story, and the response to bring people together to develop a clear risk plan was in part driven by Sarah feeling the weight of responsibility for keeping this young person safe. As she has progressed through her career, Sarah has got better at sharing out the responsibility for managing risk, amongst professionals and family members. In Sarah's example, responsibility had been experienced as unequally distributed due to mum being seen as not taking on her share. There was disagreement over what was being prioritised and by whom, and the aim was to achieve consensus and co-ordination with the objective being risk reduction.

There is a moral dimension at play, and we see this when mum is described as prioritising her job, and therefore not prioritising her daughter's safety sufficiently. The reaction is to support mum to align more with the priorities as seen by the professionals. The burden of responsibility is thereby shifted and becomes more tolerable for the professionals involved, but I am left wondering about the potential risks inherent in not prioritising one's livelihood, and the force that fear plays in decision making that may blind us to the presence of other risks. It is not clear what has enabled Sarah to get 'better' at sharing responsibility, whether this has been a lesson learnt from adverse events, a development that has come with increased experience and confidence or a response driven by fear and anxiety. What is in this notion of shared responsibility is largely left to our imagination. It conjures ideas of duty, authority, control, power, influence – all of which bring the capacity for blame, fault, culpability, liability

5.53 Competing priorities

The competing priorities between organisations, clinicians, and families provide a compelling thread through Sarah's story, and as much as she shows understanding, compassion and insight into the constraints experienced by services, 'the organisation' is characterised as being almost underhand - there is the hint that its motivations are sometimes disingenuous:

So, we had a low, medium and high risk in my previous service, and we couldn't have the option of 'no risk', it would always have to be low risk. I do wonder where those ideas come from, whether it's a form of safeguarding ourselves, so if the worst happened, well - we never thought there wouldn't be any risk - whether that's more about protecting the workers.

She asks me: would I be 'no risk' and questions what it would feel like if you could never be 'no risk'. There are elements of irreverence in this idea as it is offered as a throw-away question. But I am struck by what might be created for young people when they are defined and categorised as 'risky'. Life is inherently uncertain and risky, but the absence of a 'no risk' category is not merely meant as an acknowledgement of these unknowable aspects of life, because there is a significant difference between making a judgement about the inherent uncertainty of the world and defining and categorising a person in terms of their perceived risk status. It is also a comment that suggests that clients are not always at the heart of service structures and processes.

Sarah tells the story about the process of assessing new families, and how ensuring there is consensus and consistency around decision making is challenging:

We now have urgent, routine priority and routine, and they're words, they're terms, and they mean nothing, coz no-one's really said what each one of those things mean….we're all operating to different criteria, or different definitions.

The emotional toll that comes from navigating the complexity within what might be seen as ‘assessing for potential risk’ is acknowledged – there is potential everywhere:

I always kind of wonder - have I made the right decision there….you’ve got one assessment session and you’ve gotta make a decision whether we urgently allocate, or down-grade to routine, and knowing that would mean two years before they get help.

There are two modes of emplotment which represent end-point extremes - the organisation story that serves to bind and boundary itself and its tasks, and the clinical story that is left to function within the fluctuating contradictions and complexity of life. These stories do not complement each other and although Sarah can understand why it is this way, it leaves her looking for ways to adjust to, and navigate within the paradoxes produced. The organisation story narrows things down in order to keep some people out, to prioritise and allocate resources and to achieve targets:

Knowing that you’ve got a finite of resources, and all this demand coming through, then I think there’s more pressure to come up with something, to have that shared consensus. I’m not sure how helpful that is, and I’m not sure that it resolves the problem. But I think that push to create a definition of risk probably comes from managing waiting lists…and that’s why I find it hard, coz it’s not always client-centred, it’s more commissioner numbers, waiting times centred, and the two don’t often meet in the middle.

These are some of the practice issues posed by the risk management discourse. Sarah’s ability to see the broader context creates tensions within her practice, and she is all too aware of the limits to her expertise, the potential for making a wrong decision, a mistake, or of under-estimating risk and causing harm, leaving her exposed and vulnerable. This is storied as a place that the organisation strives to protect itself from, but which Sarah, in the mess and uncertainty of clinical life, has had to learn to face up to – there is no hiding from it, and she shares another example of how she has got better at sharing it out:

I might have a certain set of skills and knowledge because of my training, but they (families) will have a lot of skills and knowledge of them, and their lives, and I think that together, if we put those two together then we can find a way through this.

Sarah sees that the responsibility for ensuring safety is more than she can provide alone, and relationships with other professionals and families become key, alongside finding ways for self-doubt, anxiety, and discomfort to be accommodated. These are not words you often hear in the organisation story, but they invite self-scrutiny, they pull others in and alert you to the danger inherent in quick decisions and judgements made on limited information. In this way Sarah experiences anxiety as a good thing:

Because it causes you to question, it causes you to doubt too, about whether you're making good decisions.

The organisation requires that situations, families, people are defined as high or low risk, or urgent or routine, placing clinicians operating firmly within a discourse of measurement. The anxiety and doubt this produces for Sarah stems from the fact that these are subjective evaluations that lack consensus, but which have huge implications for who ends up receiving help. Sarah describes these organisational processes as:

A way of juggling how the organisation looks…. a way of trying to appear that we're working towards certain standards, when actually the risk has just been pushed elsewhere.

I am drawn to the word 'appear' and wonder what would enable the façade to be dropped. Is it a façade of clinical competence? A façade of power or control? Is everyone aware of its existence or only certain people?

Interpretation

5.54 Smoke and mirrors

Risk in the mental health field could be compared to the insurance industry – an industry that capitalises on people's fear - when we are afraid, we are pulled to look for the easiest and quickest way of feeling less afraid. Paying for insurance does not reduce the risk of something bad happening, but just paying the money gives us a peace of mind that we will be looked after. It is hard to let go of this peace of mind and Sarah's story reveals how her organisation is struggling with this. For the organisation to manage the fear arising from potential threats it appears to remain stuck in a paradigm which views risk as an objective entity that can be measured and controlled. Risk discourses in the organisation have an important job to do – playing a big part in determining who gets a service and how quickly. They exclude people. This rationing of care has gone on for so long that services have come to believe that exclusion is clinically indicated (Beale, 2021). If risk cannot be quantified and measured, how can it be used to exclude or prioritise care?

Sarah speaks of the tensions this produces - much of what is being portrayed is illusory – it is the organisational 'take' on risk which must incorporate looking after itself, protecting itself from those in need. Clinicians can then continue to behave as if risk is both predictable and quantifiable, persuading themselves that certain practices and approaches offer up a protective coating. Sarah sees through this, and much of her story refers to how she manages the paradox that this produces, from within the dominant discourses. Whilst Patrick also questions, he attempts to challenge and find new places within which to stand - counter-discourses. This says something important about hegemonic discourses, and how hegemonic practices connect different identities and political actors into a collective project, institutionalising forms of order, maintaining power, and obscuring alternative frameworks (Hopfner, M, n.d). The key element of hegemony is that it enables domination to occur by allowing people to believe that they deserve their unequal positions (Felluga, 2015).

In weaving in and out of Sarah's story, I have oscillated between admiration for how she manages to retain such empathic composure as she delicately finds ways to navigate through the tensions, to feeling incredulous that working amidst this double bind does not inflict moral injury. Moral injury is defined as the profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code (Williamson et al., 2020). The decision to place distressed, hope-filled children on a waiting list in the knowledge that there will likely be a two year wait – repeatedly, this surely has the force to violate ethical codes. There is a psychological toll that comes from having to ration care, and we see glimmers of this toll when Sarah speaks about the asylum-seeking families.

5.55 Double bind

The way Sarah manages the organisational demands on how risk practices are enacted is to draw on shared decision making wherever possible. This is because she has negligible power to influence or change the request, or the conditions surrounding the request, but must still try to find ways to make decisions, prioritise her patient's needs, and work within the parameters set, the dominant discourses, despite their incongruity. This fits with Bateson's (1956) ideas on double bind theory – a dilemma in communication where two or more reciprocally conflicting messages are received. A successful response to one message results in a failed response to the other so we end up in the wrong no matter how we respond. This communication pattern is a form of control without open coercion; the dilemma cannot be resolved because the demands exist on two different logical levels. This lived paradox becomes an inexpressible internal conflict giving rise to anxiety. Freedom and responsibility are a complementary pair – an increase in the former will always bring with it an increase in the latter (Bateson, 1987, p168).

Sarah’s organisational story and clinical story exist on two different logical levels, underpinned by two opposing epistemological orientations. Can this be resolved by sharing out the responsibility for decision making whilst remaining within the risk discourse? Aggett et al (2012) highlight that risk is more likely to be reduced if clinicians, in daily interaction, are able to give voice to their thoughts and feelings, and when values and internal dialogues are able to be expressed, heard and utilised. They argue this sees risk transformed from an objective, reductionist, rational, realist realm, to a subjective, intuitive, complex, hopeful one; where the messy-ness of practice is acknowledged, and doubt and uncertainty are invited in for consideration. We see Sarah doing this – she acknowledges her doubt, listens, and responds to her anxiety, questions the limits of her expertise. But the status quo remains intact, the hegemonic discourse survives, and I would argue that giving voice is not sufficient to align the organisational and clinical stories, nor to address the double bind.

5.6 Laura: Adapting to a changing landscape

5.60 Riskiest girl in CAMHS

My conversation with Laura was rich with stories of her work with young people and families and it was these people who comprised a central part of the plot. I was struck by how she drew on her encounters with them, to share her knowledge, her ideas, and her experiences. In this way Laura, parents, and the young people were all intimately tied together - Laura's stories required their stories, her knowledge was created with them, alongside them, through them. This contrasts with stories where knowledge and expertise are almost experienced as being placed 'over' what is under consideration, to bring understanding, to interpret or to bring order or insight.

Laura initially trained as a social worker, and then as a mental health nurse, and I wondered how this positioned her in terms of her relationship with knowledge or her experience of professional expertise. There was a generosity and a humility in Laura's attribution of her learning, and she quickly launched into telling the story of a young person whom she had worked with during her time in CAMHS, describing her as the riskiest girl in the system:

Gosh, I learnt so much I think from being her keyworker, just of processes and learning about people. She wasn't a young person who would scream and shout 'I'm gonna kill myself, I feel like this, I feel like that', she would smile and look, and you didn't really know that's what she was thinking….I learnt so much along that journey, about risk and managing, and not knowing.

This young person's consistent attempts to end her life continued throughout their work together, but Laura learnt to read the patterns, to anticipate the signs and triggers, to expect the risky behaviour because it was this girl's way of communicating something – of telling others - ‘you have invalidated me, you have not understood me’. We hear how over 5 years Laura worked hard to develop and maintain a consistent relationship with both the parents and the young person and I asked if this had made things safer. Laura was unsure – on the surface it did not appear to have reduced the risks because the “bad stuff” still happened.

As the story of this young person progresses, we hear how she attempted to hang herself whilst in hospital. She felt proud that her suicide attempt had caused policy over ligatures and bandages to be reviewed and amended. I felt a strange mix of horror and sadness over how this young person was being constituted within the parameters offered by being a ‘risky girl’. The effects of being caught up in the risk/mental illness story offered her opportunities for success and recognition as she became bound up in a system of stories by which she could say that this was ‘her’ (Gadsby, 2016). I found myself questioning how you begin to reduce such risky behaviours when they bring such accolade.

5.61 Pressure of time

Yet through this story it was clear that something had changed in terms of risk, there appeared to be less uncertainty because Laura understood the young person better, the ebbs and flows became more familiar, understood, expected, and hence fear reduced. Laura’s presence in their lives brought a sense of safety – it was contingent on her presence, her relationships with the family, on her consistency and communication, and she learnt to expect and accept the presence of risk. Working in the home treatment team feels different for Laura, she has less time to build relationships:

It's like 'skills, skills, skills, make sure they've **(the patient)** ***got skills', 'make sure you've done a risk assessment', 'make sure mum's got rid of every sharp in the house'. And, I think, you know, I need a bit more of a lower-key approach to keep families and parents in, rather than frightening them off. I think it's a real fine line, coz we can go in and just upset people really quickly, saying 'oh no, you have to stop doing that'.***

This less relational approach emplots a more technical type of expertise and knowledge, where the priority is on reducing risk. In contrast to this Laura describes below the approach she was able to take in CAMHS, when time was not quite so restricted. Here she had the opportunity to get to know people, to understand how they were making sense of things, their responses; you see her able to 'shift her horizons' giving space for empathy to develop:

Maybe around kids who have got emerging personality – we can't say that now can we – who are very dysregulated, so you're trying to nip those things in the bud as early as possible, but I think then as you work more with kids like that, you start to think a little bit like them and well, if I was them, and this happened to me, I'd bloody well show you.

There was an irreverence in Laura's comment about the terminology around personality no longer being appropriate - 'disorders of personality' have been prohibited, replaced by the classification of 'emotional dysregulation'. The labels change but the pain and distress persist. I detected a micro-resistance in Laura's story that was not evident in Sarah's. The lightness of the irreverence contrasts with the weight of risk and the story shows how Laura is pulled to feeling responsible, and this is also heavy. She compares herself to her colleagues:

Laura ***I've noticed I go a little bit further than others; I feel, I feel more responsible***.

Me ***Is it risk that drives you to do more?***

Laura ***Risk and relationships, I think. I’ve had some really good relationships with young people that I feel quite proud of.***

I wonder if her motivation to go further stems from Laura’s intuitive understanding that risk management should not be the driver.

5.62 The boy in the bedroom

Laura told me about how Adam had barricaded himself into his bedroom and was refusing to speak, or to come out. He had been severely bullied at school and following a particularly bad bullying incident, had shut himself away, coming out only for the toilet or to get food when his dad was not around. This had continued for eight months, and Laura had been asked to provide sessions through the closed door. She described how she had visited sixteen times and would talk through the door, teaching Adam about mindfulness and self-regulation techniques or reading poetry, until she told me that she ran out of things to say and so the sessions ended:

I was not getting anything. I got a knock the first time, and then he wasn’t knocking for anybody else after that. So, I could hear him behind the door maybe shuffling and moving. I don’t know whether he was listening or not….he was a very quiet, shy boy.

This was a case that saw the systems around Adam descend into paralysis. He was not ‘self-harming’ he was not considered to be suicidal – the usual risks that activate and force decisions to be taken on behalf of other people were not present:

I think there’s so many different views about risk and about what should happen, and then actually nothing’s happening, because no-one can agree….If services, say in March, had taken his door off, got in there, maybe he’d be over that trauma by now and functioning a bit better.

The family, the police, social care, GP, school, psychiatry, home-based treatment team, CAMHS – we hear how they all held different views, not only about *what* to do, but seemingly over who should be the decision-maker:

It was referred to social care as high risk, and the police came along but said, well he's in his bedroom and we know he's alright so we're not gonna do anything.

To do nothing poses risks in terms of opportunities missed, yet to act could also be risky, as Laura tells us that he could end up being traumatised further. The uncertainty lurking in the background of this story is vividly revealed as we see the multiple systems involved, all skilled at dealing with the risks presented to them according to their own logic, discourses, and structures, unable to act.

5.63 Risk and diagnosis as contagion

There is the sense of a wrestle being enacted from the outset of Laura's story as she tries to make sense of the changes she has seen within mental health services over the years. Things are not as they once were, and Laura questions whether this is real, or the result of being immersed in the world of CAMHS where every child is struggling or hurting themselves, or emotionally dysregulated - as if this immersion may have served to distort how she sees and experiences the world. One example of this 'wrestle' is around the issue of mental health diagnosis. Laura is unsure whether these labels can be helpful and/or are needed, but her experience is that diagnosis is something young people and parents sometimes expect and at times, demand:

Parents still come wanting answers to why, you know, wanting diagnosis, but it used to be more around autism and ADHD and now we're into bi-polars and personality disorders.

It seems to be popular to have a mental health diagnosis…I've had discussions with that same person who goes 'when I had an eating disorder' and I go, 'you didn't have an eating disorder'. 'Yeah, I did, I was seen by the eating disorder team'. 'Yeah, and they said you didn't have an eating disorder!' And she was really disappointed with it, but I think we had that relationship where I could say: 'but you didn't, you didn't have that.' And there's so many kids who you think, actually I won't have that argument, because you won't accept it, and then you'll just ditch me.

Laura has doubts as to whether diagnosis offers an authentic, complete story or helps to bring the change that is needed. Her tone is disparaging of the requests for diagnoses and people's apparent regard for them – another story of micro-resistance? However, she does speculate over what people may be gaining from these labels – validation, knowing what is wrong with them, not feeling to blame, and although she can understand this, she suggests that she is still left with an unease, a discomfort. Diagnosis is something that she feels pulled to question and challenge, but only when she thinks she can win the argument. Laura communicates at times a real passion for her job, but there is also a weariness evident. Working in situations where she feels required to challenge and question, whilst balancing ideas of patient choice and maintaining therapeutic relationships, is experienced as quite exhausting.

Laura reflects on her own childhood to compare the past to what she is experiencing in the present, and she recalls how there was just one boy in her class that had disappeared, only later to learn that he had mental health issues and had been in and out of hospital. In returning to the past, she is attempting to make sense of the apparent current mental health risk epidemic, but she is left feeling perplexed, there are no easy answers, and I notice the weariness creeping back into our conversation as she wonders whether it is time for her to get a job in a supermarket.

Laura continues to seek answers – is social media perhaps to blame? Are kids too connected, too aware, learning off each other? She recounts how she currently has three girls on the inpatient unit who have made suicide pacts and so they are looking to split them up; it is almost as if risk is contagious. Laura comments that the community CAMHS team used to manage perfectly well without a 24/7 crisis service; she does not think that the risks are getting more dangerous, but more widespread, with greater numbers of children presenting as risky and accessing services - more ‘shouts for help’:

I think if you put a crisis team there and a number to call, then people will call it.

This strikes me as an interesting perspective, a service that has potentially created a need, rather than a service created to fulfil a need. Is Laura suggesting that services are somehow fuelling this increase? I am reminded of the sprawling spiders-web of services listed on the white-board, spanning the length of the crisis team office wall. The implication is that it is services trying to provide a space to hear young people, that is fuelling demand from young people for more spaces - a discourse of the risks of labelling.

Interpretation

5.64 Entangled lifelines

Laura’s story plots the entangled lifelines (Tsing, 2015) of some of the families that she has worked with over the years. It is a narrative account that somehow demands that we hold on to the uniqueness of each of the young people that she evokes, a refusal to get caught up in stories that serve to ‘finalise’ people, even when some of them appear to resist the complexity of their lives and experiences through their desire for simple explanations offered by diagnoses, or a sense of identity or badge of honour. It raises the question of whether children’s services should acquiesce when these requests are being made, or whether there are dangers inherent in this – the danger of objectification, of dehumanising, as the entangled lifelines surrounding the young person are potentially rendered invisible or unnecessary. Whose ideas should triumph? Who gets to decide? Who is ultimately responsible? These are questions that lurk in the controversies around expertise in CAMHS, controversies that reach new heights when operating in contexts perceived as high-risk.

In ‘The Mushroom at the End of the World’ (2015) Tsing shows us the intricacies involved in foraging for matsutake: to discover the matsutake the pickers must be alert to the lifelines in the forest, searching with all their senses, looking for the gentle heaves, the host trees, mosses, insects, the soil bacteria. It is a dance shaped by communal histories, disparate in their aesthetics and orientations, revealing a forest knowledge without the completeness of classification - you need to *extend your focus* if you are to succeed in finding matsutake. It is not just the tree that is relevant, but the story that the area around it tells. This is a search that I saw reflected in Laura’s story, a story that points to the *“loveliness of beings experienced as subjects rather than objects”* (p243).

5.65 Risks and decision-making

Certain behaviours have become unquestioningly associated with mental health – a young girl cutting herself equals mental health services, a boy punching his wall, much less so. Mental health services seem to have accepted self-harm as being ‘their business’, and yet it comprises a range of behaviours that can represent different things, which are utilised with varying intentions and expectations. We saw this with the ‘riskiest girl in the system’ and how her identity began to feel dangerously reinforced by engaging in risky behaviours. The significance of what, or who, risk gets attached to invites questions as to how this serves to regulate and control human conduct. What becomes (un)available to us when we are deemed to be ‘risky’ or ‘low risk’, and what are the effects of that? Could assigning a risk category to a young person create more dangers than it abates? How might the forces and language of risk compel us to rethink ourselves, when it is the forces from outside that fold us into identity? (St Pierre, 2000). Identity is discursively constructed – in and through discourses, and what is apparent through Laura’s story are the intersecting discourses of labelling and discourses of identity as people navigate between uniqueness and the need for a communal sense of belonging achieved through sameness (Bamberg, et al., 2011).

We saw with Adam how the ability for professionals to respond in the face of an unknown future became too risky – for them. Risk concerns the consequences of a decision that will occur in the future, but which are unknown in the present – a situation that Luhmann (1995) terms contingency – decisions are made based on a selection of any number of possible alternatives. It is of course impossible to be certain, and therefore making a decision requires dealing with uncertainty. Generally, what is required when decisions are being made in contexts of risk is the ability to construct enough certainty, so that a decision can be made - too much uncertainty can block decision making (Japp & Kusche, 2008).

It is often underestimated how fundamentally risk is embedded within the structures and institutions of our society; in mental health services risks are predominantly seen as being an individual phenomenon. If Adam had started to cut at his arms, mental health services would have felt a responsibility to be decisive, the logic of the situation seen as fitting comfortably alongside the function of their organisation, thereby supporting them in constructing sufficient certainty. If he had started to smash up his television, the police could have broken down his door. If the father had stopped filling the fridge with food, social services may well have started proceedings to remove him from dad’s care on the grounds of neglect.

It is interesting to consider the differences these hypothetical actions could have brought, providing the forces needed to enable decision making from the systems around him. What remains unchanged in these hypothetical scenarios is Adam, who has been bullied to such an extent that the world has become an unbearable, uninhabitable place for him, forcing him to close the door on it. His feelings, struggles and pain remain unaltered – but his way of communicating it invites a whole new array of possibilities because a consensus becomes possible around who is responsible for the risk, and therefore who must decide. Risk has been described as being about attribution (Japp & Kusche, 2008) and when professionals become the decision-makers, then families are positioned as the ones affected by the decisions. There is a fundamental difference between those who decide about risks – how risks come to be defined, recognised, what they mean, how to respond to them - and those who bear the consequences of those decisions.

5.7 An unfinished story

What has been offered in this chapter are my stories that have flowed from the participants' stories. The framework that has held me through this process has been dialogical narrative analysis – a heuristic guide which has encouraged my thinking to move, nudging me out of my comfort zones. In combining different sources, and bringing them into dialogue, I have sought to enrich the participants' stories, to give life and expression to them, and through this difference re-create them into something new (Bateson, 1972). There will be an inevitable gap between experience and its symbolic expression, and my intention has not been to capture the reality of lives lived.

It is not possible to completely know another's experiences - some experiences are not even story-able, and I have come to my understandings on the basis of my own experiences (Bruner, 2004). This story has thereby been shaped, limited, and constructed; even my decision about where to begin and where to end establishes boundaries restricting what will be told. This does not render them useless, and in the next chapter I will go on to discuss what possibilities and insights have been revealed by letting these stories breathe.

Chapter 6: Findings & Discussion

"In urgent times, many of us are tempted to address trouble in terms of making an imagined future safe, of stopping something from happening that looms in the future…..In fact, staying with the trouble requires learning to be truly present, entwined in myriad unfinished configurations" (Haraway, 2016, p1).

6.0 Limits

What I offer below are the threads and openings of where the stories of the participants, and undertaking this research, have taken me. My starting point was to try and reveal and unsettle the risk discourses that are shaping practices within CAMHS, and I have therefore been alert for opportunities to challenge, rather than to reinforce the status quo. Consequently, it is likely that I have overlooked alternative threads that may have told a very different story - and different people would have told different stories.

This chapter cannot offer concrete solutions, but I hope that it may encourage practitioners to move away at times from 'safe spaces', and instead to inhabit 'brave spaces' (Arao & Clemens, 2013), in the search for counter hegemony and counter discourse. Boostrom (1998) states that bravery is crucial because *"learning necessarily involves…the pain of giving up a former condition in favour of a new way of seeing things"* (p. 399). Patrick, Sarah, and Laura all sought areas of micro-resistance, irreverence, or out and out protest. This became critical when the risk discourse resulted in them functioning under a façade, within a double bind, resulting in a misalignment between the clinician story and the organisational story, producing tensions and contradictions that could not be ignored.

It has felt risky at times to be probing at the dominant risk discourse when it is this that is believed to be offering our supposed routes to safety and protection. However, the discourses that shape healthcare services and influence practice need to be probed when they are clearly being shown to lack credibility or efficacy. Safety is defined as affording security from danger or risk, and as unlikely to produce controversy or contradiction. This research is not about avoiding controversy or contradiction but about offering a steppingstone into braver dialogues – these may not always feel safer, and they may not always provide the ‘right’ answers either. I will now consider what possibilities have emerged through the participant’s stories when we look beyond risk discourses.

6.1 Threads of possibilities

This study points to the need to acknowledge and respond to the deep, structural problems at play within the hegemonic risk discourses that serve to inhibit alternative possibilities for how we ‘go on’ together (Wittgenstein, 2019) when lives feel fractured, or when people are afraid, hopeless, or in emotional pain. Dominant discourses do not prohibit change and transformation from taking place but finding areas for possible resistance becomes fundamental. Where there is hegemony and discourse, there are opportunities for counter hegemony and counter discourse; they exist in a state of tension and there are points of resistance everywhere within the relational networks of power (Foucault, 1978, p95).

Some points of resistance to the dominant risk discourse emerged through the participants’ stories, for example, when risk was accepted as being a part of life; a part that needed to be heard, witnessed, understood – and not necessarily ‘managed’ or ‘scaled’. The task often became finding ways to make the more uncertain aspects of living, and suffering, more tolerable. We witnessed life becoming safer and more liveable in response to enhanced connections and dialogue, reduced fear, and greater understanding. These were moments that I would argue took us into a counter discourse to that of the dominant risk discourse – the felt need was less about reducing risk, and more about resisting isolation. This connects with Aggett & Messent’s (2019) suggestion of the need to re-conceptualise risk as a “collaborative conversation with shared responsibility” (p5). Unfortunately, attempts to reduce fear through greater connection and shared responsibility can be ineffective when practice is situated within discourses of risk; the sharing of responsibility can become a means of stepping away, as opposed to stepping in; of reducing one’s own burden as opposed to diminishing someone else’s.

One reason for this is because operating within a hegemonic discourse of risk establishes, maintains, and reinforces subject positions which assign duties and obligations (diagram 1). Expertise is thus often seen as necessary but can create unequal and unhelpful power relations, affording certain people more opportunities to avoid responsibility and apportion blame elsewhere. These positions fuel fear and thereby disempower, leading people to consent to unequal relations of social power.

Dominant risk discourses are knowledge discourses, with the expert positioned as the ‘knower’. Clinical expertise therefore comes to bear in how we share our ideas without annihilating other people’s expertise, how we promote inclusion, how we remain invested in dialogue and relationships, how we question the discourses that shape our ways of thinking and being, and how we support one another to keep moving, to keep changing, to keep growing.

Reducing fear and the genuine sharing of responsibility, without disempowering the other, might therefore be achieved through a re-consideration of expertise, so that more equal relationships can be established. A re-conceptualisation of expertise can offer an exit route out of the dominant risk discourse and an into an alternative discourse.

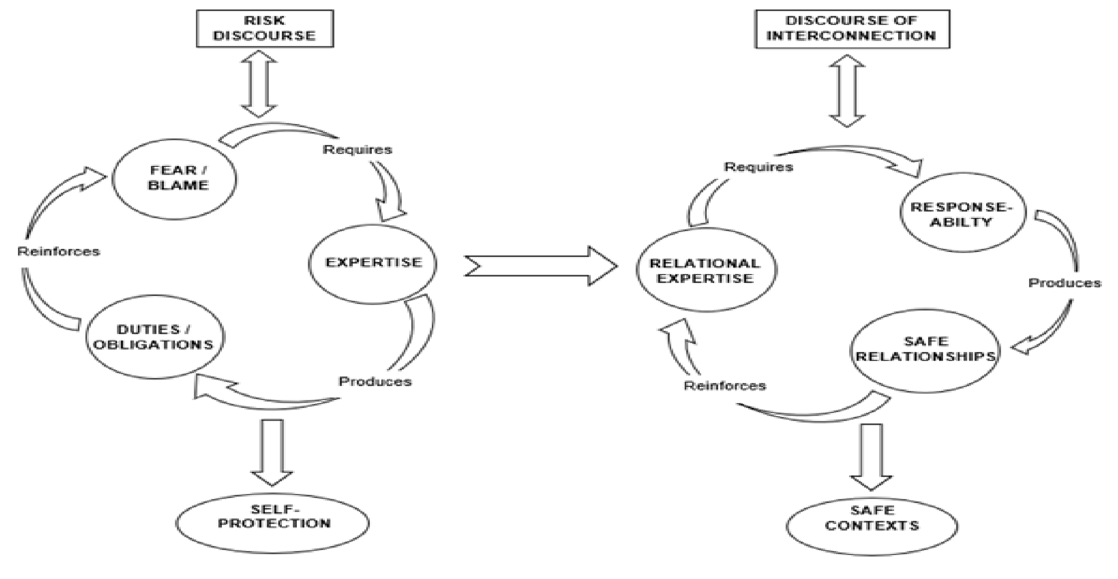

Diagram 1 Transforming discourse by reconceptualising expertise

6.2 Re-thinking expertise

“The purpose of life and the meaning of suffering have been allocated to experts and turned into technical questions on the most effective ways of managing malfunction and improving ‘quality of life’” (Rose, 1998, p151).

Hilgartner (1992) suggested that the field of risk communication should pay more attention to studying experts, and what shapes the knowledge that they produce, as *it is this that will provide us with better ways of responding.* When risk and fear are experienced, a felt need for expertise is unsurprising, but there can be a powerlessness inherent in, or engendered by this need. For Becky, Cathy, and Karen risk created a felt need for the expertise of others despite, at times, this expertise being experienced as inadequate, inaccurate, or causing more harm. They all needed to believe in the expertise of mental health professionals because they did not feel equipped to make their child well or safe.

These mothers did not always seem to notice the erosion of their own expertise that took place when faced with their children's distress; their stories of competence written out. Nor did they always seem to fully notice or acknowledge how and when they began to re-claim their own expertise, despite this having a significant bearing on their ability to cope, to support their children and to continue with their lives, notwithstanding the on-going presence of risk. Sometimes they re-connected with their own expertise when faced with the inadequacy of professional expertise, and sometimes professional expertise was seen to support the reclaiming of their intuitive forms of knowing.

The clinicians all inhabited and enacted their expertise in different ways – explicitly, tentatively, critically, with humility – and not always consistently. Patrick demonstrated what I described as a 'relational expertise' because he considered that his responsibility lay in nurturing positive relationships, but he was also deeply critical of expertise and outspoken in exposing its harmful consequences. Sarah showed how important her expertise was in helping her to navigate through competing organisational tensions and the requests made for her to make quick, and often unrealistic decisions, in contexts of uncertainty - but she was also wary of inhabiting too much expertise. Laura appeared to have a more tentative and questioning relationship with her expertise, which became visible when she wrestled to make sense of how much she should challenge when young people and their parents came with different views and ideas to her own. The question for Laura seemed to be about how she might place her expertise alongside the ideas and knowledge of her clients, and which to privilege.

Within this research study, there have been stories told of professional expertise saving the day, or being triumphant, or of trust being placed in services only to be let down or suffering further harms. There is a double-edged sword phenomenon to expertise - it can help us to feel strong, steady, in control, equipped to make decisions. It can help us to conquer fear and uncertainty and to tolerate dangers, whether that be through our intuitive expertise, parenting expertise, professional expertise. Yet too much expertise may lay claim to having access to unrealistic levels of certainty or truth, and this leaves people feeling vulnerable, accountable. Expert knowledge is not mimetic to truth, and, as we have seen, it comes in many guises. If there is too much authority, emphasis or certainty placed in one area or person, then it can reduce the capacity for expertise to be owned by other people or to reside in different places.

The participants’ stories showed how navigating through risky situations and making decisions in contexts of uncertainty often seemed to require the presence of shared expertise. It was *this* that brought a feeling of safety, calm and confidence - not the reduction of risk:

It’s like being able to have those conversations and go: ‘there’s a risk that something could happen, you can’t remove that risk, but we’ll manage it, and I won’t blame you, and you won’t blame me’. That makes the difference. That’s probably the crux of it for me. (Cathy)

The expertise visible in these stories was therefore not a one-sided expertise focused on assessing risk, imparting knowledge, or providing solutions to reduce risk, but privileged instead a more relational form of expertise.

Creating these types of relational spaces and connections is arguably the responsible focus when encountering moments of potential danger and uncertainty. Seikkula's (1994; 2018) research on the healing capacities within people's social networks and on the relational nature of the human mind supports this orientation. He demonstrates how human life is based on dialogical interchange with other human minds:

"Life is participation in an ongoing dance with whoever is present at the moment" (2018, p 857).

This emphasis creates a shift away from 'managing risk' and towards managing relationships – because shared expertise requires a certain type of relationship to enable different layers of expertise to come together in a helpful way. Expertise requires a relationship, it cannot exist without one, it is constituted within it, through the coming together of knowledge, ideas, and experience in the full spirit of their uniqueness, and with an openness from everyone to be moved by the encounter.

6.3 Relational expertise

Embracing relational expertise requires a move away from expertise as *possessed*, as mastery, or as attribute, and towards seeing expertise as situated performance (Nicolini, et al., 2018). Beck (2015) was interested in how experience is made, transformed, and applied in skillful practices that are then open to reflection and revision. What counts as expertise is therefore socially negotiated, and located, and this requires the de-centring of mastery to allow it to emerge within a practice community (Lave and Wenger 1991; Greeno & Gresalfi, 2008); expertise is thereby inherently mediated and interconnected (Gherardi and Nicolini, 2002).

Edwards (2010) used the term ‘relational expertise’ to show how expertise, rather than conceived as an objective and enmeshed concept, is something constructed and enacted through relations between the practice, practice setting, and the people. Ingold’s (2006, 2021) relational anthropology also reminds us that knowledge is put into action reflexively, it is embodied, temporal and emplaced. Relational expertise is thus a *capacity* that arises when everyone is able to bring their unique knowledges to bear in their joint action (Edwards, 2010).

Benhabib (1992) wrote that we cannot ethically take a stand without knowing how to reason from ***“the standpoint of the concrete other”*** *(p10)* and this for me points to the need to develop a relational expertise that will support people in building trust and respect in each other – learning to trust the *relationship*, rather than the *knowledge,* because it is through relationships that knowledge is generated. Furthermore, expertise is relational because it can only be imparted at the request of someone who wants it (Grundman, 2017). This means that relational expertise cannot be taken for granted but needs to be negotiated, made explicit and co-produced.

Relational expertise may require us to sit within uncomfortable tensions, to navigate through and hold on to opposing views, to find common knowledges, to listen to what matters for each person, and to search for the opportunities for movement. Relational expertise is therefore not about simply ensuring that people can bring and share their own expertise, it is a capacity for joint action that arises out of a dialogue between multiple stakeholders (Shotter, 1995). If we privileged this in our practice then we would be operating within a counter-discourse of relational interconnection – where the emphasis is not on knowledge possessed (discourse of individualism), but on knowledge jointly constructed.

6.4 From individualism to relational interconnection

The dominant discourse of individualism ensures that the individual is the unquestioned, natural entity of concern in our attempts to understand social life (McNamee, 2012). This is a perspective that dominates the mental health field where the main focus is on treating or supporting the individual - it is the person that is ‘at risk’, and the person that needs to be made safe or well. Yet this distinctive sense of self we experience is a cultural creation, but one we struggle to recognise due to being subsumed within an individualistic ethos (Kirmayer, 1989; 2019). Within the NHS, and British culture more broadly, human separateness, firm boundaries, and personal control (Westerhof, et al., 2000; Lu, 2008) are generally emphasised, placing a high value on independence, competitiveness, and self-reliance (Sampson, 1988; Thompson, et al., 2023). People are thereby seen as distinct agents, responsible for their actions and safety - and capable of modifying or restraining their behaviour.

The responsibilities experienced and narrated by this study’s participants were predominantly individual responsibilities: to get well, to be a good patient, to protect, to make safe, to not make things worse, to follow advice, to show the right amount of emotion, to know the level of risk, to bring solutions. The success stories, however, came through in moments of relational connection: doing things together, sharing responsibility, creating space for dialogue (not always through words), being there, listening and being heard, prioritising relationships, finding ways to understand each other, learning from each other, trusting in each other, being needed, or simply ‘turning up’. These success stories could be seen to embody a discourse of relational interconnection as opposed to a discourse of individualism.

A discourse of relational interconnection creates an impetus for dialogue and foregrounds the person-other relationship, giving pre-eminence to the relational over the individual (Sampson, 2000; Argüello, 2023). It is an ethos that both engenders and requires relational expertise, and it positions the parents of children in CAMHS as being an integral, needed, required part of the dialogue. Parents often come with enormous amounts of knowledge and expertise, but expertise that they have sometimes lost sight of when faced with their child being under threat. Safe-enough individuals require safe-enough contexts, safe-enough relationships, safe-enough lives. The practices and values of relational expertise go some way towards challenging the boundary between self and other and therefore confronts the pervasiveness of individualism.

6.5 Offerings from the systemic family therapy field

Systemic family therapy positions itself firmly within a relational discourse and foregrounds the development of collaborative relationships as a key aspect of any intervention. Michael White and David Epston (1990) have been hugely influential within the family therapy field, highlighting the need for practitioners to question, examine, and critique the analogies and concepts employed in clinical practices - analogies that determine our examination of the world, the questions we ask, and ultimately the realities we thereby construct.

White and Epston (1990) stated that often the analogies we select are determined by ideological factors and cultural practices which create distinctions and frames, serving to structure experience (p5). Bruner (1986) also gave prominence to how there are always feelings and lived experience not fully encompassed by the dominant stories revealed through the frameworks employed. Events make sense depending on the forces which take possession of them (Deleuze, 1983) and in this way it becomes an essential aspect of clinical work for systemic practitioners to question and deconstruct all knowledge discourses to expose what they inhibit and produce.

Michael White was ethically opposed to scientific generalisations or generalisations about what ‘works’ for people, but was instead drawn to the complexity of living that we encounter with embodied persons, revealed and shaped through stories (Byers, 2019). Living with emotion, and risk, is a powerful relational act (Seikkula, 2018). This requires a resistance to dominant cultural stories that limit understanding, an acceptance that we need to mobilise the resources of both the patient and family members, and an avoidance of the hierarchical positionings placing therapists as the sole experts. These ‘expert’ positions are seen as a barrier to being receptive to discovery, to seeing each encounter as ‘distinct and particular’, and instead reinforce dominant stories that shape expectations about how people ‘ought to live’ and how they ‘ought to feel’ about their lives and ipso facto themselves.

Harlene Anderson (2012) posed the questions: “Why do some shapes of relationships and forms of talk engage while others alienate? Why do some invite possibilities and ways forward not imagined before and others imprison us?” (p8). She goes on to remind us of the importance of fitting our practice to the uniqueness of each person’s circumstances and to reassess how we understand the world, clients, ourselves and our roles. The stories of the mothers in this research demand that attention be paid to their wisdom, knowledges, competencies and ‘truth’, and this requires the chasm that can exist between the ‘knower’ and the ‘not-knower’ to be bridged.

I would argue that the field of family therapy offers practitioners navigating the complex territory of risk and mental health a much needed philosophical stance, a collaborative ethical orientation and a questioning spirit. This study demonstrates that these are required if we are to avoid being seduced into practices that are out of sync with contemporary societies and alien to the people we work with (Anderson, 2012). As a conceptual notion, risk is deeply abstract, entangled within social processes, and highly subjective – profoundly bound up with power, authority and blame (Brown, 2014). Finding ways to work in accord with our collective ethics and hold onto solidarity when operating in political contexts that have the power to set us up against each other, (Reynolds, 2012) must be essential priorities if we are to nurture safety in people’s lives.

6.6 Spaces of resistance

British society is a "risk society" - a society increasingly preoccupied with identifying and managing risks that it has itself produced (Beck, 1992). This can prevent us from embracing a counter discourse and thinking and practising in a different way - failures of risk management and communication can significantly undermine the legitimacy of public institutions, leaving politicians exposed and the public fearful and uncertain where to turn (Jasanoff, 1999; Arvai & Rivers, 2013). Risk and safety are therefore hugely important politically (Beck, 1992).

Yet the stories from this study suggest that there are times when we need to move away from discourses of risk, and individualism more broadly, and to embrace a counter discourse – a discourse that foregrounds interconnection, because it is relationships, rather than an absence of risk, that are often shown as being key to safety. The stories reveal how operating within discourses of risk can inhibit positive, equal, honest relationships from developing due to the pull to self-protect. These types of relationships are required between clinicians and families in CAMHS if we are to remain responsible to one another (McNamee & Gergen, 1999), to ensure that everyone's voice and expertise is valued and utilised, and to create safe contexts for young people to be able to thrive in.

This inquiry goes some way to capturing the complexity of the field of mental health, the epistemic uncertainty, the contradictions, the safety issues encountered, the fear, the tensions, the multiple ways that are available to all of us - clinicians, parents, young people, to respond, to think, to understand, always with the knowledge that our actions can be a source of good as well as harm. The stories of the participants, and the dialogues these have opened-up, have shown me that this complexity should be heard and valued, not reduced – neither danger nor safety require simplification, nor quick and easy answers, nor should this complexity feel like a burden to be carried alone.

Inquiry can be a means to disturb unquestioned assumptions and open new possibilities for action (Gergen, 1978). Stories are generative and have the power to transform practice, to move us away from the domain of documenting the way the world is, to participating in the creation of how the world *could* be (McNamee, 2012, p152). The stories from this research have opened up the potential offered by practices that invite inclusion, reduce power, and where the focus remains on the coming together of individuals in relationships - the building of communities where people can co-ordinate their activities – this is how I would like to see us 'go on together' (Wittgenstein, 1953) within CAMHS.

There needs to be space for innovation, and an appetite for meaningful change. Sometimes when problems feel so ‘wicked’ (Crowley & Head, 2017) and outside our sphere of influence, it can be helpful to find space for the smallest particles of difference to take root – the words that we use, what we give time to, what we choose to foreground, how we respond to one another, the values we enact and embody, and importantly, the stories we tell – and the stories we listen to.

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Appendix A

CONSENT FORM

Title of study: How does the perception of risk affect relationships between clinicians and carers in a Child and Adolescent Mental Health Service?

	Please initial box
1. I confirm that I have read the information sheet version 3.0, dated 04 August 2021 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study up until the point of data analysis without giving any reason, without my legal rights being affected. I understand that the data I have provided up to the point of withdrawal will be retained.	☐
3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations.	☐
4. I understand that all personal data relating to volunteer research participants is held and processed in the strictest confidence and in accordance with the Data Protection Act (2018).	☐
5. I give permission for the collection and use of my data to answer the research question in this study.	☐
6. I agree to take part in the above study.	☐

______________________	______________________	______________________
Name of participant	Date	Signature
______________________	______________________	______________________
Name of person taking consent	Date	Signature

Appendix B

The Tavistock and Portman NHS
NHS Foundation Trust

PARTICIPANT INFORMATION SHEET (parent/carer)

Research Study:

How does the perception of risk affect relationships between clinicians and parents/carers in a Child and Adolescent Mental Health Service (CAMHS)?

We would like to invite you to take part in a research study. Whether or not you wish to take part is entirely up to you. Before you decide it is important for you to understand why the research is being done and what it will involve. To help you decide please take time to read the following information carefully. Feel free to talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information.

Please take the time to decide whether you wish to take part

Part 1 of this leaflet tells you the purpose of this research and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the research.

Part 1 - Overview of the Study

What is the purpose of the study?

We know that positive relationships between CAMHS clinicians and families are important in improving outcomes for young people in CAMHS. Less is known about how these relationships are affected when concerns about risk increases. This study is looking to understand more about how clinicians and the carers of young people in CAMHS experience their relationships with one another when situations are feeling unsafe. The hope is that this study will increase understanding in order to improve service provision.

Why have I been invited to take part?

You have been invited to participate in this study because you are a parent or carer of a young person currently receiving a service from CAMHS. This information leaflet will have been given to you by your CAMHS key-worker because of the experiences you have had supporting a young person in situations that have felt risky or unsafe.

What will happen if I take part?

If you would like to take part in this study you can contact me, Liz Darwell, via the email or phone number at the end of this form. We will then arrange a meeting at a convenient place and time. A video conference call may be used if it is not possible or convenient to meet in person. I will ask you to answer some short questions about you, for example your gender, age and ethnicity. Then you will have a conversation with me about your experiences which will last around 60-90 minutes. I will audio record the discussion. There are no right or wrong answers and I am only interested in your experiences and stories. Once I have transcribed the interview you will be offered a copy and I would welcome any comments you might have.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you or your young person's treatment in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. If you decide to take part I will ask you to sign a consent form and you will be given a copy to keep.

What are the possible risks of taking part?

You may experience emotional distress when talking about your experiences of supporting a young person who is placing themselves at risk. It may bring to mind difficult memories. If this happens to you I will offer support and help you to gain access to further help, for example from counselling services or your GP, if needed.

What are the possible benefits of taking part?

There cannot be any promise that you will have any direct benefit from taking part in the study. However, it is hoped that the study will offer you the opportunity to have your voice heard. The findings may also help to inform services and improve how they support families and practitioners working in these potentially difficult situations.

Part 2 – Further Information

This section details the organisation of the study and complaint procedures if you are not happy with the conduct of the study.

Will my taking part in this study be kept confidential?

All information which is collected about you during the study will be kept strictly confidential and will be securely stored and anonymised. The report describing the research findings will be written in a way that no-one can work out that you took part in the study. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these.

To protect the security of the audio recordings an encrypted recording device will be used. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in The Essex University storage repository for a period of 2-4 years.

All data will be processed in accordance with the General Data Protection Act 2018. Responsible members of the Tavistock and Portman Foundation NHS Trust may be given access to data for monitoring and/or audit of the study to ensure the study is being carried out correctly and complying with regulations. Access to paper and electronic files would be given to authorised people, which would be set up on a limited basis for the duration of the monitoring/audit period. All will have a duty of confidentiality to you as a research participant. See https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/ for more information.

There is one important exception to the guarantee of confidentiality. If you tell us something that suggests that you or others are being placed at risk of significant harm, we are obliged to pass this information on. We will talk to you about the procedures involved before the information is shared.

Who has reviewed the study?

This research has been reviewed by an independent group of people, called a Research Ethics Committee who are there to protect your safety, rights, well-being and dignity. This research has been formally approved by the Tavistock Research Ethics Committee and by the NHS Health Research Authority.

What will happen to the results of the research study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Advanced Systemic Psychotherapy Practice and Research at The Tavistock and Portman NHS Foundation Trust. The research may also be published in academic journals or presented at conferences.

What would happen if I don’t want to continue with the study?

You are free to withdraw from the study without having to give a reason. Withdrawing from the study will not affect you in any way. You will be able to withdraw the information that you have shared during the interview up until the analysis of this has commenced, after which withdrawal will no longer be possible as the information will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point your information will be destroyed.

Who should I contact for further information?

If you would like to participate in this research, have any questions or require more information about the study, please contact me, the Chief Investigator, using the following contact details:

Elizabeth Darwell
Family Therapist (CAMHS)

Rivendell House
Union Street
Driffield
YO23 6AT
Tel 01377 208 280
Mobile 07903 303 699
Email: elizabeth.darwell@nhs.net

What if I have further questions, or if something goes wrong?

If you have any queries about the conduct of the study, or wish to make a complaint you can contact the Trust Quality Assurance Officer using the details below:

Simon Carrington: academicquality@tavi-port.nhs.uk
Quality Assurance
The Tavistock and Portman NHS Foundation Trust
The Tavistock Centre
120 Belsize Lane London
NW3 5BA

Appendix C

The Tavistock and Portman NHS
NHS Foundation Trust

PARTICIPANT INFORMATION SHEET (clinicians)

Research Study:

How does the perception of risk affect relationships between clinicians and parents/carers in a Child and Adolescent Mental Health Service (CAMHS)?

We would like to invite you to take part in a research study. Whether or not you wish to take part is entirely up to you. Before you decide it is important for you to understand why the research is being done and what it will involve. To help you decide please take time to read the following information carefully. Feel free to talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information.

Please take the time to decide whether you wish to take part

Part 1 of this leaflet tells you the purpose of this research and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the research.

Part 1 - Overview of the Study

What is the purpose of the study?

We know that positive relationships between CAMHS clinicians and families are important in improving outcomes for young people in CAMHS. Less is known about how these relationships are affected when concerns about risk increases. This study is looking to understand more about how clinicians and the carers of young people in CAMHS experience their relationships with one another when situations are feeling unsafe. The hope is that this study will increase understanding in order to improve service provision.

Why have I been invited to take part?

You have been invited to participate in this study because you are a Clinician working with young people and their families in CAMHS. This information has been given to you because you have expressed an interest in participating in this research study. You can take part if you have been qualified for at least a year and have had experience working with and managing situations that have felt risky or unsafe within the last 3 months.

What will happen if I take part?

If you would like to take part you can contact me, Liz Darwell, via the email or phone number below. We will then arrange a meeting at a convenient place and time. A video conference call may be used if it is not possible or convenient to meet in person. I will ask you to answer some short questions about you, for example your gender, age, profession and ethnicity. Then you will have a conversation with me about your experiences which will last around 60-90 minutes. I will audio record the discussion. There are no right or wrong answers and I am only interested in your experiences and stories. Once I have transcribed the interview you will be offered a copy and I would welcome any comments you might have.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. If you decide to take part I will ask you to sign a consent form and you will be given a copy to keep.

What are the possible risks of taking part?

You may experience emotional distress when talking about your experiences as it may bring to mind difficult memories. If this happens to you I will offer support, and if required, discuss other support options that are available, such as a referral to occupational health.

What are the possible benefits of taking part?

There cannot be any promise that you will have any direct benefit from taking part in the study. However, it is hoped that the study will offer you the opportunity to have your voice heard and to generate greater insights into your practice. The findings may also help to inform services and improve how they support families and practitioners working in these potentially difficult situations.

Part 2 – Further Information

This section details the organisation of the study and complaint procedures if you are not happy with the conduct of the study.

Will my taking part in this study be kept confidential?

All information which is collected about you during the research will be kept strictly confidential and will be securely stored and anonymised. The research report will be written in a way that no-one can work out that you took part in the study. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these.

To protect the security of the audio recordings an encrypted recording device will be used. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in The Essex University storage repository for a period of 2-4 years.

All data will be processed in accordance with the General Data Protection Act 2018. Responsible members of the Tavistock and Portman Foundation NHS Trust may be given access to data for monitoring and/or audit of the study to ensure the study is being carried out correctly and complying with regulations. Access to paper and electronic files would be given to authorised people, which would be set up on a limited basis for the duration of the monitoring/audit period. All will have a duty of confidentiality to you as a research participant. See https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/ for more information.

There is one important exception to the guarantee of confidentiality. If you tell us something that suggests that you or others are being placed at risk of significant harm, we are obliged to pass this information on. We will talk to you about the procedures involved before the information is shared.

Who has reviewed the study?

This research has been reviewed by an independent group of people, called a Research Ethics Committee who are there to protect your safety, rights, wellbeing and dignity. This research has been formally approved by the Tavistock Research Ethics Committee and by the NHS Health Research Authority.

What will happen to the results of the research study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Advanced Systemic Psychotherapy Practice and Research at The Tavistock and Portman NHS Foundation Trust. The research may also be published in academic journals or presented at conferences.

What would happen if I don't want to continue with the study?

You are free to withdraw from the study without having to give a reason. Withdrawing from the study will not affect you in any way. You will be able to withdraw the information that you have shared during the interview up until the analysis of this has commenced, after which withdrawal will no longer be possible as the information will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point your information will be destroyed.

Who should I contact for further information?

If you would like to participate in this research, have any questions or require more information about this study, please contact me, the Chief Investigator, using the following contact details:

Elizabeth Darwell
Family Therapist (CAMHS)
Rivendell House
Union Street
Driffield
YO23 6AT
Tel 01377 208 280
Mobile 07903 303 699
Email: elizabeth.darwell@nhs.net

What if I have further questions, or if something goes wrong?

If you have any queries about the conduct of the study, or wish to make a complaint you can contact the Trust Quality Assurance Officer using the details below:

Simon Carrington: academicquality@tavi-port.nhs.uk
Quality Assurance
The Tavistock and Portman NHS Foundation Trust
The Tavistock Centre
120 Belsize Lane London
NW3 5BA

Appendix D

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Ms Elizabeth Darwell
Family Therapist
Humber NHS Foundation Trust
Rivendell House
Union Street
Driffield
YO25 6ATN/A

13 September 2021

Dear Ms Darwell

HRA and Health and Care Research Wales (HCRW) Approval Letter

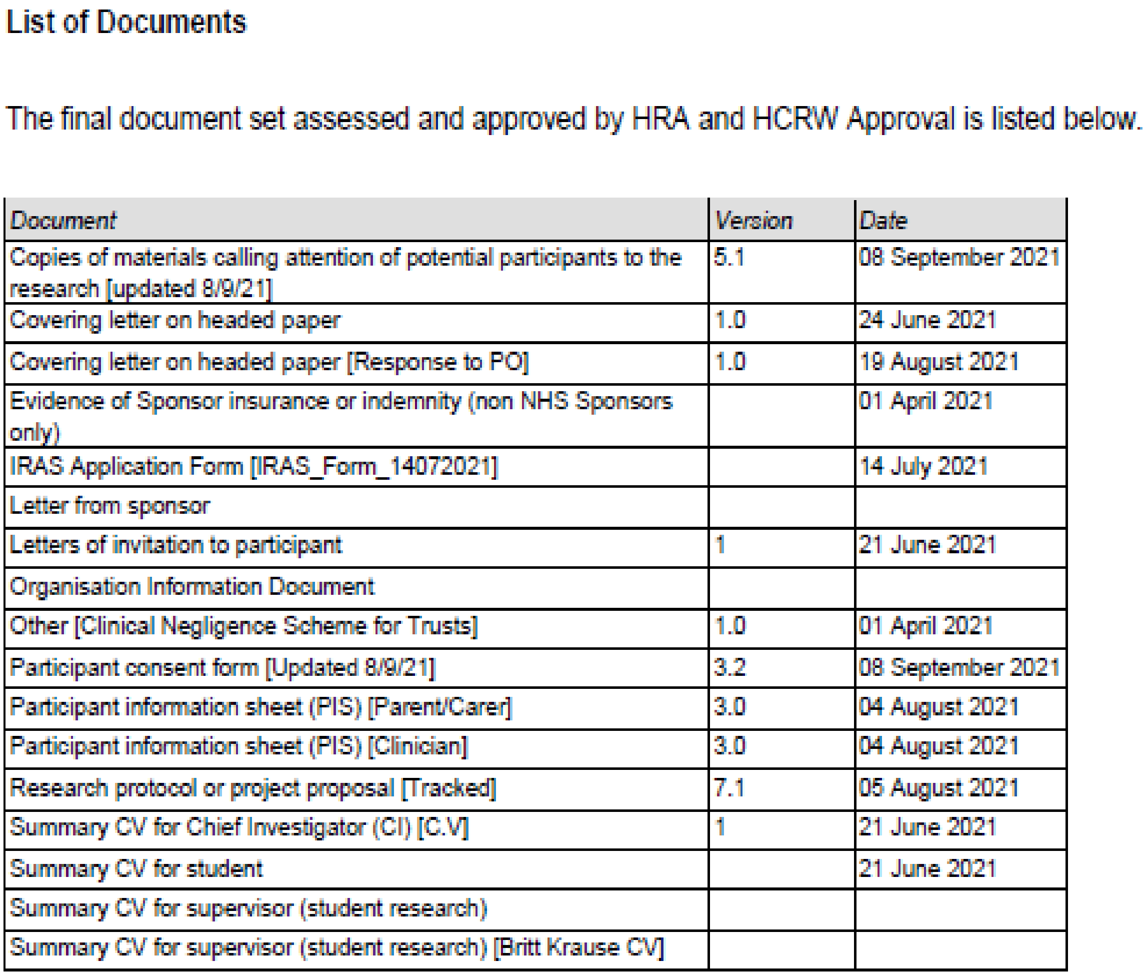
Study title:	**Risk perception and its effect on therapeutic relationships in a Child and Adolescent Mental Health Service: A Dialogical Narrative Analysis**
IRAS project ID:	**299593**
Protocol number:	**N/A**
REC reference:	**21/WS/0084**
Sponsor	**The Tavistock and Portman NHS Foundation Trust**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [updated 8/9/21]	5.1	08 September 2021
Covering letter on headed paper	1.0	24 June 2021
Covering letter on headed paper [Response to PO]	1.0	19 August 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		01 April 2021
IRAS Application Form [IRAS_Form_14072021]		14 July 2021
Letter from sponsor		
Letters of invitation to participant	1	21 June 2021
Organisation Information Document		
Other [Clinical Negligence Scheme for Trusts]	1.0	01 April 2021
Participant consent form [Updated 8/9/21]	3.2	08 September 2021
Participant information sheet (PIS) [Parent/Carer]	3.0	04 August 2021
Participant information sheet (PIS) [Clinician]	3.0	04 August 2021
Research protocol or project proposal [Tracked]	7.1	05 August 2021
Summary CV for Chief Investigator (CI) [C.V]	1	21 June 2021
Summary CV for student		21 June 2021
Summary CV for supervisor (student research)		
Summary CV for supervisor (student research) [Britt Krause CV]		

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

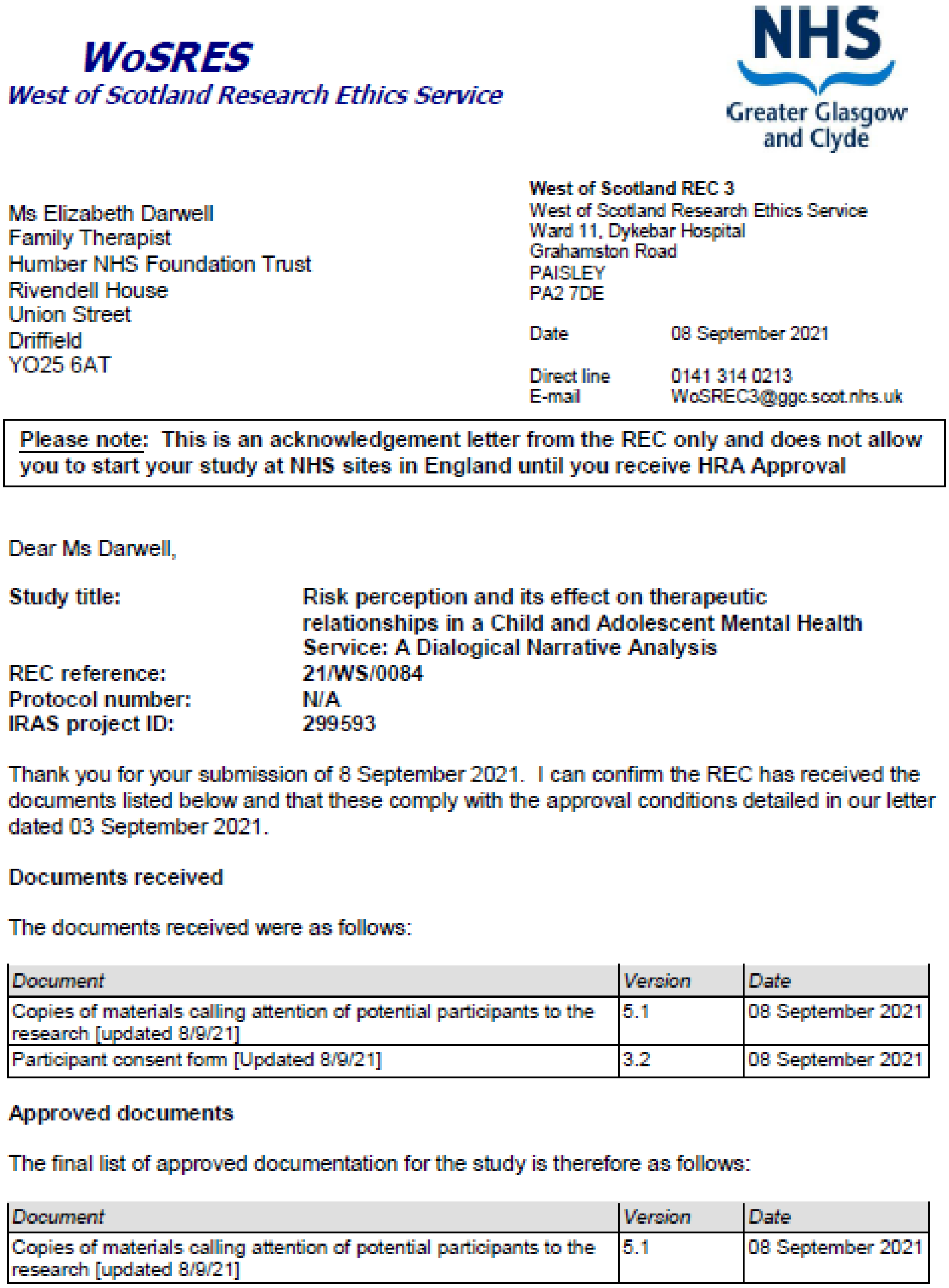
Your IRAS project ID is 299593. Please quote this on all correspondence.

Yours sincerely,
Hayley Henderson
Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Dr Brian Rock, Sponsor Contact*

Appendix E



WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow
and Clyde

Ms Elizabeth Darwell
Family Therapist
Humber NHS Foundation Trust
Rivendell House
Union Street
Driffield
YO25 6AT

West of Scotland REC 3
West of Scotland Research Ethics Service
Ward 11, Dykebar Hospital
Grahamston Road
PAISLEY
PA2 7DE

Date 08 September 2021

Direct line 0141 314 0213
E-mail WoSREC3@ggc.scot.nhs.uk

Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

Dear Ms Darwell,

Study title:	**Risk perception and its effect on therapeutic relationships in a Child and Adolescent Mental Health Service: A Dialogical Narrative Analysis**
REC reference:	**21/WS/0084**
Protocol number:	**N/A**
IRAS project ID:	**299593**

Thank you for your submission of 8 September 2021. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 03 September 2021.

Documents received

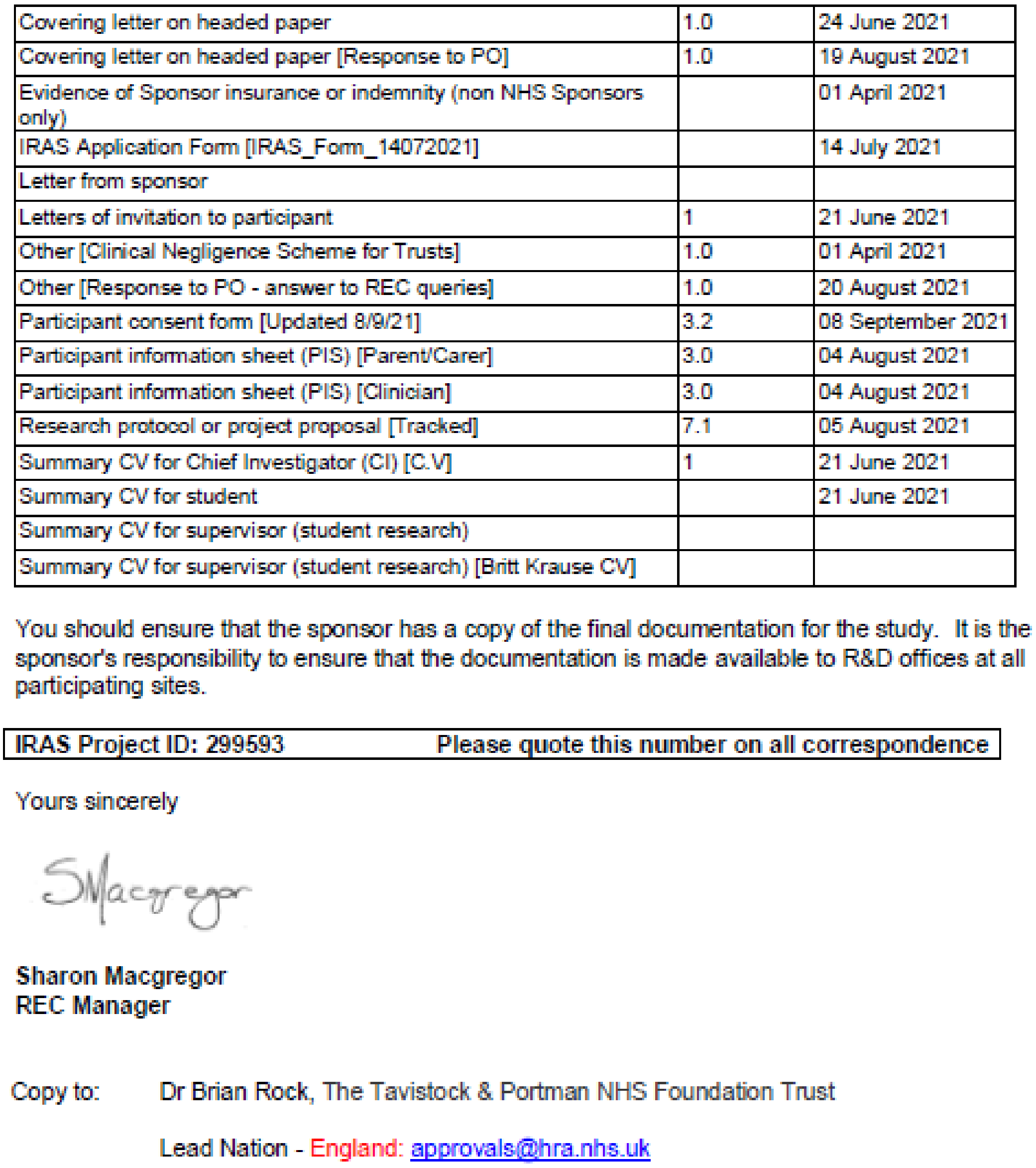
The documents received were as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [updated 8/9/21]	5.1	08 September 2021
Participant consent form [Updated 8/9/21]	3.2	08 September 2021

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [updated 8/9/21]	5.1	08 September 2021



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Summary CV for student		21 June 2021
Summary CV for supervisor (student research)		
Summary CV for supervisor (student research) [Britt Krause CV]		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

IRAS Project ID: 299593 Please quote this number on all correspondence

Yours sincerely

SMacgregor

Sharon Macgregor
REC Manager

Copy to: Dr Brian Rock, The Tavistock & Portman NHS Foundation Trust

Lead Nation - England: approvals@hra.nhs.uk

Appendix F

CAMHS context

Prior to the mid 1970s, there were two mental health service provisions for children and young people: the community child guidance clinics which responded to less severe mental health problems, leaving the more severe problems treated by psychiatrists in a hospital setting (Barrett, 2019). Throughout the 1950's there were attempts made to integrate these two services, but this proved problematic due to differences of opinion regarding treatment approaches and disagreements over who should be in charge. There were those who saw psychological problems as resulting from social factors, such as poverty, others who viewed family relationships as key in creating 'maladjustment'.

The work of Melanie Klein and Sigmund Freud introduced the idea of the 'internal life' of the child in the 1930s, meaning that treatment could be delivered without the contribution of the caregiver. Later, John Bowlby's (1969) work served to bring the focus back onto relationships with his seminal work demonstrating the importance of attachment stability for good mental health in children. It continues to remain the case today, 90 years on, that the different disciplines typically comprising a CAMHS team – psychiatry, psychology, psychotherapy and nursing, continue to maintain different views on both the causes of mental distress, the responses (treatment) needed, and who these responses should involve.

In 1987 an integrated NHS child and adolescent mental health service was finally established but the process of co-ordinating two very distinct services was fraught with difficulty; they were funded through different sources and underpinned by contrasting ideas and approaches. Almost a decade on from this, Together We Stand (1995) was published, a report which set out to review CAMH services, and which highlighted years of disjointed organisation and regional inequality.

A review of CAMHS policy between 2000 and 2015 was undertaken and evidenced:

"a shift from seeing children's mental health challenges as produced by social and economic inequities, to a view that children's mental health must be addressed early to prevent future socio-economic burden" (Callaghan, et al, 2017).

Callaghan et al (2017) revealed through their CAMHS policy analysis, a clear shift in terminology used in post 2010 policies indicating increased individualisation, medicalisation, and professionalisation of children's distress, thereby positioning mental health as a predominantly bio-medical problem solvable through mental health professionals delivering the best evidence-based treatments.

In contrast, pre-2010 mental health policy for CAMHS was focussed specifically on children and young people, before a clear change occurred post-2010 whereby children's mental health needs were incorporated into the wider remit of 'mental health', through a catch-all policy focus. In 'Every Child Matters' (2003) children had been described as "precious" (p3) and in need of the correct support to foster their development so that they may reach their potential. In contrast, 'No Health Without Mental Health' (2011) sees children incorporated into the broad term 'people', with the focus being on how to keep the whole population mentally well, perhaps due to the estimate that poor mental health had cost the world economy approximately $2·5 trillion per year in poor health and reduced productivity in 2010.

The Health and Social Care Committee's Inquiry into Children and Young People's Mental Health in December 2021 stated that the mental health of children and young people had worsened since 2017 and even before the Covid pandemic in 2019, children and young people were facing a mental health crisis. Calls for change within mental health services and CAMHS continue to be made, and transformation, expansion, new concepts, and different approaches, continue to be offered.

Despite the work undertaken to address these issues, CAMH services in 2023 arguably remain in a state of disorganisation and confusion. Young people's mental health needs are responded to by a range of organisations, including the NHS, local authorities, and the private and voluntary sectors. Within these organisations there is an increasing array of services, specialisms and disciplines targeting specific groups, disorders, or levels of need. Both between and within these services, exists varying and often conflicting views regarding the nature of poor mental health, the increase in distress that is being witnessed within this population, and what responses are needed.